COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 1, POLICY 009

ACCESS AND AVAILABILITY OF SERVICES

POLICY NUMBER:	5-1-009
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	02/15/2024
EFFECTIVE:	01/01/2024
SUPERSEDES # :	**Supersedes Policy #'s:** 5-5-004 BH Network Adequacy and Timely Access to Services 5-10-002 Access and Toll-Free Number 5-10-003 Access Log 5-10-005 Out of Network Access 5-5-002 Provider Directory 6-5-007 Behavioral Health Network Adequacy and Timely Access to Services SUD 6-5-008 Provider Directory PP 304 Consumer Access to Provider List (11-28-11) PP 502 Access and Toll-Free Number (11-30-11) PP 516 Parameters for Service Relationships in a Recovery-based Mental Health System PP 604 TBS PP 1104 Access and Crisis Logs (1-24-12) PP 1104-A Access Log Page (1-5-09) PP 1110 Day Rehab PP 1112 Intake and Authorization Process for Outpatient Services PP 1114 Individual and Group Provider Selection and Retention (10-24-008) PP 1120 Authorization of Out of Plan Services After Hours Script 4-4-17 Business Hours Script SG v1

A. PURPOSE: To establish a uniform Access and Availability of Services policy, to ensure the provision of appropriate access to timely and medically necessary services for members of Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) and Network Providers consistent with state and federal requirements.

B. RELATED DOCUMENTS: N/A

C. DEFINITIONS:

1. **24/7 Access line:** A statewide, toll-free telephone number available 24 hours a day, seven days per week, with language capability in all languages spoken by Medi-Cal members in the county.

2. **Administrator**: Yolo County HHSA BH is the administrator of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan, hereby referred to as the "Administrator".

3. **American Indian / Alaska Native (AI/AN):** Any person defined in 25 United States Code sections 1603 (13), 1603(28), or 1679(a), or who has been determined eligible as an Indian under 42 CFR section 136.12.

4. **DHCS:** California Department of Health Care Services

5. **Distance**: The number of miles a member must travel from the member's residence to the nearest provider site.

6. **Drug Medi-Cal Organized Delivery System Services (DMC-ODS Services)**: Mandatory DMC-ODS Covered Services include:
    a. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (for members under age 21)
    b. Withdrawal Management (minimum one level)
    c. Intensive Outpatient Treatment Services
    d. Outpatient Treatment Services
    e. Opioid (Narcotic) Treatment Programs
    f. Recovery Services
    g. Care Coordination
    h. Clinician Consultation
    i. Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT)
    j. Residential Treatment Services (ASAM Levels 3.1, 3.3, and 3.5)

7. **Indian Health Care Provider (IHCP)**: A health care program operated by the IHS ("IHS facility"), an Indian tribe, a Tribal Organization, or Urban Indian Organization.

8. **Indian Tribe**: Any Indian tribe, band, nation or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act which is recognized as

eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

9. **Network Providers**: Any provider, group of providers, or entity that has a network provider agreement with the Administrator and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract.

10. **Specialty Mental Health Services (SMHS)**: as defined by the MHP Contract between HHSA BH and the California Department of Health Care Services (DHCS) and shall include:
    a. Mental Health Services
    b. Medication Support Services
    c. Day Treatment Intensive
    d. Day Rehabilitation
    e. Crisis Intervention
    f. Crisis Stabilization
    g. Adult Residential Treatment Services
    h. Crisis Residential Treatment Services
    i. Psychiatric Health Facility Services
    j. Intensive Care Coordination (for members under the age of 21)
    k. Intensive Home-Based Services (for members under the age of 21)
    l. Therapeutic Behavioral Services (for members under the age of 21)
    m. Therapeutic Foster Care (for members under the age of 21)
    n. Psychiatric Inpatient Hospital Services
    o. Targeted Case Management
    p. Peer Support Services
    q. For members under the age of 21, the Provider shall provide all medically necessary specialty mental health services required

11. **Time:** The number of minutes it takes a member to travel from the member's residence to the nearest provider site.

