# *C. ACCESSING SERVICES*

- Consistent with the Health and Human Services Agency's "No Wrong Door" policy (BHIN 22-011) , clients may access mental health services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), call or walk into an organizational provider's program directly, or walk into a County-operated program.

- Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services, and the Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services, MCPs are required to provide or arrange for the provision of the following non-specialty mental health services (NSMHS):

    - Mental health evaluation and treatment, including individual, group and family psychotherapy.

    - Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.

    - Outpatient services for purposes of monitoring drug therapy.

    - Psychiatric consultation.

    - Outpatient laboratory, drugs, supplies, and supplements.

- The county MHP shall provide or arrange for clinically appropriate, covered SMHS to include prevention, screening, assessment, treatment services. These services are covered and reimbursable even when:

    - Services were provided prior to determining a diagnosis, during the assessment, or prior to determination of whether NSMHS or SMHS access criteria are met.

    - The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

    - The beneficiary has a co-occurring mental health condition and substance use disorder; or

    - NSMHS and SMHS services are provided concurrently if those services are coordinated and not duplicated.

## Screening for Access to Specialty Mental Health Services

- All referrals shall be **screened** by a clinician for access criteria for specialty mental health services and appropriate level of care. Screening will facilitate timely and appropriate services

which are family centered and support maximizing capacity at the Organizational Provider level. Direct referrals from the Access and Crisis Line (ACL) do not require program screening as screening was completed by the ACL, and therefore an assessment appointment shall be offered. *See Screening Tools information in this section for more information*.

- In addition to the use of natural community resources, the **Outpatient Level of Care** consists of:
    - Primary Care Physician through Medical Home and Health Plans
    - Fee For Service (FFS) Network via Access and Crisis Line (ACL)
    - Organizational Provider
    - Children/Youth who present with safety risk factors may require a 911 contact and/or an evaluation at the Emergency Screening Unit (ESU) to determine need for crisis stabilization or inpatient psychiatric care.

## *SMHS Provided During the Assessment Period Prior to Determination of a Diagnosis or Prior to Determination of Whether SMHS Access Criteria Are Met*

- Clinically appropriate SMHS are covered and reimbursable during the assessment process prior to determination of a diagnosis or a determination that the beneficiary meets access criteria for SMHS. Services rendered during the assessment period remain reimbursable even if the assessment ultimately indicates the beneficiary does not meet criteria for access to SMHS.

- MHPs must not deny or disallow reimbursement for SMHS provided during the assessment process described above if the assessment determines that the beneficiary does **not** meet criteria for access to SMHS or meets the criteria for NSMHS.

- MHPs, DMC and DMC-ODS programs and providers may use the following options during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established:

    - ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances" may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision of, a Licensed Practitioner of the Healing Arts (LPHA) or Licensed Mental Health Professional (LMHP).

    - ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA or LMHP during the assessment phase of a beneficiary's treatment when a diagnosis has yet to be established.

    - In cases where services are provided due for a suspected disorder that has not yet been diagnosed, options are available for an LPHA or LMPH in the CMS-approved ICD-10 diagnosis code list11, which may include Z codes. LPHA and LMHP may use any clinically appropriate ICD-10 code12.

- For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services."

## Access Criteria for Adult/Older Adult Outpatient Specialty Mental Health Services

- As specified in Welfare and Institutions Code section 14184.402, the revised definitions and criteria below are effective January 1, 2022. AB 133 gives DHCS authority to implement the criteria for access to SMHS and medical necessity through BHIN 20-073 and supersedes California Code of Regulations (CCR), title 9, sections 1830.205 and 1830.210 and other guidance published prior to January 1, 2022 regarding access criteria for MHP reimbursement of SMHS (other than psychiatric inpatient hospital and psychiatric health facility services) until DHCS implements new regulations by July 1, 2024.

- For beneficiaries **21 years of age or older**, a county mental health plan shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
    a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
    b. A reasonable probability of significant deterioration in an important area of life functioning.

**AND**

2. The beneficiary's condition as described in paragraph (1) is due to either of the following:
    a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
    b. A suspected mental disorder that has not yet been diagnosed.

## Access Criteria for Children and Youth Outpatient Specialty Mental Health Services

- Welfare and Institutions Code section 14184.402(i), outlines Access Criteria for Specialty Mental Health Services. For enrolled beneficiaries under 21 years of age, a county mental health plan shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r)(5) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria, (1) or (2) below:

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness (Note: Children/Youth meeting medical necessity due to significant trauma shall be based on the assessment of a licensed mental health professional.).

**OR**

**2.** The beneficiary meets **both of the following** requirements in a) and b) below:

a. The beneficiary has **at least one** of the following:

i. significant impairment

ii. A reasonable probability of significant deterioration in an important area of life functioning

iii. A reasonable probability of not progressing developmentally as appropriate.

iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide.

**AND**

b) The beneficiary's condition as described in subparagraph (2) above is due to **one of the following:**

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.

ii. A suspected mental health disorder that has not yet been diagnosed.

iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

- If a beneficiary under age 21 meets the criteria as described in (1) above, the beneficiary meets criteria to access SMHS; it is not necessary to establish that the beneficiary also meets the criteria in (2) above.

## *Co-occurring Substance Use Disorder*

- Clinically appropriate and covered SMHS delivered by MHP providers are covered Medi-Cal services whether or not the beneficiary has a co-occurring SUD. MHPs must not deny or

disallow reimbursement for SMHS provided to a beneficiary who meets SMHS criteria based on the beneficiary having a co-occurring SUD, when all other Medi-Cal and service requirements are met. Similarly, clinically appropriate, and covered Drug Medi-Cal (DMC) services delivered by DMC providers and Drug Medi-Cal Organized Delivery System (DMC-ODS) services delivered by DMC-ODS providers are covered by DMC counties and DMC-ODS counties, respectively, whether or not the beneficiary has a co-occurring mental health condition.

- Likewise, clinically appropriate and covered NSMHS are covered Medi-Cal services via the FFS and MCP delivery systems whether or not the beneficiary has a co-occurring SUD. Similarly, clinically appropriate, and covered SUD services delivered by MCP providers (e.g., alcohol and drug screening, assessment, brief interventions, and referral to treatment; MAT) are covered by MCPs whether or not the member has a co-occurring mental health condition.

## *Concurrent NSMHS and SMHS*

- Beneficiaries may concurrently receive NSMHS via FFS or MCP provider and SMHS via a MHP provider when the services are clinically appropriate, coordinated and not duplicative.

- When a beneficiary meets criteria for access to both NSMHS and SMHS, the beneficiary should receive services based on individual clinical need and established therapeutic relationships. MHPs must not deny or disallow reimbursement for SMHS provided to a beneficiary based on the beneficiary also meeting NSMHS criteria and/or also receiving NSMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

- Likewise, MCPs must not deny or disallow reimbursement for NSMHS provided to a beneficiary based on the beneficiary also meeting SMHS criteria and/or receiving SMHS services, provided that the concurrent services are clinically appropriate, coordinated and not duplicative. Any concurrent NSMHS and SMHS for adults, as well as children under 21 years of age, must be coordinated between MCPs and MHPs to ensure beneficiary choice. MHPs must coordinate with MCPs to facilitate care transitions and guide referrals for beneficiaries receiving SMHS to transition to a NSMHS provider and vice versa, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a patient-centered shared decision-making process.

- Beneficiaries with established therapeutic relationships with a FFS or MCP provider may continue receiving NSMHS from the FFS or MCP provider (billed to FFS or the MCP), even if they simultaneously receive SMHS from an MHP provider (billed to the MHP), as long as the services are coordinated between these delivery systems and are non-duplicative (e.g., a beneficiary may only receive psychiatry services in one network, not both networks; a beneficiary may only access individual therapy in one network, not both networks).

- Beneficiaries with established therapeutic relationships with a MHP provider may continue receiving SMHS from the MHP provider (billed to the MHP), even if they simultaneously receive NSMHS from an FFS provider or MCP provider (billed to FFS or the MCP), as long as the services are coordinated between these delivery systems and are non-duplicative.

## Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

- The Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (i.e. "Medi-Cal Transformation") initiative for "Screening and Transition of Care Tools for Medi-Cal Mental Health Services" aims to ensure all Medi-Cal beneficiaries receive coordinated services across Medi-Cal mental health delivery systems and improve health outcomes. The goal is to ensure beneficiary access to the right care, in the right place, at the right time.

- The Screening and Transition of Care Tools for Medi-Cal Mental Health Services guide referrals to the Medi-Cal mental health delivery system (i.e., Medi-Cal Managed Care Health Plan (MCP) or MHP) that is expected to best support each beneficiary. DHCS is requiring MCPs and MHPs to use the Screening and Transition of Care Tools – for beneficiaries under age 21 (youth) and for beneficiaries age 21 and over (adults). (BHIN 22-065)

- The *Screening and Transition of Care Tools for Medi-Cal Mental Health Services* consist of:

    1. The Adult Screening Tool for Medi-Cal Mental Health Services.
    2. The Youth Screening Tool for Medi-Cal Mental Health Services.
    3. The Transition of Care Tool for Medi-Cal Mental Health Services.

## Adult and Youth Screening Tool

- The Adult and Youth Screening Tools determine the appropriate delivery system referral for beneficiaries who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The Screening Tools are not required or intended for use with beneficiaries who are currently receiving mental health services. The Screening Tools are also not required for use with beneficiaries who contact mental health providers directly to seek mental health services.

- Mental health providers who are contacted directly by beneficiaries seeking mental health services are able to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the *No Wrong Door for Mental Health Services Policy* described in BHIN 22-011 or subsequent updates.

- The Screening Tool will be completed by either the MCP or Optum ACL and if deemed appropriate, a referral will be made to the appropriate individual FFS or organizational

provider. Upon receiving the referral, the provider/program will ensure that Timeliness Standard requirements are followed.

- The Adult and Youth Screening Tools do **not** replace:
    - MHP policies and procedures (P&P) that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
    - MHP protocols that address clinically appropriate, timely, and equitable access to care.
        - MHP clinical assessments, level of care determinations, and service recommendations.
        - MHP requirements to provide EPSDT services.
- *Completion of the Adult or Youth Screening Tool is <u>not considered an assessment</u>. Once a beneficiary is referred to the MCP or MHP, they shall receive an assessment from a provider in that system to determine medically necessary mental health services*.

