

 <p style="text-align: center;">County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	QM
	Policy Number	QM-01-12
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Title: Process for Change of Provider Requests	Functional Area: Access	
Approved By: (Signature on File) Signed version available upon request Alexandra Rechs, LMFT Program Manager, Quality Management		

BACKGROUND/CONTEXT:

The Division of Behavioral Health Services (BHS), which includes both the Sacramento County Mental Health Plan (MHP) and the Sacramento County Drug Medi-Cal Organized Delivery System (DMC-ODS) within the Substance Use Prevention and Treatment program (SUPT), desires to ensure that beneficiaries of the plan (also referred to as members), and providers, have access to a process for change of provider requests. This will be done in accordance with California Code of Regulations (CCR), Title 9, California Department of Health Care Services (DHCS), 42 and 45 Code of Federal Regulations (CFR), MHP Contract, Ex. A, Attachment 8.

Providers are to abide by all county policies and procedures, State and Federal laws. BHS Member Services will be responsible for monitoring change of provider requests, member dissatisfaction and provider concerns, privacy issues, grievances, appeals, State Fair Hearings, and applicable Mental Health Services Act (MHSA) related issues. All written communications involving members and providers will be written in clear, concise language in a format understandable to the member. BHS Member Services staff will be available to give members any reasonable assistance in completing forms or other procedural steps related to change of provider requests. This includes, but is not limited to, interpreter services and alternative formats.

DEFINITIONS:

ADVERSE BENEFIT DETERMINATION: An adverse benefit determination occurs when the MHP or SUPT does any of the following: denies or limits authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; reduces, suspends, or terminates a previously authorized service; denies, in whole or part, payment for a service; fails to provide services in a timely manner, as determined by the MHP or SUPT, or fails to act within the timeframes for disposition of grievances, the resolution of standard appeals, or the resolution of expedited appeals; or denies a disputed financial liability, including, but not limited to, cost sharing, copayments, premiums, deductibles, and coinsurance.

CONTINUITY OF CARE: Beneficiaries with pre-existing provider relationships, who make a request to the Sacramento County MHP or SUPT for continuity of care services, will be given the option to continue services for a period up to, and not to exceed 12 months with an eligible out-of-network Medi-Cal provider or a terminated network provider to complete a course of

treatment or to arrange for a safe transfer of services in accordance with BHS Continuity of Care policies and procedures.

DISCRIMINATION: The MHP and SUPT complies with applicable State and Federal civil rights laws and does not unlawfully discriminate against, exclude, or treat people differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

GRIEVANCE BY BENEFICIARY (MEMBER): A grievance is defined as any expression of dissatisfaction about any matter other than an adverse benefit determination by a member, verbally or in writing or, with the member's permission, by a support person such as family, friend, or advocate, regarding services offered through the MHP or SUPT. Examples of possible grievances include, but are not limited to the quality of care or service, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect a member's rights, barriers accessing services, etc.

LATERAL TRANSFER: A member transferring from one Sacramento County Behavioral Health Program within the same Plan (MHP or SUPT) of the same type of service and the same level of service.

LEVEL OF CARE TRANSFER: A member transferring from one level of service to another level of service within the same Plan (MHP or SUPT) based upon medical necessity criteria. For example, within the MHP transferring between FIT, FSP, WRAP, or Residential for children or between CORE and FSP for adults. Within SUPT transferring between outpatient, intensive outpatient, or residential. For residential services, prior authorization is required. Adjunct services, which include, but are not limited to, TBS, crisis residential, SUPT medication management, and inpatient psychiatric services are not considered a change of provider but may be in addition to services with the primary provider.

MENTAL HEALTH PLAN (MHP): Sacramento County is the entity responsible for the oversight and implementation of Managed Care Medi-Cal Specialty Mental Health Services for Sacramento County and the Mental Health Services Act. All County providers, contract organizational providers, and network providers are Providers for the MHP. All people who receive services under the MHP are the members. BHS Member Services is the unit responsible for activities and oversight relating to change of provider requests.

SUBSTANCE USE PREVENTION AND TREATMENT PLAN (SUPT): Sacramento County is the entity responsible for the oversight and implementation of the Managed Care Plan for the Drug Medi-Cal Organized Delivery System (DMC-ODS) for Sacramento County members. SUPT is the name of Sacramento County's Plan. All drug and alcohol county providers, contract organizational providers, and network providers are Providers for SUPT.