12. **Timely access**: The time from the initial request for behavioral health care services, by a member or the member's treating provider, to the earliest date offered for the appointment for services.

13. **Tribal Organization:** The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, that in any case where a contract is let or grant made to an organization to perform services benefitting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.

14. **Urban Indian Organization:** A nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating

with other public and private entities for the purpose of performing the activities of contracts and grants for the provision of health care and referral services.

15. **Urgent care:** A non-life-threatening situation experienced by a member which disrupts normal activities of daily living, and that without timely intervention, is highly likely to result in an immediate emergency condition.

D. POLICY: It is the policy of Yolo County HHSA BH ("The Administrator") and its Network Providers to ensure eligible members seeking behavioral health services receive timely, accessible, and appropriate care. The Administrator shall:

1. Establish and maintain:
    a. Provider Networks,
    b. Policies & Procedures (P&P's),
    c. Quality assurance monitoring systems and processes, sufficient to ensure compliance with clinical appropriateness standards.

2. Ensure that all Administrator and Network Providers processes necessary to obtain covered behavioral health services including, but not limited to, prior authorization, are completed in a manner that assures the provision of covered behavioral health care services to members in a timely manner appropriate for the member's condition and in compliance with Title 28 CCR, section 1300.67.2.2.

3. Provide, or arrange and pay for, medically necessary covered services for Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder Services (SUD), as appropriate and consistent with good professional practice.

4. Provide Language Accessibility. The Administrator and Network Providers, shall facilitate adequate access to BH services for all members within Yolo County, including those with limited English proficiency or physical or mental disabilities and shall make available oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available to members, free of charge, for any language.

5. Require Network Providers to have hours of operation during which services are provided to Medi-Cal members that are no less than the hours of operation during which the Network Provider offers services to non-Medi-Cal members. If the Network Provider only serves Medi-Cal members, the Administrator shall require that hours of operation are comparable to the hours the Network Provider makes available for Medi-Cal services that are not covered by the Administrator, or another Administrator.

E. PROCEDURE:

1. **Accessibility:** Member's may access behavioral health services through the Administrator's access points. Requests for access can be received by phone, in person or in writing. Walk-ins shall be made available at clinics located in the county's major cities: Woodland, West Sacramento, and Davis.

a. **Access Points:** The Administrator's access points shall, at minimum, determine the appropriate treatment service (Mental Health and/or Substance Use Disorder) and any additional linkages that shall benefit the member.

b. **Access Line:** The Administrator shall make available 24 hours a day, 7 days a week, Behavioral Health services, when medically necessary, with language capability in all languages spoken by members of the county.
   i. A statewide, toll-free Behavioral Health 24/7 Access Line telephone number (1-888-965-6647 / TDD 1-800-735-2929) shall provide information to members on:
      1. How to access behavioral health services, including services required to assess whether medical necessity criteria are met,
      2. Referrals to services, including for urgent conditions and medical emergencies,
      3. How to access services needed to treat a member's urgent condition,
      4. How to use the member problem resolution and fair hearing process,
      5. How to access the Provider Directory.
   ii. The Administrator shall ensure staff responsible for the statewide toll-free 24-hour telephone receive appropriate training to ensure linguistic capabilities.

c. **Access Logging Requirements:**
   The Administrator shall maintain a written log of initial requests for BH services from members meeting Yolo County's target population.
   i. Requests shall be recorded whether they are made via telephone, in writing, or in person. The log shall contain at minimum:
      1. the name of the member,
      2. the date of the request, and
      3. the initial disposition of the request.
   ii. When a service request is pending disposition or requires additional follow-up/engagement, access point staff shall be required to document all attempts to engage the client and close out the access episode.
   iii. Access staff shall follow-up on all service requests pending disposition and shall make appropriate attempts to engage members.

d. **Mechanism to Assess the Accessibility of Services**
   As part of its Quality Assessment and Performance Improvement Work Plan, the Administrator will assess the accessibility of services within its service delivery area. This shall include:
   i. The assessment of responsiveness of the 24-hour toll-free Access Line,
   ii. Timeliness of scheduling routine appointments,
   iii. Timeliness of services for urgent conditions, and,
   iv. Access to after-hours care.