## *<u>Description of the Adult and Youth Screening Tools</u>*

- The Adult and Youth Screening Tools are designed to capture information necessary for identification of initial indicators of a beneficiary's mental health needs for the purpose of determining whether the MHP must refer the beneficiary to their MCP or to an MHP provider (county-operated or contracted) to receive an assessment. The Adult and Youth Screening Tools include both screening questions and an associated scoring methodology. The screening questions and associated scoring methodology of the Adult and Youth Screening Tools are distinct and described below.

## *<u>Adult Screening Tool</u>*

- The Adult Screening Tool includes screening questions that are intended to elicit information about the following:
    - <u>Safety</u>: information about whether the beneficiary needs immediate attention and the reason(s) a beneficiary is seeking services.
    - <u>Clinical Experiences</u>: information about whether the beneficiary is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.

- Life Circumstances: information about challenges the beneficiary may be experiencing related to school, work, relationships, housing, or other circumstances.

- Risk: information about suicidality, self-harm, emergency treatment, and hospitalizations*
  - *If the beneficiary responds affirmatively to the question related to suicidality, the MHP must immediately coordinate referral to an MHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.

  - Referral coordination should include sharing the completed Adult Screening Tool and follow up to ensure an evaluation was rendered. The referral and subsequent evaluation may or may not impact the mental health system referral generated by the screening score.

- The Adult Screening Tool also includes questions related to substance use disorder (SUD). If a beneficiary responds affirmatively to these SUD questions, they shall be offered a referral to the county behavioral health plan for SUD assessment. The beneficiary may decline this referral without impact to their mental health delivery system referral.

## *Youth Screening Tool*

- The Youth Screening Tool includes screening questions designed to address a broad range of indicators for beneficiaries under the age of 21. A distinct set of questions are provided for when a beneficiary under the age of 21 is contacting the MHP on their own. A second set of questions with slightly modified language is provided for use when a person is contacting the MHP on behalf of a beneficiary under the age of 21.

- The Youth Screening Tool screening questions are intended to elicit information about the following:

  - Safety: information about whether the beneficiary needs immediate attention and the reason(s) a beneficiary is seeking services.

  - System Involvement: information about whether the beneficiary is currently receiving treatment and if they have been involved in foster care, child welfare services, or the juvenile justice system.

  - Life Circumstances: information about challenges the beneficiary may be experiencing related to family support, school, work, relationships, housing, or other life circumstances.

- Risk: information about suicidality, self-harm, harm to others, and hospitalizations.

    - *If the beneficiary responds affirmatively to the question related to suicidality, the MHP must immediately coordinate referral to an MHP provider (county-operated or contracted) for further clinical evaluation of suicidality after the screening is complete.

    - Referral coordination should include sharing the completed Adult Screening Tool and follow up to ensure an evaluation was rendered. The referral and subsequent evaluation may or may not impact the mental health system referral generated by the screening score.

- The Youth Screening Tool includes questions related to SMHS access and referral of other services. Specifically:

    - Questions related to SMHS access criteria, including those related to involvement in foster care or child welfare services, involvement in the juvenile justice system, and experience with homelessness. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the questions related to SMHS access criteria, they shall be referred to the MHP for an assessment and medically necessary services.

    - Please reference BHIN 23-041 for additional detail on SMHS criteria and definitions of key terminology.

    - A question related to substance use. If a beneficiary under the age of 21, or the person on their behalf, responds affirmatively to the question related to substance use, they shall be offered a referral to the county behavioral health plan for SUD assessment. The beneficiary may decline this referral without impact to their mental health delivery system referral.

## Administering the Adult and Youth Screening Tools

- The Adult and Youth Screening Tools can be administered by clinicians or non-clinicians in alignment with MHP protocols and may be administered in a variety of ways, including in person, by telephone, or by video conference. Adult and Youth Screening Tool questions shall be asked in full using the specific wording provided in the tools and in the specific order the questions appear in the tools, to the extent that the beneficiary is able to respond.

- Additional questions shall not be added to the tools. The scoring methodologies within the Adult and Youth Screening Tools shall be used to determine an overall score for each screened beneficiary.

- The Adult and Youth Screening Tool score determines whether a beneficiary is referred to their MCP or the MHP for assessment and medically necessary services. Please refer to the Adult and Youth Screening Tools for further instructions on how to administer each tool.
  - The Adult and Youth Screening Tools are provided as portable document formats (PDFs) and are available on the Optum Website > BHS Provider Resources> MHP Provider Documents > *UCRM* tab.

  - MHPs <u>are not required</u> to use the PDF format to administer the tools. MHPs may build the Adult and Youth Screening Tools into existing software systems, such as electronic health records (EHRs). The contents of the Adult and Youth Screening Tools, including the specific wording, the order of questions, and the scoring methodology shall remain intact.

## *<u>Following Administration of the Adult and Youth Screening Tools</u>*

- After administration of the Adult or Youth Screening Tool, a beneficiary's score is generated. Based on their screening score, the beneficiary shall be referred to the appropriate Medi-Cal mental health delivery system (i.e., either the MCP or the MHP) for a clinical assessment.

- If a beneficiary is referred to an MHP based on the score generated by MCP administration of the Adult or Youth Screening Tool, the MHP must offer and provide a timely clinical assessment to the beneficiary without requiring an additional screening and in alignment with existing standards as well as medically necessary mental health services.

- If a beneficiary shall be referred by the MHP to the MCP based on the score generated by the MHP's administration of the Adult or Youth Screening Tool, MHPs shall coordinate beneficiary referrals with MCPs or directly to MCP providers delivering NSMHS. Referral coordination shall include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the beneficiary. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice.

- The Adult and Youth Screening Tools shall not replace MHPs' protocols for emergencies or urgent and emergent crisis referrals. For instance, if a beneficiary is in crisis or experiencing a psychiatric emergency, the MHP's emergency and crisis protocols shall be followed.

- For complete instructions on how to complete the Adult and Youth Screening Tools, please refer to the *Explanation Sheets* and other resources that can be found on the

Optum Website > BHS Provider Resources> MHP Provider Documents > *UCRM* and *SmartCare* tabs.

## Transition of Care Tool

### *Description of Transition of Care Tool*

- The Transition of Care Tool is designed to leverage existing clinical information to document a beneficiary's mental health needs and facilitate a referral for a transition of care to, or addition of services from the beneficiary's MCP or MHP, as needed. The Transition of Care Tool documents the beneficiary's information and referring provider information. Beneficiaries may be transitioned to their MCP or MHP for all, or a subset of, their mental health services based on their needs. The Transition of Care Tool is designed to be used for both adults and youth alike. The Transition of Care Tool provides information from the entity making the referral to the receiving delivery system to begin the transition of the beneficiary's care.

- The Transition of Care Tool includes specific fields to document the following elements:

    - Referring plan contact information and care team.
    - Beneficiary demographics and contact information.
    - Beneficiary behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications.
    - Services requested and receiving plan contact information.

- Referring entities may provide additional documentation, such as medical history reviews, care plans, and medication lists, as attachments to the Transition of Care Tool.

- The Transition of Care Tool for Medi-Cal Mental Health Services is intended to ensure that beneficiaries who are receiving mental health services from one delivery system receive timely and coordinated care when either:

    1. Their existing services need to be transitioned to the other delivery system; or

    2. Services need to be added to their existing mental health treatment from the other delivery system consistent with the *No Wrong Door* policies regarding concurrent treatment set forth in W&I section 14184.402(f) and described in BHIN 22-011 and APL 22-005 and continuity of care requirements described in MH SUD IN 18-059 and APL18-008, or subsequent updates. The Transition of Care Tool documents beneficiary needs for a transition of care referral or a service referral to the MCP or MHP.

- The Transition of Care Tool and the Transition of Care Tool Explanation Sheet are both located on Optum Website > BHS Provider Resources> MHP Provider Documents > *Forms* tab.

- Please note: *completion of the Transition of Care Tool is not considered an assessment.*

- The Transition of Care Tool does not replace:
  - MHP P&Ps that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals.
  - MHP protocols that address clinically appropriate, timely, and equitable access to care.
  - MHP clinical assessments, level of care determinations, and service recommendations.
  - MHP requirements to provide EPSDT services.
    - *Completion of the Transition of Care Tool is not considered an assessment.*

## *Administering the Transition of Care Tool*

- MHPs are required to use the Transition of Care Tool to facilitate transitions of care to MCPs for all beneficiaries, including adults aged 21 and older and youth under age 21, when their service needs change. The determination to transition services to and/or add services from the MCP delivery system must be made by a clinician via a patient-centered shared decision-making process in alignment with MHP protocols.

- Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician. Beneficiaries shall be engaged in the process and appropriate consents obtained in accordance with accepted standards of clinical practice. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference.

- The Transition of Care Tool is provided as a PDF document, but MHPs are not required to use the PDF format to complete the tool. MHPs may build the Transition of Care Tool into existing systems, such as EHRs. However, the contents of the Transition of Care Tool, including the specific wording and order of fields, shall remain intact. The information shall be collected and documented in the order it appears on the Transition of Care Tool, and additional information shall not be added to the forms but may be included as attachments. Additional information enclosed with the Transition of Care Tool may include documentation such as medical history reviews, care plans, and medication lists.

## *Following Administration of the Transition of Care Tool*

- After the Transition of Care Tool is completed, the beneficiary shall be referred to their MCP, or directly to an MCP provider delivering NSMHS if appropriate processes have been established in coordination with MCPs. Consistent with BHIN 22-011 and APL 22-005, or

subsequent updates, MHPs shall coordinate beneficiary care services with MCPs to facilitate care transitions or addition of services, including ensuring that the referral process has been completed, the beneficiary has been connected with a provider in the new system, and the new provider accepts the care of the beneficiary, and medically necessary services have been made available to the beneficiary. All appropriate consents shall be obtained in accordance with accepted standards of clinical practice.

| Health Plan | Transition Tool Referrals & Contact |
|---|---|
| **Blue Shield CA Promise Health Plan** | BSCPromiseCMC@beaconhealthoptions.com |
| **Community Health Group** | Salvador Tapia<br>1-800-404-3332<br>Stapia@chgsd.com |
| **Kaiser Permanente** | Transition Tools Fax: 858-451-5199<br>Questions: Michelé Buland<br>Michele.k.buland@kp.org |
| **Molina Healthcare** | Adults: (833) 234-1258 – Care Mngmnt<br>Email: CMescalationCA@MolinaHealthCare.Com and<br>cc: MHC_BH_Solutions@MolinaHealthcare.com<br><br>Youth: (562) 506-1249 – Care Mngmnt<br>Email: MHCHealthcareservicesCCS/RCCasemanagement@MolinaHealthcare.com<br>and cc: MHC_BH_Solutions@MolinaHealthcare.com |

## Network Adequacy

- The State requires County Behavioral Health Plans (which include Mental Health Plans and DMC-ODS Plans) to comply with BHIN 24-020 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, BHP's 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 monthly for these purposes.