PURPOSE:

The purpose of this policy is to delineate policies and procedures for the management of transfer requests within Sacramento County Behavioral Health Services (referred to as Change of Provider Requests). MHP and SUPT services will be referred to together as "Plan", unless otherwise specified. The roles and responsibilities of BHS Member Services,

beneficiaries (members) and providers will be specified. BHS will not discriminate or penalize a beneficiary or provider for using the change of provider process.

DETAILS:

BHS strives to honor a member's voice and choice regarding Plan provider options. However, the Plan may put some limitations on available choices. Members must meet medical necessity criteria for the type and level of service being requested. When initiating behavioral health services, the Plan accommodates a member's ability to access services by assigning them to a provider within reasonable proximity to their residence. Members have the right to request to choose between at least two Plan providers for which they qualify. Once enrolled with a Plan provider, the member may request to change to a different in-network provider, at any time, and may be given the option to choose between at least two providers for which they qualify, to the extent possible, appropriate, and available. Provider directories are available upon request, and are posted on the county website, www.dhs.sacounty.gov. Residential and inpatient services (excluding outpatient withdrawal management services), require prior authorization from the Plan.

If the member is already enrolled in a managed care plan, the member has the right to continue care from that provider while receiving services from the Plan, as long as the services are coordinated between the providers and the services are not the same.

In addition, if the member is already receiving services from another behavioral health plan, managed care plan, or an individual provider, the Member may request "continuity of care" to remain with this provider for up to 12-months. See PP-BHS-QM-08-02-Continuity of Care, for additional information.

A decision to transfer a member from an out-of-network provider to the Plan is not considered a Change of Provider request. This is an initial request for services, either from the member or their out-of-network provider. The referring provider must complete and submit the Sacramento County Bi-Directional Transition of Care Tool and forward it to the Plan or the member may contact the Plan directly for consideration. Appropriate screening and assessment is required to determine eligibility for Plan services.

Similarly, a member's decision to transfer from the Plan to an out-of-network provider is not considered a Change of Provider Request. Plan providers are expected to assist members with linkage to an out-of-network provider using the Sacramento County Bi-Directional Transition of Care Tool and comply with any NOABD requirements.

Process for Initiating Services

Members may either call the MHP Access Team, SUPT Adult System of Care, SUPT Youth System of Care, or call/walk-in to the desired provider site to initiate services.

When a member walks-in to a provider site to initiate services, if the desired provider site is not able to immediately assess for services, the member will be given the option to schedule an appointment for assessment or be linked to another similar provider, chosen by the member.

1. The provider completes the following steps in SmartCare:

- Complete Inquiry (Provider Inquiries Tip Sheet posted on the EHR webpage at: <https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/EHR-Training.aspx>)
 - Enroll the client into their program.
2. The provider creates a service note documenting the request and outcome in the member's SmartCare medical record.
 3. The provider completes all existing intake practices.
 4. If the requested service is denied, the provider follows NOABD protocols.

Change of Provider Process:

The following process applies to Change of Provider Requests that do not involve a grievance issue. Grievance issues must follow the grievance process prior to a change of provider request resolution. See PP-BHS-QM-03-01-Problem Resolution, for additional information.

A member may request a different staff within the same provider agency directly from the provider or they may contact BHS Member Services for assistance.

Members must qualify for a higher level of care Change of Provider based on medical necessity for the level of care being requested. Due to this, members must request level of care changes directly from their current provider. The current provider will determine, based upon behavioral health history, collateral information, current functioning, clinical assessment, and in consultation with BHS staff, as necessary and appropriate, if a level of care change meets medical necessity for the level of care being requested.

Members may request a lateral Change of Provider either verbally or in writing. The request must be made by the member or with the member's permission, their appointed representative to act on their behalf. A member may request a lateral Change of Provider when initiating services and at any time thereafter. The member may request a Change of Provider in the following ways:

1. Directly from the current provider. – MHP ONLY
2. By calling or walking into the desired provider site.
3. By contacting QM Member Services by telephone, email, in-person, letter, or Change of Provider form.