2. **Provider Directory**
   a. The Administrator shall maintain a Provider Directory that shall be made available in electronic and paper form, when the member first accesses services and thereafter

upon request. The Provider Directory shall include the following for all Administrator and Network Providers:

i. Information on the category or categories of services available from each provider.
ii. The names, any group affiliations, street addresses, telephone numbers, specialty, and website URLs of current contracted providers by category.
iii. Hours of Operation
iv. The cultural and linguistic capabilities of network providers, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
v. Lists of services available for members in their primary language by location of the services.
vi. Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
vii. Which providers are accepting new members.
viii. Type of practitioner as appropriate.
ix. National Provider Identifier number.
x. California License number and type of license.

b. Provider directory shall be updated at least monthly or updated no later than 30 calendar days after the Administrator receives updated provider information.
c. The Administrator shall ensure processes are in place to allow providers to promptly verify or submit changes to information required to be in the directory.
d. Provider directories shall be made available on the Administrator’s website in a machine-readable file and format as specified by the Secretary.

3. **Network Adequacy:** The Administrator shall adhere to Network adequacy standards, in accordance with DHCS requirements and shall meet time and distance standards specified in the Welfare & Institutions Code.

   a. **Network Adequacy Monitoring**

      i. The Administrator shall submit documentation to DHCS for both MHP SMHS and DMC-ODS SUD, in a format specified by DHCS, that ensures the Administrator complies with the following requirements:
         1. Offers an appropriate range of services that are adequate for the anticipated number of members.
         2. Maintains a network of providers that are sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members.
      ii. Network providers shall be monitored regularly to ensure compliance with timely access requirements and corrective action shall be taken if there is a failure to comply with timely access requirements.

b. **Time and Distance Standards**.

i. The Administrator shall adhere to, in all geographic areas within Yolo County, the time and distance standards developed by DHCS.

1. For outpatient Medi-Cal SMHS including Mental Health Services, Targeted Case Management, Crisis Intervention, and Psychiatrist Services, the Administrator shall ensure that Network Providers are located within 45 miles or 75 minutes of a member's residence, or as specified by DHCS.
2. For outpatient DMC-ODS Substance Use Disorder (SUD) services other than Opioid Treatment Programs (OTPs), the Administrator shall ensure that Network Providers are located within 60 miles or 90 minutes of a covered member's residence, or as specified by DHCS.
3. For OTPs DMC-ODS SUD services, the Administrator shall ensure that providers are located within 45 miles or 75 minutes of a member's residence, or as specified by DHCS.

c. **Network Capacity:**

i. The Administrator shall meet or exceed network provider capacity requirements, as set by the DHCS, proportionately adjusting the number of network providers to support any anticipated changes in enrollment.

ii. The Administrator shall ensure that it's directly operated and/or contracted provider network has adequate capacity and maintains a network availability of licensed providers to offer member's appointments that meet timeliness standards.

iii. The Administrator shall report to DHCS when there has been a significant change in Behavioral Health Network Capacity, within 10 business days of reported change.

d. **Network Timely Access:**

i. The Administrator and Network Providers for SMHS shall meet state standards for timely access to care and services, taking into account the urgency of the need for services as outlined below:

1. Non-urgent appointments with specialist physicians (i.e., psychiatrists) shall be provided within 15 business days of the request for appointment
2. Non-urgent appointments with a non-physician provider shall be provided within 10 business days of the request for appointment
3. Urgent care appointment for services that do not require prior authorization within 48 hours of the request for appointment
4. Urgent care appointments for services that require prior authorization within 96 hours of the request for appointment
5. Non-urgent appointments with a non-physician provider for OTP appointments shall be provided within 3 business days of the request for appointment.
6. The Administrator and/or Network Providers may extend an appointment time, if the referring or treating (licensed health care) provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice

and consistent with professionally recognized standards of practice, has determined and noted in the member's record that a longer waiting time will not have a detrimental impact on the health of the member

7. The Administrator and/or Network Providers may schedule periodic office visits, in advance, to monitor and treat BH conditions consistent with professionally recognized standards of practice as determined by the treating licensed provider acting within the scope of his or her practice.
8. When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's behavioral health care needs and ensures continuity of care consistent with good professional practice.
9. Interpreter services shall be coordinated with scheduled appointments in a manner that ensures timely access.

ii. The Administrator and Network Providers for DMC-ODS services shall meet state standards for timely access to care and services, taking into account the urgency of the need for services.

1. Outpatient Services for SUD shall be offered an appointment within 10 business days of the request for services.
2. Residential Services for SUD shall be offered an appointment within 10 business days of the request for services.
3. Opioid (Narcotic) Treatment Program services shall be offered an appointment within 3 business days of the request for services.
    a. For OTP patients, the OTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations (i.e., with take home medications, time in treatment requirements are not applicable to buprenorphine patients.)
4. Non-urgent follow up appointments with a non-physician shall be offered an appointment within 10 business days of the request for services.
5. Urgent appointments shall be made in a timely fashion appropriate to the nature of the member's condition, not to exceed 72 hours.
    a. DHCS defines urgent as when the member's condition is such that they face 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, decisions to approve, modify, or deny requests by providers prior to or concurrent with the provision of health care services to members.

e. **Urgent Timeliness standards**:
   i. Urgent care appointment for mental health services that do not require prior authorization shall be made available within 48 hours of the request for appointment
   ii. Urgent care appointments for mental health services that require prior authorization shall be made available within 96 hours of the request for appointment
   iii. Urgent care appointment for SUD services that do not require prior authorization shall be made available within 24 hours of the request for appointment
   iv. Urgent care appointments for SUD services that require prior authorization shall be made available within 72 hours of the request for appointment

f. **Alternative Access:**
   i. The Administrator shall submit an Alternative Access Standards Request to DHCS for approval, when unable to meet time and distance standards for all coverage areas where members reside, and when all other reasonable options to obtain providers to meet the applicable standards have been exhausted.
   ii. The Alternative Access Standards shall include a description of how the Administrator intends to arrange for members to access covered services.

4. **Out of Network:**
   a. The Administrator shall adequately and timely cover services out of network for covered members, when the Administrator is unable to provide necessary services through its Network Providers and shall continue to provide services for as long as the Administrator and Network Providers are unable to provide them.
   b. In cases where an out of network provider is not available within the time and distance standards, the Administrator will arrange for telehealth or transportation to an in-person visit. Members have the right to an in-person visit if they do not want to accept a telehealth visit. Services rendered by in-network or out of network providers, including those provided within a DHCS approved alternative access standard, must comply with timely access standards as well.
   c. In the event, a member requests a second opinion, the Administrator shall arrange for a second opinion from a network provider, or with an out of network provider, at no cost to the member.
   d. Out of network providers are required to coordinate with the Administrator for payment and must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.
   e. If an individual is eligible for American Indian Health Services (IHS), and there are no American Indian Health Care Providers (IHCP) within the county, the Administrator shall permit out-of-network services from an IHCP. The Administrator shall make efforts to contract with IHS for medically necessary services as deemed appropriate for eligible participants.
   f. AI/AN Medi-Cal members whose county of responsibility is a DMC-ODS county may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the member's county of responsibility and whether or not the IHCP is located in the member's county of responsibility.

g. AI/AN Medi-Cal members may choose to receive SMHS at any DHCS Medi-Cal certified IHCP, whether or not the IHCP has a current contract with the member's county of responsibility. MHPs are not obligated to pay for SMHS provided to non-AI/AN members by IHCPs that are not contracted with the MHP.