- The System of Care (SOC) Application hosted by Optum (BHS' Administrative Services Organization) is intended to streamline workflows and provide data collection related to

Network Adequacy. Additionally, the information from the SOC Application is used to create information used for the Provider Directory which is also a state requirement.

## Required Actions on the SOC Application

1. Registration
    a. 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. Until further notice, Program Managers can submit modification forms as needed to maintain the provider roster:
        i. MH: MHEHRAccess.Request.HHSA@sdcounty.ca.gov
        ii. SUD: SUDEHRSupport.HHSA@sdcounty.ca.gov

3. Monthly Attestations
    a. Staff/Providers and Program Managers are required to attest to the accuracy of all SOC information monthly.

- For tips, FAQs, and other resources on how to complete registration and attestations on the SOC Application, visit the SOC Tips and Resources webpage on the Optum Website. If direct assistance is needed, providers should contact the Optum Support Desk:

Optum Support Desk
1-800-834-3792
sdhelpdesk@optum.com

## Provider to Member Ratio Requirements

- DHCS has established specific practitioner-to-member ratio standards for mental health services to ensure adequate access to care. San Diego BHP organization providers are expected to ensure sufficient staff to meet these ratios.

| Category | Practitioner Classifications | Ratio Standard |
|---|---|---|
| Psychiatry – Adults (ages 21+) | Psychiatrists, Physicians, PMHNPs (non-psychiatry NPs excluded) | 1:457 |
| Psychiatry – Children/Youth (ages 0-20*) | | 1:267 |
| Mental Health Services – Adults | | 1:85 |

| | | |
|---|---|---|
| (ages 21+) | Clinical SW Trainee, ACSW, LCSW, MFT Clinical Trainee, AMFT, LMFT, Professional Counselor Clinical Trainee, APCC, LPCCs, Psychologist Clinical Trainee Psychologists, WAP, LVN, RN, CNS, Psychiatric Technicians, MHRS, PA, Pharmacists | |
| Mental Health Services – Children/Youth (ages 0-20*) | | 1:49 |

*The children/youth age range is from birth through age 20 years, up to but not including the 21st birthday.

## Timely Access Standards

- In Accordance with BHIN 24-020, Behavioral Health Plans (BHPs) are required to have a system in place for tracking and measuring timeliness of care. To align with the Department of Health Care Services (DHCS) documentation requirements recorded inquiries should be documented within three (3) business days of the request for services in the electronic health record, with the exception of emergent or urgent type which shall be completed within one (1) calendar day.

    - To see a step by step guide for documenting timely access to services for non-psychiatric SMHS How to Complete the MH Non-Psychiatric SMHS Timeliness Record - 2023 CalMHSA and psychiatric SMHS How to Complete the MH Psychiatric SMHS Timeliness Record - 2023 CalMHSA.

- BHPs must use the TADT to report on new members who request a non-psychiatry SMHS, and any new or established member requests for psychiatric services. If the BHP is determined to not meet network adequacy requirements and the provider is unable to provide timely access to necessary services, the BHP shall adequately and timely cover these services Out of Network (OON) for the member. The BHP must permit OON access for as long as the BHP's provider network is unable to provide the services in accordance with the standards. For further guidance, please see BHIN 21-008, BHIN 24-020.

- MHPs are required to submit timely access data for the following:

    - An urgent or non-urgent appointment with a non-physician mental health provider of an outpatient SMHS;

    - An urgent or non-urgent appointment with a provider of psychiatry;

- Non-urgent follow-up appointments with a non-physician mental health provider; and

- Appointments with OON providers in cases where appointments with network providers are not available within timely access standards.

- DHCS calculates compliance using the Date of First Contact to Request Services and the number of business days between that date and the date of the first **available** appointment that qualifies as a billable service. For a BHP to be in compliance with the timely access standards, 80% of members must have been **offered** an available appointment within the applicable time frame.

- The access times listed below apply for all children, youth, adolescents, adults and older adults accessing care under the MHP. Programs shall issue a Notice of Adverse Benefit Determination (NOABD) when the access standard in the table below is not met. (See OPOH Section F: Beneficiary Rights, Grievance & Appeals for NOABD requirements).

**Timely Access Standards**

| Service Type | Standard* |
|---|---|
| Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services | Offered an appointment within 10 business days of request for services. |
| Psychiatric Services | Offered an appointment within 15 business days of request for services. |
| All SMHS Urgent Appointments | Urgent Care:**<br>48 hours without prior authorization.<br>96 hours with prior authorization. |
| Non-urgent Follow-up Appointments | Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.[27] |

*The above standards apply unless the waiting time for an appointment is extended pursuant to HCS 1367.03(a)(5)(H) or 28 CCR section1300.67.2.2(c)(5)(H).

** 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..[28]

- ***Urgent Condition:*** The County further refers to an "Urgent" as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

- **Non-Urgent (Routine) Condition:** A "Non-Urgent (Routine) Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services (SMHS).

## Out of Network (OON) Access

- The State requires Behavioral Health Plans (BHPs) to comply with BHIN 24-020 and BHIN 21-008 to ensure covered services are available, accessible, and in accordance with timely access and time or distance standards per the Medicaid Managed Care Final Rule (Mega Regs). Providers are expected to refer clients to in-network providers when arranging for services related to the beneficiary's care. If required treatment services are not available adequately and timely within the County of San Diego provider network, the member may access required services from an out-of-network (OON) provider. The County of San Diego contracts with Optum as its Administrative Services Organization (ASO) for the execution of OON accommodation agreements.

### *Procedure for Out-of-Network Service Access*

1. Accommodation Agreements with OON providers are executed when one or more of the following criteria are met:

    a. There are no San Diego County network providers within a reasonable geographic range who meet the cultural, ethnic, and/or clinical needs of the beneficiary

    b. Treatment by an OON is in the best clinical interest of the beneficiary as determined by County of San Diego Behavioral Health Services (BHS)

    c. Special requests made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds

2. Providers who determine medically necessary SMHS or SUD treatment and cannot provide the indicated level of care shall provide case management services and assist the beneficiary in contacting the ASO's Access and Crisis Line at 888-724-7240 (TTYL 711) for information and referral to an OON SUD provider and facilitate a warm-handoff of the beneficiary to the identified OON SUD provider capable of meeting their individualized needs.

3. In cases where an OON provider is not available within the time or distance standard, the ASO will identify a provider who can deliver services via telehealth. If the beneficiary does

not want to receive services via telehealth, ASO staff will work with the County of San Diego to arrange transportation of the beneficiary to an in-person visit.

4. On behalf of the County MHP or DMC-ODS plan, the ASO will manage the OON request service approvals. Upon receipt of the request, the ASO shall send the beneficiary written acknowledgement of receipt of the request and begin the process within three (3) working days.

5. ASO staff contact the professional OON provider identified, or who is requesting accommodation, and arranges for the Accommodation Agreement in which the professional provider:

    a. Agrees to follow County of San Diego standard care procedures;

    b. Accepts standard San Diego County Medi-Cal rates, unless otherwise negotiated;

    c. Meets the following criteria and submits supporting documentation, as applicable:
        i. A copy of the provider's current state license to practice at the independent level,
        ii. A copy of proof of professional liability coverage, and
        iii. DEA certification (MDs only)

    d. Primary Source Verification process does not occur, but staff can confirm the active license online. The provider is not presented to the San Diego Credentialing Committed for approval.

6. The Provider receives two original Accommodation Agreements for the OON provider to sign and return if no fax machine is available. If using a fax machine, only one Accommodation Agreement is faxed to the provider. The signed agreement may be faxed back to the ASO.

7. The ASO sets up the provider in the Designated Database (DDS) so that authorizations and payment can occur.

8. The Accommodation Agreement is time limited to cover only those dates on which the services were delivered or are anticipated to occur.

    a. The agreement shall be updated to reflect needed treatment as long as there is no in-network provider available to serve the beneficiary adequately and timely.

9. If the County of San Diego MHP or DMC-ODS plan and OON provider are able to enter into a suitable arrangement, then the County shall allow the beneficiary to have access to that provider as long as deemed medically necessary, unless the OON provider is only willing to provide services to the beneficiary for a shorter timeframe. In this case, the

MHP or DMC-ODS plan shall allow the beneficiary to have access to that provide for the shorter period, as established by the OON provider.

10. Within seven (7) calendar days of approving the OON service request, the ASO shall notify the beneficiary of the following in writing:
    a. The request approval
    b. The duration of service arrangement
    c. The process that will occur to transition the beneficiary's care at the end of the service arrangement
    d. And the beneficiary's right to choose a different provider from the MHP or DMC-ODS plan's provider network.

11. At any time, beneficiaries may change their provider to an in-network provider. When the Accommodation Agreement has been established, the County shall work with the provider to establish a care plan for the beneficiary.

12. Each request for OON SMHS or SUD service shall be completed within thirty (30) calendar days from the date the ASO, on behalf of the MHP or DMC-ODS plan, received the request.

13. The ASO shall notify the beneficiary in writing thirty (30) calendar days before the end of the Accommodation Agreement period about the process that will occur to transition the beneficiary's care to an in-network provider. This process includes engaging with the beneficiary and affected provider(s) before the end of the agreement period to ensure continuity of services through the transition to an in-network provider.

## Access and Crisis Line: 1-888-724-7240

- Optum, the Administrative Services Organization (ASO) for the MHP, operates the statewide San Diego County Access and Crisis Line (ACL). The ACL 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 initial access point into the MHP for routine, urgent or emergency situations.

- All ACL clinicians are trained in crisis intervention, with client safety as the primary concern. Staff evaluates the degree of immediate danger and determines 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, ACL staff makes direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL staff makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

- The ACL provides access to interpreter services 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 TTY line at 711.

## MHP Services Authorization Requirement Provided by Optum

- Outpatient mental health services for children, adolescents and adults delivered to beneficiaries through the Fee-for-Service (FFS) Provider Network. This is a network of contracted licensed mental health professionals.
- Acute Inpatient Mental Health Services
- Crisis Residential Treatment Services
- Adult Residential Treatment Services
- Intensive Home-Based Services
- Child/Adolescent Day Treatment Program Services
- STRTP
- Therapeutic Behavioral Services
- Therapeutic Foster Care

- **Note**: Most outpatient services provided through County-operated and contracted provider programs do not require authorization. Clients who first access services by calling or walking into an organizational provider site or a County-operated program may not require authorization from Optum.