Current Provider Responsibilities

Members may ask their current provider to transfer to a different agency. The current provider is responsible to consider the request and take the following actions:

1. Determine if the request is clinically appropriate.
2. Determine if the member qualifies for the level of service being requested.
3. Discuss potential barriers to successful participation in services at the requested site and plan how to mitigate the barrier(s), as appropriate.
4. If the request is being made by an authorized representative of an unconserved adult, the transferring provider must first confirm with the member that the transfer is desired.
5. Document in a service note the request and outcome in the member's SmartCare medical record or provider EHR.
6. Submit an Inquiry in SmartCare to transfer to the requested provider.
7. Initiate warm hand-off to include communication with the receiving provider.

8. Ensure the member has sufficient medication to last until the appointment with the psychiatrist at the new site, as clinically appropriate.
9. Keep member open to the current site until the member is successfully enrolled in the receiving provider site (attended intake and/or psychiatrist appointment).
10. The current provider closes the case and completes a discharge note in SmartCare.
11. The current provider may not transfer a member without their express permission. All requests must be documented in the member's medical record. All written transfer requests must be scanned into the member's medical record.
12. Mail the member a letter confirming the request and its outcome and scan a copy into the member's medical record.
13. If a transfer request is denied based upon the type or level of service being requested, a Denial NOABD must be mailed to the member within 2 business days of the decision. A denial of transfer does not impact existing services. See PP-BHS-QM-02-01-Notice of Adverse Benefit Determination.

Requested Provider Responsibilities

1. When a linked member walks into a provider site, other than the one assigned to, and requests services with this new provider.
2. New provider communicates with existing provider to determine appropriateness of transfer (stability, treatment concerns, housing concerns that may be impacted by transfer, medication supply, etc.)
3. New provider completes the following steps in SmartCare:
 - a. Complete Inquiry (Provider Inquiries Tip Sheet posted on the EHR webpage at: <https://dhs.saccounty.gov/BHS/BHS-EHR/Pages/EHR-Training.aspx>)
 - b. Enroll the client into their program
4. New provider creates a service note documenting the request and outcome in the member's SmartCare medical record.
5. New provider completes all existing intake practices.

BHS Member Services Process

The Member may seek assistance with a Change of Provider request by contacting BHS Member Services. When this happens, Member Services will take the following actions:

1. Member Services staff may review the request by interviewing the member and provider regarding the circumstances prompting the request and address any grievance issues, as appropriate.
2. Member Services will inform the assigned County Contract Monitor of any grievance issues and include them in all correspondence.
3. Member Services will consider the following factors when considering a Change of Provider Request:
 - a. Availability of resources.
 - b. Culture-specific needs.
 - c. Level of care requested.
 - d. Reason for the request.
 - e. Resources of the member (e.g., transportation).
 - f. Member's utilization of services/involvement at a site (e.g., working as a volunteer).
 - g. Available options within the provider site.

- h. Whether the request involves a service option or activity available at the site requested, but not at the current or geographic site.
 - i. Clinical appropriateness
4. Member Services will mail the member a letter confirming the change of provider request and/or the grievance issue and its resolution.

REFERENCE(S)/ATTACHMENTS:

Code of Federal Regulations, Titles 42 and 45
 California Code of Regulations (CCR), Title 9, Section 1830.225(a) and (b)
 Sacramento County MHP Beneficiary Handbook-SMHS 2024
 Sacramento County DMC-ODS Beneficiary Handbook- 2024
 Sacramento County Bi-Directional Transition of Care Tool

RELATED POLICIES:

PP-BHS-QM-02-01-Notice of Adverse Benefit Determination
 PP-BHS-QM-03-01-Problem Resolution
 PP-BHS-QM-03-08-Problem Resolution Forms Brochures Distribution
 PP-BHS-QM-08-02-Continuity of Care
 PP-BHS-QM-10-30-Progress Notes – Non-Medical Services – MHP
 PP-BHS-QM-01-07 Determination of Medical Necessity & Access to Specialty Mental Health Services
 PP-BHS-QM-20-04-Timely Access
 PP-BHS-QM-01-08-Inpatient Hospitalization Treatment Authorization Requests
 PP-BHS-SUPT-01-01-SUPT-Overview
 PP-BHS-SUPT-03-01-Coordination and Continuity of Care

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Plan County Operated Staff	X	Children’s Contract Providers
X	Adult Contract Providers	X	Substance Use, Prevention and Treatment

CONTACT INFORMATION:

Quality Management Information
QMInformation@SacCounty.net