5. **American Indian / Alaska Native and American Indian Health Services:**
    a. The Administrator and Network Providers shall comply with federal regulations addressing protections for AI/AN and American Indian Health Services provided within a managed care system.
    b. AI/AN and American Indian Health Facilities (AIHF) are not required to contract with the Administrator; however, the Administrator shall document good faith efforts to contract with all AIHFs within Yolo County.
    c. The Administrator shall submit an explanation to DHCS that may include supporting documentation, to justify the absence of contracts with all AIHFs in Yolo County.
    d. The Administrator will allow AI/AN to obtain SMHS or DMC-ODS services from out of network AIHFs, if the members meet the medical necessity and other requirements to receive SMHS or DMC-ODS services.
    e. The Administrator and Network Providers shall permit an out of network DMC-certified IHCP to refer an AI/AN member to a network provider.

6. **Community Based and Mobile Services:** BH services shall be provided in the least restrictive setting, consistent with the goals of recovery and resiliency.
    a. For services where the individual provider travels to the member to deliver services, the Administrator and/or Network Providers shall ensure services are provided in a timely manner in accordance with the timely access standards and consistent with the member's individualized client plan.
    b. The Administrator shall submit information to DHCS on the availability and provision of community-based or mobile services, using the mechanism developed by DHCS.

7. **Telehealth Services:**
    a. The Administrator and/or Network Providers may use telehealth services to meet network adequacy standards.
    b. When telehealth is used to fulfill network adequacy requirements for time and distance standards, telehealth services shall be provided to members in the defined service area.
    c. When the Administrator utilizes telehealth to comply with time, distance and timely access standards, the Administrator shall submit supporting documentation and evidence to DHCS for contracting efforts made with providers that are physically located for DHCS review and approval. In the absence of an emergency that would preclude in-person service delivery, the Administrator will not require a member to access services via telehealth.
    d. The physical location where members receive telehealth services shall meet the State's time and distance standards or an approved alternative access standard.
    e. Telehealth services shall be furnished in accordance with approved and executed Network Provider policies and shall meet federal, state and Yolo County regulations.

F. REFERENCES:

1. Title 42, CFR, sections 438.10, 438.14, 438.2, 438.206, 438.207, 438.214, and 438.68
2. Title 25, US Code, sections 1603, 1653, and 5304
3. Title 42, US Code, section 1396d(r)
4. Title 43, US Code, section 1601 et seq
5. Title 9, CCR, sections 1810.253, 1810.360, 1810.405, 1810.410, 1810.435
6. Title 28, CCR, subdivision (d)(1), section 1300.67.2.2
7. Health & Safety Code 1367.03(a)(5)
8. Welfare and Institutions (W&I) Code sections 14717.1, 14184.402(d), 14197
9. DHCS Program Oversight and Compliance Annual Review Protocol for Specialty Mental Health Services and Other Funded Services, Category 1, Network Adequacy and Array of Services
10. Behavioral Health Information Notice 20-065: Obligations Related to Indian Health Care Providers in Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties
11. Behavioral Health Information Notice 21-008: Federal Out-of-Network Requirements for Mental Health Plans
12. Behavioral Health Information Notice 21-034: Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Plans
13. Behavioral Health Information Notice 22-020: County Mental Health Plan Obligations Related to Indian Health Care Providers
14. Behavioral Health Information Notice 23-041: 2023 Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plans
15. Behavioral Health Information Notice 24-001: Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022-2026
16. Yolo County Mental Health Plan Contract
17. Yolo County DMC-ODS Intergovernmental Agreement

Approved by:

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Karleen Jakowski, LMFT, Mental Health Director **Date**
Yolo County Health and Human Services Agency