### *Referrals to the ACL*

- It is appropriate to refer individuals to the ACL for:
    - Access to publicly funded Specialty Mental Health Services
    - Crisis intervention for urgent situations
    - Suicide Prevention
    - Referrals for routine behavioral health services
    - Information about mental health and mental illness
    - Referrals to community resources for vocational, financial, medical, and other concerns.

- Providers shall inform clients about the option of directly using the Access and Crisis Line by calling 1-888-724-7240.

## *Provider Interface with the ACL*

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state: "*If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-888-724-7240."*

- If a client is high risk and may be calling the ACL for additional support, the client's therapist or care coordinator may call (with client's approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

## *Receiving Referrals from the ACL*

- The ACL considers multiple screening criteria when making referrals. Referrals take into consideration:

  - Urgency
  - Level of Care
  - Type of treatment or services
  - Geographic location
  - Cultural issues
  - Any specific client requests, such as provider gender, language, or ethnicity.

## *Hours of Service Availability*

- In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours-of-service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities and adhere to the specifics in the Statement of Work. The MHP QA Unit will document program service hours at annual site reviews and/or Medi-Cal Certifications/Recertifications.

## *Language Assistance*

- Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs.

- According to 42 CRF, clients shall be routinely asked, at the time of accessing services, about their needs for language assistance. According to Title 9 and BHS policy, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages.

- BHS policy prohibits the expectation that family members, including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

- To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other disabilities, making every effort to accommodate an individual's preferred method of communication.

- If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated programs can contact Interpreters Unlimited at (800) 726-9891 to arrange for language assistance via ASL, written and/or oral interpreter services .

- Detailed instructions can be found on the reference sheet posted on the County of San Diego's Department of Purchasing and Contracting website and San Diego's Insite- Purchasing & Contracting > Language website.

## Provider Selection, Terminations, Incentives

- In accordance with 42 CFR 438.10 and Title 9, enrollees (all clients) have the right to choose and obtain a list of MHP providers, including name/group affiliation, location, telephone number, specialties, hours of operation, type of services, cultural and linguistic capabilities, ADA accommodation, and whether provider is accepting new enrollees. MHP Provider Directory is available on the County's website and by calling Behavioral Health Services at (619) 563-2788. The Fee-for-Service Provider Directory is available by calling Optum at 1-888-724-7240 and online at the Optum website.

- When feasible and/or upon request, enrollees shall be provided with their initial choice of provider. Each enrollee shall be offered a paper copy of the MHP Provider Directory at the time of enrollment and anytime at enrollee's request within (5) five business days. If requested, staff shall assist the client or responsible adult, in reviewing the list of available options and/or obtaining an appointment. Providers shall log all requests for services prior to the onset of services on the Request for Service Log.

- Providers shall make a good faith effort to give written notice of a termination of a contracted provider, within fifteen (15) calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

- Providers shall report to the QA Unit and COR upon receiving any changes affecting the Provider Directory. The MHP shall update the paper Provider Directory monthly. The MHP shall update the electronic provider directory no later than 30 days after receiving updated provider information.

- The MHP does not currently offer any physician incentive plans.

## *Requests for Continuity of Care*

- Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State (and MHP) to have in effect a transition of care policy to ensure continued access to services during a beneficiary's transition from Medi-Cal fee-for-service (FFS) to a managed care program or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

- All eligible Medi-Cal beneficiaries who meet access criteria for SMHS have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the county MHP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider or a terminated network provider (i.e., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner).

- This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

    - The provider has voluntarily terminated employment or the contract with the MHP.

    - The provider's employment or contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.

    - Transitioning from one county MHP to another county MHP due to a change in the beneficiary's county of residence.

    - Transitioning from an MCP to an MHP; or,

    - Transitioning from Medi-Cal FFS to the MHP.

- A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to an MHP for continuity of care. Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request. MHPs must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

## *Validating Pre-existing Provider Relationships*

- An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the 12-months prior to the following:
    - The beneficiary establishing residence in the county.
    - Upon referral by another MHP or MCP; and/or,
    - The MHP determining the beneficiary meets criteria for access to SMHS.

- A beneficiary or provider may make available information to the MHP that provides verification of their pre-existing relationship with a provider.

- Following identification of a pre-existing relationship with an out-of-network provider, the MHP must contact the provider and make a good faith effort to enter a contract, letter of agreement, single-case agreement, or other form of formal relationship to establish continuity of care for the beneficiary.

## *Timeline Requirements*

- Each continuity of care request must be completed within the following timelines:
    - Thirty (30) calendar days from the date the MHP received the request.
    - Fifteen (15) calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,
    - Three (3) calendar days if there is a risk of harm to the beneficiary.

- MHPs must retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:
    - The provider meets the continuity of care requirements.
    - Services were provided after a referral was made to the MHP (this includes self-referrals made by the beneficiary); and,
    - The beneficiary is determined to meet criteria for access to SMHS.

- A continuity of care request is considered complete when:
    - The MHP informs the beneficiary and/or the beneficiary's authorized representative, that the request has been approved; or,
    - The MHP and the out-of-network provider are unable to agree to a rate and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,

- The MHP has documented quality of care issues with the provider and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,

- The MHP makes a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied.

*Requirements Following Completion of Continuity of Care Request*

- If the provider meets all the required conditions and the beneficiary's request is granted, the MHP must allow the beneficiary to have access to that provider for a period of up to twelve (12) months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider. When the continuity of care agreement has been established, the MHP must work with the provider to establish a Care Plan and transition plan for the beneficiary.

- Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

  - The MHPs approval of the continuity of care request.

  - The duration of the continuity of care arrangement.

  - The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and

  - The beneficiary's right to choose a different provider from MHPs provider network.

- The written notification to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

  - The MHPs denial of the beneficiary's continuity of care request.

  - A clear explanation of the reasons for the denial.

  - The availability of in-network SMHS.

  - How and where to access SMHS from the MHP.

  - The beneficiary's right to file an appeal based on the adverse benefit determination; and,

  - The MHPs beneficiary handbook and provider directory.

- At any time, beneficiaries may change their provider to an in-network provider whether or not a continuity of care relationship has been established. MHPs must provide SMHS and/or refer beneficiaries to appropriate network providers without delay and within established appointment time standards.

- The MHP must notify the beneficiary, and/or the beneficiary's authorized representative, thirty (30) calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

### *Repeated Requests for Continuity of Care*

- After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in the MHPs network for SMHS. If the beneficiary later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the MHP for SMHS, the 12-month continuity of care period may start over one time.

- If a beneficiary changes county of residence more than once in a twelve (12) month period, the 12-month continuity of care period may start over with the second MHP and third MHP, after which, the beneficiary may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the MHP should communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

## Beneficiary and Provider Outreach and Education

- MHPs must inform beneficiaries of their continuity of care protections and must include information about these protections in beneficiary informing materials and handbooks. This information must include how the beneficiary and provider initiate a continuity of care request with the MHP. The MHP must translate these documents into threshold languages and make them available in alternative formats, upon request. MHPs must provide training to staff that come into regular contact with beneficiaries about continuity of care protections.

### *Reporting Requirements*

- MHPs are required to report to DHCS all requests, and approvals, for continuity of care. The MHP must submit a continuity of care report, with the MHPs quarterly network adequacy submissions, that includes the following information:

    - The date of the request;
    - The beneficiary's name;
    - The name of the beneficiary's pre-existing provider;
    - The address/location of the provider's office; and,

- Whether the provider has agreed to the MHPs terms and conditions; and,
- The status of the request, including the deadline for deciding regarding the beneficiary's request.

## *Continuity of Care Requests Processed by ASO*

- All continuity of care requests shall be directed to the Administrative Services Organization (ASO), Optum. Optum will manage all continuity of care requests for the Mental Health Plan (MHP). Providers shall notify all beneficiaries with existing non-MHP providers that continuity of care requests are available as the beneficiary transfers care over to the MHP. Providers are expected to assist clients and work directly with Optum to ensure a smooth transfer of care. To begin the process, instruct the beneficiary to call the Access and Crisis Line and initiate the Continuity of Care request.

## *Clients Who Must Transfer to a New Provider*

- Many clients are unable to complete an entire treatment episode with the same therapist or mental health worker. This happens because of staff resignations, program closings, client change of residence or placement, transition of youths from Children, Youth and Families Services (CYFS) to the Adult / Older Adult (A/OA) system of care, and completion of internships and field placements. Good clinical practice indicates that the following should be implemented whenever possible to ease transition.

    - The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first provider.

    - The client and caregiver should be informed of the client's right to request a new provider.
    - The client and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.

    - Report transfers on the *Suggestion and Provider Transfer Log*, which is found on the required Quarterly Status Report.

    - The client should be assisted in making a first appointment with the new program.

    - The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.

    - A thorough discharge summary (or a transfer note if the client will continue in the same program) should be written and incorporated into the chart.

- Final outcome tools should be administered if the client will go to another provider program.

- A written plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

## Non- Mental Health Plan Services: Screening, Referral and Coordination

- All providers shall give appropriate referrals and/or coordination for treatment of services provided outside of the Mental Health Plan's (MHP's) jurisdiction. When an individual contacts a provider and requests referral and coordination of services that are outside of the MHP's jurisdiction, (education, health, Regional Center, housing, transportation, vocational, etc.), the provider will make or coordinate such referrals based on the individual's residence and specific need.

- Appropriate referrals will include providing necessary information such as phone numbers, addresses, etc. If the provider lacks the necessary information, they will offer the individual two options:

    1. Give the individual the number to Optum's Access and Crisis line # at 1-888-724-7240 or

    2. Get the individual's phone number and call them back with requested information. Requests for assistance shall be entered in the Access to Services Journal in the EHR.

## Mobile Crisis Services

- Mobile crisis services provide rapid response, individual assessment and community-based stabilization to client who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care and psychiatric inpatient hospitalizations.

## Psychiatric Emergency Response Team (PERT)

- PERT contributes to the well-being of individuals experiencing a mental health crisis that have come in contact with law enforcement. PERT has been designed to improve collaboration between the behavioral health and law enforcement systems with the goal of a more humane and effective handling of incidents involving law enforcement officers and individuals with mental illness, developmental disabilities and/or substance use disorders.

- Service Delivery and Training:
    - Contractor shall provide direct client interventions in conjunction with law enforcement officers to individuals experiencing a mental health crisis.
    - Contractor shall reduce inappropriate hospitalization and/or incarceration for clients and to refer the client to the most appropriate, least restrictive mental health program.
    - Contractor shall refer and link individuals to needed services.
    - Contractor shall provide client follow up services as appropriate.
    - Contractor shall provide required trainings and community outreach as outlined within the contractual requirements.

## Mobile Crisis Response Teams (MCRT)

- No sooner than January 1, 2023, and upon receiving approval from DHCS, county MHPs, DMC counties, and DMC-ODS counties (collectively, "Medi-Cal behavioral health delivery systems") shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements set forth in the BHIN 23-025.
- The County of San Diego has contracted with current system of care providers to provide these services and align with the requirements outlines in the BHIN. All mobile crisis teams, regardless of delivery system, shall meet the same requirements. The County of San Diego has implemented a fully integrated approach across both the mental health and SUD delivery systems.
- Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary is experiencing the behavioral health crisis. Locations may include, but are not limited to, the beneficiary's home, school, or workplace, on the street, or where a beneficiary socializes.
- Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year. Mobile crisis teams shall meet the standards outlined in BHIN 23-025.
- Mobile crisis response teams shall arrive at the community-based location where a crisis occurs in a timely manner (2 42 U.S.C. § 1396w–6(b)(2)(C); CMS, SHO #21-008, (Dec. 28, 2021) p. 7). Specifically, mobile crisis teams shall arrive within sixty (60) minutes of the beneficiary being determined to require mobile crisis services in urban and within one hundred and twenty (120) minutes in rural areas.
- Each service encounter shall cover the following service components:

- Initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging the beneficiary in crisis planning;
- Facilitation of a warm handoff, if needed;
- Referrals to ongoing services, if needed; and
- Follow-up check-ins, or documentation in the beneficiary's progress note that the beneficiary could not be contacted for follow-up despite reasonably diligent efforts by the mobile crisis team.
    - Note: follow-ups to the beneficiary shall occur within seventy-two 72 hours of the initial crisis response.

- Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care.

- Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support person(s) if the purpose of the support person's participation is to assist the beneficiary in addressing their behavioral health crisis and restoring the beneficiary to the highest possible functional level.

- For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.

- All mobile crisis teams shall meet DHCS' core and enhanced training requirements before delivering qualifying mobile crisis services, as outlined in BHIN 23-025. The core training curriculum will include crisis intervention and de-escalation strategies, harm reduction strategies, delivering trauma-informed care, conducting a crisis assessment, and crisis safety plan development. The enhanced training curriculum will include, but is not limited to, training in provider safety, delivering culturally responsive crisis care, and crisis response strategies for special populations (e.g., children, youth and families, tribal communities, and beneficiaries with I/DD).

## Urgent Walk-In Clinical Standards– Adult/Older Adult Mental Health Services

### *Urgent Psychiatric Condition*

- Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition. The County further refers to Urgent as a condition for which treatment should not wait for a normally scheduled appointment, as it would place the health or safety of the individual or another individual in serious jeopardy in the absence of an intervention.

- **Access Standard:** Face-to-face clinical contact for urgent services shall be within forty-eight (48) hours of initial client referral.

### *Exodus and Jane Westin – Full Time Access*

- Individuals who walk in and who are not currently receiving services will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to a primary care provider with known capacity, the closest outpatient mental health provider, or a fee for service provider, via the Access and Crisis Line phone number (client should mention that your program referred them to ACL). The client's choice prevails as per DHCS regulations.

- Clients who are already receiving mental health services and walk in and request medication will be triaged/screened. If they are not deemed in need of urgent services, they may be referred back to their own mental health provider, fee for service provider, or primary care provider. Alternatively, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.
- Clients who walk in after missing an appointment with their provider will be triaged/screened. If they are not deemed in need of urgent services, they may be referred to their own mental health provider, fee for service provider, or primary care provider. If they are requesting medication, the client may be advised/assisted to call their pharmacist to contact their prescribing physician for a refill.

- Clients with urgent mental health needs and/or urgent medication needs shall be triaged/screened and offered appropriate services, regardless of where the client may be receiving mental health services. If a walk-in clinic staff treats a client open to another program due to urgent service needs, the assigned program should be notified within twenty-four (24) hours, or the next business day, for follow-up services.

- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within forty-eight (48) hours.

- All referrals received that indicate urgency or high risk and that do not show up to the walk-in clinic will prompt a response from the walk-in clinic to the referring party for follow up. If the referring party is a Hospital or Crisis Residential program, the walk-in clinic will follow up with the client directly.

## *Outpatient Clinics with Walk-In Urgent Components*

- All outpatient clinics in all HHSA Regions shall accommodate their ongoing, opened clients for urgent services to prevent clients from needing to access services at Exodus and Jane Westin.

- All clients who are triaged/screened and are deemed appropriate for routine admission must be admitted in accordance with acceptable access times already established for routine services, or according to the seventy-two (72) hour policy for clients leaving twenty-four (24) hour settings or known case management clients.

- Institutions and Case Managers can call a clinic to arrange for a triage day during walk-in times, within seventy-two (72) hours, and individuals will be given the highest priority to be triaged/screened that day.

- New clients assessed as needing urgent services that are referred from Exodus or Jane Westin must be prioritized for admission at an outpatient clinic within forty-eight (48) hours.

- Programs must have processes in place to follow up with clients who come in for walk-in services, are triaged/screened and not deemed urgent, but need specialty mental health services at the clinic and are asked to return the following day but who do not show up.

- Clinics receiving urgent or at-risk referrals are responsible for ensuring clients are screened within designated timelines and shall be responsible for contacting the client for follow up if they do not show up during walk in times. The minimum expectation for client follow-up includes a phone call (if number is available) or a letter to known address and/or informing the referring party of client status.

## *All Programs:*

- The initial site providing service shall ensure that clients do not have to go to multiple facilities for an evaluation.

- MD's/Nurse Practitioners (NP's) must be prepared to provide care to a client who is in urgent need of medications even though the client may be open at another clinic.

- MD's/NP's should be prepared to provide outpatient detox medications to COD clients entering County-contracted detox programs, if in the MD's/NP's opinion it is deemed safe. This will be evaluated on a case-by-case basis.

- All programs shall post signage to inform clients what to do after hours. i.e. "In case of an emergency after business hours please go to the nearest emergency room, call the Access and Crisis Line at-1-888-724-7240, or call 911."

- HIPAA Privacy Rule Sec. 164.506 states that a covered entity may use or disclose protected health information for treatment. This would apply in the case of a clinical referral source (another clinic, case management, hospital, IMD, etc.) inquiring whether a referred client appeared for their intake process.

*Priority List*

- Prioritization is always based on clinical judgment regarding highest acuity and risk; however the following will generally be highest priority: A client appearing agitated in the waiting room, any Psych hospital/crisis residential discharge, Police/PERT, jail, IMD Client/Out of County locked facility referral, Case Management client with a case manager, acute JWWRC/Exodus referral, homeless or at risk of homelessness with SMI or COD client whose mental status jeopardizes SUD residential placement.

## Referral Process for Strength-Based Case Management (SBCM) and Assertive Community Treatment (ACT) Services

- Any person or agency can complete a referral to a SBCM or ACT program. The program receiving the referral may determine that it is best able to serve the person and will open the case. If the program receiving the referral determines the person might be better served through another provider, contact is made with the other program and the referral may be forwarded for review. Each program maintains a log of all referrals and referral dispositions.

    - For more information, regarding the system of care Strength-Based Case Management (SBCM) and Assertive Community Treatment (ACT) programs, please reference the Technical Resource Library (TRL) for hyperlinks directly to Section 2 (Adult/Older Adult System of Care) subsection 2.3 (Case Management) where the following can be found:

        - Assertive Community Treatment Brochure
        - Strength Based Case Management Flyer

## Assisted Outpatient Treatment- Laura's Law

- Laura's Law/Assisted Outpatient Treatment authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for individuals who

have a history of untreated mental illness and meet all seven of the following criteria stipulated in the Code.

1. The person is at least 18 years of age.

2. The person is mentally ill as defined in WIC 5600.3

3. There has been a clinical determination based on the person's treatment history and current behavior that at least one of the following is true:

    a. The person is clinically determined to be unlikely to survive safely in the community without supervision.

    b. The person is in need of assisted outpatient treatment in order to prevent relapse or deterioration that would result in grave disability or serious harm to the person or others.

4. The person has a history of treatment non-compliance as evidenced by one of the following:

    a. Two occurrences of hospitalizations, or mental health treatment in prison or jail within the last 36 months

    **OR**

    b. One occurrence of serious and violent behavior (including threats) within the last 48 months.

5. The person has been offered treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.

6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.

7. The person is expected to benefit from AOT.

- A request for an assisted outpatient treatment examination is made through one of the two In Home Outreach Team (IHOT) programs (Telecare or Mental Health Systems, Inc.). The IHOT program is an outreach and engagement program for individuals who are resistant to treatment.

- The request may only be made by one of the following:

    - Anyone at least 18 years of age living with the person.

- Any parent, spouse, sibling at least 18 years of age.
- A director of a public or private agency, treatment facility, charitable organization, or licensed residential care facility providing MH services to the person.
- A director of the hospital where the person is being hospitalized.
- The licensed mental health treatment provider supervising treatment of or treating the individual.
- A peace officer, parole officer, or probation officer assigned to supervise the individual.

- In the event that the referred individual is not engaged in IHOT services, a clinical determination will be made to refer the individual for an assisted outpatient examination. Following the assisted outpatient examination, the individual will be provided with the opportunity to voluntarily enter the assisted outpatient treatment program.

- If the individual refuses to enter the assisted outpatient treatment program voluntarily, and the individual continues to meet all nine (9) criteria as stated in Laura's Law, a request for an assisted outpatient treatment examination is made through the BHS Director or his designee. Upon receiving the request, the BHS Director or his designee must conduct an investigation into the appropriateness of the filing of the petition.

1) The petition with an affidavit from the designated IHOT licensed mental health clinician (LMHC) shall state that s/he has personally evaluated the person within ten (10) days prior to the submission of the petition; the person meets all nine (9) criteria; the LMHC recommends AOT and is willing and able to testify at the hearing on the petition,

   **OR**

   The licensed mental health clinician has made within ten (10) days of filing the petition appropriate attempts to elicit the cooperation of the person but has not been successful in persuading the person to submit for the AOT examination and is willing and able to testify at the hearing on the petition.

2) If the individual refuses to be examined by a licensed mental health clinician from IHOT, the court may request the individual's consent to the examination by a licensed MH treatment clinician appointed by the court. In the County of San Diego, the Public Conservator's Office is the designated program to conduct the AOT court order examination for individuals who refused the initial examination by IHOT.

3) If the individual does not consent and the court finds reasonable cause, the court may conduct the hearing in the person's absence OR order an individual to be transported to

San Diego County Psychiatric Hospital for examination by a licensed mental health professional under WIC 5150. The hold may not exceed seventy- two (72) hours.

4) In the event that the AOT examination is upheld, the County's designee, San Diego County Counsel, will file the petition with the AOT Judge and upon receipt of the petition, the court must schedule a hearing within five (5) business days. Individuals will be personally served with the petition and notice of hearing date.

5) If after hearing all evidence the court finds the individual does not meet criteria for AOT, the court may dismiss the petition.

6) If the court finds that all nine criteria are met, the court may order the person to AOT for an initial period not to exceed six (6) months. The individual may voluntarily enter into a settlement agreement for services after a petition for an order of AOT is filed, but before the conclusion of the hearing. Settlement agreements may not exceed one hundred and eighty (180) days and has the same force as an order for AOT.

7) If the person is court ordered for AOT services and is not participating in the AOT program, and if unsuccessful attempts are made to engage the person in AOT, the person may be transported to San Diego Psychiatric Hospital for up to seventy-two (72) hours to be examined to determine if the person is in need of treatment pursuant to Section 5150.

## Community Assistance Recovery and Empowerment (CARE) Act

- The Community Assistance, Recovery and Empowerment (CARE) Act program was implemented on October 1, 2023. In collaboration with County and community partners, the CARE Act program creates a new pathway to deliver mental health and substance use services to individuals who are diagnosed with schizophrenia or other psychotic disorders and are not engaged in treatment.

- Families, clinicians, first responders, and others may begin the process by filing a petition with the civil court to connect people (ages 18+) to court-ordered, voluntary treatment if they meet criteria and may benefit from the program.

### *CARE Eligibility Criteria:*

- An individual shall qualify for the CARE process only if **ALL** of the following are true:

  1. The person is 18 years of age or older.

  2. The person is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3 and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

a. This section does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.

b. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for CARE process.

c. A person with a diagnosis identified in the class of mood disorders, including mood disorders with psychotic features, does not meet the required eligibility criteria for CARE process.

3. The person is not clinically stabilized in on-going voluntary treatment.

4. Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

5. It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

6. At least one of the following is true:
   a. the person's condition is substantially deteriorating.
   b. The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

- *If the individual meets criteria above, a CARE petition may be initiated.*

## *CARE Process:*

1. **Referral:** A referral can be initiated by family members, behavioral health providers, first responders, or other approved petitioners, by filing a petition with the Superior Court. Petitions must include required State documentation to establish clinical history. Detailed instructions on filing a CARE petition and forms can be found here: CARE Act | Superior Court of California - County of San Diego

2. **Initial Determination:** The Superior Court makes an initial determination as to whether the petition appears to meet criteria for the CARE Act program. If the petition appears to meet initial criteria, the Superior Court will order County Behavioral Health Services (BHS) to conduct an investigation.

3. **Investigation and Engagement:** County BHS will investigate and report back to the Superior Court within 14 days with a recommendation regarding the establishment of a CARE Act case. During the investigative process, BHS will conduct outreach and attempt to engage petitioned individuals with treatment and may avoid the need for a CARE Act case.

4. **Establishing a CARE Agreement/ Plan:** If the Superior Court determines that a case should be established, a CARE Agreement/Plan will be developed with County BHS, in partnership with the petitioned individual and their counsel. The CARE Agreement/Plan will be submitted to the Superior Court for review.

5. **Connection to Services:** Once a CARE Agreement/Plan is accepted by the Superior Court, BHS and its network of community-based providers such as the Telecare CARE ACT team, will actively engage the individual for whom a CARE Agreement/Plan has been established to connect to services, including behavioral health treatment, stabilization medication, a housing plan, and other supports as needed.

    a. Program participation is 12 months but may be extended for an additional 12 months depending upon individual circumstances.

## Accessing Secure Facility/ Long-Term Care (SF/LTC) – Adult Mental Health Services

- Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private. SF/LTC Facilities funded by the County of San Diego include Institution for Mental Disease Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities/Special Treatment Program (SNF-STP), additional funds for a County SNF Patch, and State Hospitals.

### *Referral Process*

- Optum, which provides mental health administrative services to the County of San Diego Mental Health Plan, provides Utilization Management for County-funded locked/secure facilities. Referring agencies shall submit an information packet to the Optum Long-Term Care (LTC) Coordinator.

- The packet shall include the following:

    1. Referral form for a San Diego County-funded SF/LTC

    2. Court Investigative Report for San Diego County LPS Conservatorship

3. Complete Psychiatric Assessment including psychiatric history, substance abuse history and history of self-destructive or assaultive behavior, if applicable

4. Current Physical and Medical History

5. Current medications

6. One week of progress notes (including nursing, group notes, and psychiatrist notes)

7. Hospital face sheet

8. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) or proof that client is Medi-Cal eligible, and that Medi-Cal has been applied for.

9. Current completed Mini-Cog Exam

10. Current lab reports and toxicology screen from day of admission

11. Result of purified protein derivative (PPD) (tuberculosis [TB] test) or clean chest x-ray done within the past 30 days

12. Recommendation and information from the case manager if client has case management services.

13. Signed payee form

    - If the packet is not complete, the referral shall not be processed until all the information is available.

- The Optum Long-Term Care Coordinator shall review all referrals for completeness of information and eligibility for admittance. If the Coordinator has questions or concerns, he/she shall consult with the Optum Long-Term Care Medical Director. The San Diego County Long-Term Care Manager and/or the County Adult/Older Adult Mental Health Services Medical Director shall also be available for consultation.

- At times, even though the referral is complete, there may be concerns about whether the individual meets admittance criteria for SF/LTC. In these cases, the Optum LTC Medical Director or his/her designee may complete an independent on-site evaluation of the referred individual. Once Optum has established that the referred individual meets the admittance requirements for SF/LTC, Optum will provide the clinical packet to SF/LTC facilities. SF/LTC facilities will determine if the client is appropriate for their facility.

*Target Population*

- The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have a Title 9, ICD 10 psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent Lanterman-Petris-Short (LPS) Conservator. For an MHRC and SNF/STP, the age range is 18 years to 64 years old.

## Eligibility Criteria for Admittance to SF/LTC

*To County-Funded Secure Facilities/Long-Term Care*

- Individuals must meet all the following criteria:

1. Have met Title 9 medical necessity criteria for psychiatric inpatient services at time of referral.

2. Be unable to be maintained at a less restrictive level of care.

3. Have an adequately documented Title 9, ICD 10 diagnosis of a serious, persistent, major**,** non-substance-abuse-related mental disorder as stated in Title 9. This diagnosis must not be primarily a manifestation of developmental delay or other developmental disorder. Clients may also have a secondary, co-occurring substance abuse diagnosis not covered under Title 9. If the sole diagnosis is not covered under Title 9, that diagnosis alone is not sufficient to meet criteria.

4. Have the potential to benefit from psychiatric rehabilitation services and potential to progress to a less restrictive level of care.

5. Be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship.

    a. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h) (1) (A) as: *"A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."*

6. A current resident in the State of California with Medi-Cal eligibility for the County of San Diego.

7. Not be entitled to comparable services through other systems (i.e., Veterans Administration Regional Center, private disability insurance, Forensic system, etc.).

8. Be 18 to 64 years old, although persons 65 and older may be admitted to Skilled Nursing Facilities (SNFs).

9. Have absence of a severe medical condition requiring acute or complex medical care in accordance with applicable Skilled Nursing Facility/Special Treatment Program (SNF/STP) or Mental Health Rehabilitation Center (MHRC) regulations.

10. Have current tuberculosis (TB) clearance.

11. Be on a stable, clinically appropriate medication regimen.

12. Have absence of chronic or recurrent dangerousness to self or others. This includes absence of chronic or recurrent episodes of assaultive behavior.

## *To San Diego County Funded SNF Patch Facilities*

- San Diego County provides additional funds for clients who are placed in a Skilled Nursing Facility with a SNF patch. To be considered for admittance to this program, individual must meet as 12 criteria for admittance to County-funded secure facilities. In addition, individuals must have Medi-Cal as the only source of funding. To request a SNF patch the hospital completes an SNF-LTC and submits the packet to Optum.

## *To Vista Knoll*

- San Diego County has a contract with Vista Knoll, a Skilled Nursing Facility in North County, in the specialized Neurobehavioral Health Unit for residents with Traumatic Brain Injuries (TBI). To be considered for admittance to these San Diego County-funded beds, individuals must meet all 12 criteria for admittance to County-funded secure facilities.

- In addition: Individuals must have a current, adequately documented diagnosis of a serious, persistent, major, non-substance-abuse-related mental disorder as stated in Title 9, with evidence it existed prior to their Traumatic Brain Injury. Referral packets shall include complete documentation of this history.

## *To a State Psychiatric Hospital*

- Individuals must meet all the following criteria:

  1. Individual must be a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior**.** Documentation must show that assaultive behavior is a result of psychosis that has been resistant to treatment rather than antisocial behavior, Dementia or Traumatic Brain Injuries (TBI).

2. Individual cannot be admitted or maintained at an Institution for Mental Disease/Mental Health Rehabilitation Center (IMD/MHRC).

3. Admissions to state hospitals shall be approved by the County LTC Coordinator.

4. Individual shall be on LPS Permanent Conservatorship. The Lanterman-Petris-Short (LPS) Conservator must authorize A/OAMHS to provide case management services to monitor the individual's placement and progress.

## Reviews of Determination Decisions

- Situations may arise in which the referring agency does not agree with the decision regarding admittance. The attending M.D., the conservator/client or the referring agency may request a review of the decision by notifying the San Diego County Healthcare Oversight Unit in writing within five business days. This request shall include submission of the following information:

    - New detailed specific information as to why the individual meets the criteria for admittance.

    - Supportive documentation, as relevant.

- The Healthcare Oversight Unit shall review the information and a case conference will be held that includes the Behavioral Health Services Chief Medical Officer. After review of the documentation, San Diego County shall render the final determination regarding admittance.

## Placement

- Individuals who meet SF/LTC Admission Criteria are placed in SF/LTC facilities that are contracted with the County of San Diego. Placement decisions are made by County Contracted SF/LTC facilities and Optum.

- In some cases, the most appropriate placement may not be clear. In these situations, more information may be requested from the referring agency or the case manager. In some cases, an on-site evaluation of the referred individual may be appropriate. Optum LTC Coordinator is responsible for notifying the referral agency as to the outcome after the placement decision. At times, placement in a County-funded, out-of-County located program may be appropriate.

- In these cases, the following criteria shall be met:

    1. Individual meets all criteria for in-County placement;

2. Individual has been refused placement by all in-County facilities, or there are compelling clinical reasons (e.g., deaf program) established that the individual would benefit from out-of-County placement

3. Public Conservator's Office has approved the placement

4. San Diego County Programs and Services Long Term Care Manager verified that funding is available for placement.

## MHP and MCP Responsibility to Provide Services for Eating Disorders

- BHIN 22-009 states that the MHPs and MCPs share a joint responsibility to provide medically necessary services to Medi-Cal beneficiaries with eating disorders. Some treatment for eating disorders (both inpatient and outpatient SMHS) are covered by MHPs. Some treatment for eating disorders is also covered by MCPs. Since eating disorders are complex conditions involving both physical and psychological symptoms and complications, the treatment typically involves blended physical health and mental health interventions, which MCPs and MHPs are jointly responsible to provide.

  1. MCPs are responsible for the physical health components of eating disorder treatment and NSMHS, and MHPs are responsible for the SMHS components of eating disorder treatment.

  2. MHPs must provide or arrange and pay for, medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

  3. MCPs must provide inpatient hospitalization for beneficiaries with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

  4. MCPs must cover and pay for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations.

  5. For partial hospitalization and residential eating disorder programs, MHPs are responsible for the medically necessary SMHS components, and MCPs are responsible for the medically necessary physical health components.

  6. DHCS does not require a specific funding split for MHPs and MCPs to share the cost of services provided in partial hospitalization and residential eating disorder programs. DHCS recommends that both parties mutually agree upon an arrangement to cover the cost of these medically necessary services.

## Placement in a State Hospital

1. Each client shall be approved for admission to a state hospital by the County LTC Coordinator. The case manager reviews and exhausts all possible alternatives with Optum Medical Director and LTC Coordinator prior to authorizing state hospital placement.

2. Upon approval, the LTC Coordinator at Optum sends the current information provided by the hospital and case manager to the Admissions Coordinator at one of the following State Hospitals: Atascadero, Coalinga, Napa, Patton, Salinas Valley, and Metropolitan State Hospital.

3. Once the state hospital has accepted the client, the county case manager/conservatorship designee shall ensure that all legal documents and paperwork are in order enabling transportation and admission to state hospital.

   a) Certification must be obtained from the County LTC Optum that funds are available to support the placement, by his or her signature on the "Short/Doyle" form.

   b) Current Letters and Orders of Conservatorship must be obtained from the Conservator.

   c) Authorization must be obtained for the county to provide case management services if conservator is a private conservator.

   d) The case manager shall notify the facility and the Optum LTC Coordinator of the discharge and transportation date and time.

   e) The referring facility is responsible for arranging for transportation to the state hospital and shall have the client and the client's belongings ready to go.

## Transitional Age Youth (TAY) Referral Process

- Youth receiving behavioral health services in the Children, Youth and Families Behavioral Health System of Care and who are between the ages of 18-21 may require system coordination to successfully transition to the Adult/Older Adult Behavioral Health System of Care when continued care is needed. Youth receiving services in other sectors and needing behavioral health services often require coordinated efforts as well.

- To appropriately identify those youth and to coordinate care and assist with successful linkages, including the implementation of a process when routine referrals have been unsuccessful, the following procedures are established:

    1. The Children, Youth and Families Behavioral Health service array includes:

a. The critical care/emergency screening unit, which provides emergency psychiatric evaluation, crisis stabilization, and screening for inpatient care for families during mental health crisis.

b. Outpatient services which include crisis intervention, mental health assessments, medication management, family therapy, group therapy, substance use disorder (SUD) issues and case management. Services are clinic based, school based, institutionally based, and community based and offered through contracted and Fee for Service providers. These include a number of specialized programs that focus on specific populations.

c. Full-Service Partnerships are outpatient programs which provide intensive services that comprehensively address client and family needs and "do whatever it takes" to meet those needs.

d. Case Management/wraparound services are for children, youth and families with complex needs and require intensive supports in addition to treatment service.

e. Therapeutic Behavioral Services are one on one behavioral service provided by BHS contractors in conjunction with other treatment services.

f. Day treatment services are several hours per day and all-inclusive in terms of the mental health services provided.

    a. School based day rehabilitation services are provided through the San Diego Unified, Cajon Valley, and Grossmont Union School Districts. Services are accessed through referral by the district.

    b. Day Treatment is offered for Dependents of the Court residing in residential treatment and long-term placement at San Pasqual Academy.

g. Inpatient services which are for mental health emergencies that require a hospital setting.

h. Non-residential SUD programs, which provide non-residential specialized SUD services that build a more integrated and coordinated strategy to meet the unique substance abuse treatment and recovery needs of youth. Programs also provide appropriate referrals for youth and their family, if needed.

i. Residential SUD programs, which provide 24/7 structured residential alcohol and other drug (SUD) treatment/recovery and ancillary services.

j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment/referral services.

k. Case Management Juvenile Justice Programs support clients referred by the Probation Department and Juvenile Drug Court to assist in the intervention, treatment and recovery from substance abuse issues. Juvenile justice programs offer services at designated County Probation service centers and the Juvenile Drug Court.

2. The Adult/Older Adult system serves individuals living with serious psychiatric disabilities who may have alcohol and other drug induced problems, and the service array includes:

   a. Clubhouses which are informal centers with employment and education supports and socialization opportunities with a focus on well-being.

   b. Outpatient clinics which provide individual and group therapy and medication support services.

   c. Case Management services which provide assistance with linkage to services and community supports as well as psychosocial intervention and resource management to assist individuals to obtain optimum independence.

   d. Full-Service Partnership programs which provide intensive services that comprehensively address client and family needs and "do whatever it takes" to meet those needs.

   e. Residential programs, which are 24/7, structured treatment programs that may provide individual, group, family therapy and other treatment modalities as appropriate.

   f. Crisis Residential programs which are an alternative to acute hospitalization for persons in crisis of such magnitude so as not to be manageable on an outpatient basis.

   g. Inpatient services which are for mental health emergencies that require a hospital setting.

   h. Non-residential alcohol and other drug (SUD) treatment and recovery programs which provide process, educational and curriculum groups to assist individuals in recovering from substance abuse disorders on an outpatient basis. Programs may also provide specialized services for special populations including criminal justice populations (on a referral basis).

   i. Residential SUD programs which provide 24/7 structured treatment and recovery services for individuals requiring a higher level of care.

j. Residential detoxification programs which provide 24/7 SUD detoxification and pre-treatment and referral services.

k. Non-residential and residential women's programs, which provide gender-specific, trauma-informed SUD treatment and recovery services, designed for adult women over the age of eighteen (18), including pregnant, parenting women, and their dependent minor children from birth through and including age seventeen (17).

l. Drug Court programs, which provide non-residential alcohol and other drug (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court.

m. Driving under the Influence (DUI) programs which provide state licensed and mandated education and counseling programs for offenders arrested and convicted of Wet Reckless or first or multiple offense DUI. Programs are funded entirely by participant fees; SUD is responsible for local administration and monitoring.

n. Special population programs which provide SUD
o. Treatment and recovery services to traditionally harder to reach populations, such as Gay, Lesbian, Bi-sexual, and Transgender (GLBT), serial inebriates and HIV positive adults.

- Please note: The appropriate level of service within CYF and A/OA behavioral health services must be identified as there are different levels of services available.

## *Identify the System Target Population*

- CYF provides services to youth (up to a youth's 21st birthday) who are seriously emotionally disturbed. Services are provided to clients with co-occurring mental health and substance use, Medi-Cal eligible clients that meet criteria for access to SMHS criteria, as well as Indigent, and/or low income/underinsured individuals. All specialty mental health providers will evaluate and assess the treatment needs of the client.

- This process will encourage and involve the active participation of the client's significant others such as: the parent/caregiver, for children and youth, family members, friends and/or advocates selected by the adult client. Orientation and education of significant others includes discussion of what services are available, treatment goals, role of the provider, and expectations of the client and provider. It also includes legal limits around confidentiality.

- Seriously emotionally disturbed children or adolescents means minors under the age of 21 who have a mental disorder as identified in the ICD-10, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

- BHIN No: 21-073 which supersedes BHIN 20-043, in part, provides the criteria for beneficiary access to Specialty Mental Health Services that meet criteria for medical necessity.

- For individuals under 21 years of age, a service is meets criteria for access to SMHS and the services are medically necessary if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not such services are covered under the State Plan.

- Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that mental health services need not be curative or restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services. Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

- Covered specialty mental health services shall be provided to enrolled beneficiaries who meet **either of the following criteria** below. If a beneficiary under age 21 meets the criteria as described in (1), the beneficiary meets criteria to access SMHS. It is not necessary to establish that they also meet criteria in (2).

    1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma by scoring high-risk under a trauma screening tool approved of by the department; involvement in the child welfare system; juvenile justice involvement; experiencing homelessness, imminent risk of homelessness, unaccompanied youth under 25 who qualify as homeless under Federal statues, fleeing/attempting to flee domestic violence.

    **OR**

    2. The beneficiary meets **both of the following** requirements:

        a. The beneficiary has **at least one** of the following:
            1. a significant impairments reasonable probability of significant deterioration in an important area of life functioning

2. a reasonable probability a child will not progress developmentally as appropriate

3. a need for specialty mental health services, regardless of impairment that are not included in the mental health plan benefits that a Medi-Cal managed care plan is required to provide.

**AND**

b. The beneficiary's condition is due to **one of the following**:

1. a diagnosed mental health disorder

2. a suspected mental health disorder that has not yet been diagnosed

3. significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

- A short-term model of treatment is utilized in CYFBHS.

- All mental health programs will be on a time-based Utilization Management (UM) cycle and reviews will occur within the program level Utilization Management Committee at each program's identified time-based interval.

    - Outpatient: 6-month UM cycle

        - STRTP: 3-month UM cycle aligned with DHCS 90-day Clinical Review

- In the SUD Adolescent programs, the target population is defined as adolescents aged twelve (12) through seventeen (17) years of age with substance use problems. Adolescents learn how to socialize, grow, and recover in a safe and supportive, youth-focused, alcohol and drug free environment.

- In the A/OA BHS, the target population is defined as individuals with a serious psychiatric illness that threatens personal or community safety or that places the individual at significant risk of grave disability due to functional impairment. In addition, the system of care serves people with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens.

- Required psychosocial services may include illness management, or skill development to sustain housing, social, vocational, and educational goals. In the Adult SUD programs, the target population is defined as individuals in need of SUD treatment and recovery services.

- The goal of alcohol and other drug treatment and recovery services is to assist individuals to become and remain free of alcohol and other drug problems, which lead to improved individual and family capability, overall functioning, decrease the incidence of crime, and support the person's ability to become self-sufficient through employment. Additionally, Regional Recovery Centers and select residential programs serve a target population of PROs (Post Release Offenders) and Probationers who are referred for services and are assigned to high-risk caseloads and supervision by the Probation Department.

- When youth are between ages 18-21 and the most appropriate level of care is being determined, the following shall be considered:

    - System of care target population defined above, with individual needs being considered

    - Youth's goals and preference

    - Youth's functional level

    - Youth's need for shorter term or longer-term services
    - Youth's relationship with current provider and impact of consistency based on youth's history

## Coordinated Care Between Sectors:

1. Child and Family Wellbeing Services: In an effort to coordinate care with CFWB, a call to 858-694-5191can be made to access the name and phone number of a San Diego County foster youth's social worker. To access the name of a youth's Independent Living Skills (ILS) worker, the ILS INFO Line can be called at 866-ILS INFO (866-457-4636). The ILS INFO Line can also be used as the starting point for an eligible former foster youth to re-enter foster care after age 18. Additional information about ILS and transitional housing opportunities can be found at www.fosteringchange.org.

2. Probation: If a youth has probation involvement, communication with the Probation Officer would be an important aspect of services.

3. Education: If a youth has been in Special Education and did not receive a diploma, they are eligible for educational services through their school district until age 22. Their last school of attendance would be able to assist with school records and educational placement. If there is any difficulty at the school site getting information, it is advised to contact either the Special Education Department Chair at that school site or the Vice Principal of Special Education.

- If a youth was not receiving Special Education services, they can be referred to "Adult Education" which is provided through the San Diego Community College District.

*Coordinate Care When Making Referrals:*

1. Planning and consultation with the youth prior to a referral is needed so that the planned services match the needs and desires of the transition aged youth. Clinical staff shall meet with the youth and their supports, including other system of care partners such as CFWB & Probation as applicable, to strategize about planned services as some youth may be best served by continued services in CYFBHS and for others a referral to the A/OABHS may be indicated.

2. Involvement of the family in transition planning is integral when family is available. It is critical that the youth and family understand the differences within the CYFBHS and the A/OABHS in terms of consent to treat and expectations of support systems.

3. If a referral to the Adult/Older Adult System of Care is determined, it is recommended that a call to the selected program be made to discuss the referral process and to allow for some transition time when the youth can be introduced to the new program on a timeline that is comfortable to all parties.

4. It is also recommended that visits with the youth, their supports, the existing provider, and the prospective provider occur, as this can be a helpful step in supporting a transition.

- **Procedures to follow if unsuccessful routine referral is below:**

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the CYF System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:

    - Referral Form/Cover Letter
    - Children's Mental Health Assessment and most recent update
    - The Mental Health Diagnosis
    - Youth Transition Evaluation
    - Mental Status conducted by psychiatrist within the last 45 days
    - Physical Health Information
    - Medication Sheet

- Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS) Plan
- Psychological Testing done within past year (if available)
- Individual Education Plan and Individual Transition Plan
- Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday if applicable)
- Any self-evaluations recently given to youth.

2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where the youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.

3. The MHPC will review the packet to determine if access criteria are met for SMHS and the Service Eligibility Policy for the Adult/Older Adult System of Care.

4. If the client does not meet criteria to access SMHS, then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will be requested from an adult provider agreeable to the client and family. If the assessment indicated a Medi-Cal beneficiary does not meet criteria to access SMHS, a Notice of Adverse Benefit Determination (NOABD) will be issued, advising him/her of his/her rights to appeal the decision.

5. If a transition plan is agreed upon, the client's CYFBHS Case Manager or Care Coordinator will attempt to link the client with the appropriate service.

6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary support team within two weeks of the initial referral that will include relevant persons that may include, but are not limited to, the following:

   - Youth
   - Support System as defined by the youth/family (parent, social worker, family members)
   - CYF BHS Case Manager and /or Therapist
   - Current Psychiatrist
   - CYF BHS Contracting Officer's Representative (CORS), or designee
   - Adult/Older Adult BHS COR if applicable, or designee

- Probation Officer (if applicable)
- CWS Social Worker (if applicable)
- Education/Vocational Specialist

7. Team will review youth defined needs and options and create a transition plan, complete a Transition Age Youth Referral form, including all signatures. The Care Coordinator will include a copy of a Transition Age Youth Referral Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified, and same procedure followed.

## Accessing Services– Children, Youth and Families Services (CYFS)

### *Organizational Provider Outpatient Services or County Operated Services*

- If a client first accesses services by calling or walking into an organizational provider site or a county-operated program, the client can be seen and assessed, and the organizational provider authorizes services based on meeting criteria for access to SMHS as outlined in Welfare and Institutions Code Section 14184.402.

### *Day Intensive and Day Rehabilitative Services (CYFS)*

- Day services are offered in school/community settings and as enhanced treatment services in residential facilities for the most severely emotionally disturbed children and youth who meet criteria for access to SMHS and the services must be medically necessary. Referral and admission to all day services may come from Juvenile Probation, Child and Family Wellbeing Services, or schools. All programs are Medi-Cal certified and comply with Medi-Cal standards regardless of funding source.

- Prior authorization is required for all day services. Clients referred to day services shall begin treatment services within contract guidelines. Prior to admission of the client, day programs shall comply with authorization procedures for day services as set forth in the DHCS Informational Notice No. 19-026. An Administrative Services Organization (ASO) provides authorization for all day services. Optum acts as the ASO.

- Reauthorization is required every three (3) months for day intensive services and every six (6) months for day rehabilitative services. Copies of Optum's current *Prior Authorization Day Services Request* (DSR) as well as the *Ancillary Specialty Mental Health Services Request* are located on the Optum Website > BHS Provider Resources> MHP Provider Documents> *UCRM* tab.

- If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

    - See *OPOH Section D* for information on Out of County clients and all other authorizations.

## *Service Priority for Outpatient Assessment Services – CYFS*

- High
    - Children and adolescents requiring emergency services should be seen within one (1) hour of contact with program. They may be seen at the program or referred to Emergency Screening Unit.

    - Children and adolescents with Urgent referrals, defined as a condition that, without timely intervention, would very likely become an emergency, shall be seen within 48 hours of contact with program.

    - Children and adolescents being discharged from acute psychiatric hospital care shall be assessed by program within seventy-two (72) hours. If the referral is Urgent, client shall be seen within 48 hours of contact with program.

    - Seriously Emotionally Disturbed (SED) children and adolescents take priority over routine admissions.

- Routine
    - Children and Adolescents with a relatively stable condition and a need for an initial behavioral health assessment for Specialty Mental Health Services shall be seen within 10 business days from request.

    - Children and Adolescents with a relatively stable condition and a need for an initial psychiatric evaluation for Specialty Mental Health Services shall be seen within fifteen (15) business days from request.

- Ongoing Services
    - Children and adolescents with moderate mental health needs who meet criteria for access to SMHS and the services must be medically necessary shall be provided with appropriate services based on the client needs as well as the program's Utilization Management process.

- For children and adolescents with mild, non-complex mental health needs clinicians at all programs shall assist the parent/caregiver in accessing services within the region through the Optum individual/group provider network, if the child is Medi-Cal eligible.

## Therapeutic Behavioral Services (TBS)

- Prior authorization through Optum is required preceding the provision of Therapeutic Behavioral Services (TBS). Clients are referred to New Alternatives, Inc. (NA), who is the point of contact for TBS. The referring party may include COSD SOC, CFWB and Probation Department. The referring party will complete and return an authorization request form to the Administrative Services Organization (ASO) who provides authorization for TBS.

- Optum acts as the ASO. Authorization requests are then screened and assessed by Optum UM licensed clinicians for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 08-38. Optum UM licensed clinicians will then send authorization response to the referring party within 5 business days of receipt of request. The provider assigned to the client/family will conduct assessment to ensure client meet the class, service, and other TBS criteria prior to services being delivered.

- If a request for authorization is considered to be incomplete, the request will be withdrawn. Optum will notify the provider of the incomplete submission and request that the provider resubmit with additional clinical information. Without a complete authorization request, determination to approve or deny authorization cannot be made. Without authorization approval services may not be billable.

### *Utilization Review*

- Authorization management for extended Therapeutic Behavioral Services is retained by the MHP. If a client requires more than twenty-five (25) hours of coaching per week of TBS, the Contractor shall contact COR for approval. However, if client requires more than four (4) months of services, provider will use internal/tracking request system that does not require COR approval.

- Authorization for services for San Diego clients placed out of county are referred to the COR for authorization for TBS services.

## Dual Diagnosis Capable Programs

- Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. BHS has adopted the Comprehensive, Continuous Integrated System of Care (CCISC) Model for individuals and families with co-occurring substance use and mental health disorders. Programs must organize their infrastructure to routinely welcome, identify, and address co-occurring substance use issues in

the clients and families they serve. They shall provide properly matched interventions in the context of their program design and resources. For specific information regarding CCISC and dually diagnosed clients, please see *OPOH Section A*.

## Mental Health Services for Indian Enrollees

- The contract between the State DHCS and the MHP, to the extent that the MHP has a provider network, which enroll Indians must:
    - Require the MHP to demonstrate that there is sufficient Indian Health Care Providers (IHCP) participating in the provider network of the MHP to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.
    - Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers.
    - Permit Indian enrollees to obtain services covered under the contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.
- The MHP shall provide behavioral health care services to Indian enrollees who choose to have their services delivered by an Indian Health Care Provider. Programs shall contact Optum to arrange for services and payment for clients referred to Indian Health Care Providers.

## Residency

- The Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition and is established by the client's verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any client must be billed at full cost.
    - See *OPOH Section D* for additional information on the provision of specialty mental health services to Child/Youth Out of County Medi-Cal clients.