START-ODS
SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

ELIGIBILITY REQUIREMENTS FOR SUBSTANCE USE DISORDER TREATMENT SERVICES:
Ensuring Patients Qualify for Services and Providing Assistance

Eligibility for Publicly Funded Services

Los Angeles County's (LAC) substance use disorder (SUD) system is designed to serve people with low incomes and who are unable to purchase coverage in the health insurance exchange through Covered California. This group includes individuals who are eligible for Medi-Cal or My Health LA, as well as individuals who are mandated to participate in certain criminal justice programs, such as Assembly Bill (AB) 109 and Drug Courts. While individuals with commercial insurance do not qualify, including those with high deductibles or copays, treatment providers can choose to serve this population based on sliding scale or ability-to-pay determinations.

Medi-Cal Eligibility:

MAGI Medi-Cal: Adults without minor children in the household (19-64), children under age 19 regardless of documentation status, pregnant women, or parent/ caretakers based on federal poverty level and where deprivation requirement is no longer considered. Property and resources are exempt from eligibility determination.

Non-MAGI: Foster care and former foster care children, minor consent, medically needy, seniors and people with disabilities, and others.

To Apply: The preferred method is to visit the Department of Public Social Services (DPSS) Your Benefits Now! website. Alternative methods are to call 1-866-613-3777 or go to a DPSS location, or call 1-800-300-1506 or visit the Covered California website.

My Health LA Eligibility:

Program: No-cost primary health care to income-eligible LAC residents 19 years of age and older who do not have and cannot get health insurance. The SUD benefits are the same as LACs' Drug Medi-Cal (DMC) benefits.

To Apply: My Health LA partners with nearly 200 clinics called Community Partners. Locate a nearby clinic by viewing the map or directory and then contact a site to see if it is accepting new patients. More information is at the Department of Health Services' My Health LA webpage.

Enrollment Responsibilities

The SUD network provider is responsible for assisting all eligible referrals to obtain and maintain Medi-Cal or My Health LA benefits. This includes assisting new referrals in completing the application; requesting retro-active coverage, if medical expenses were incurred in the preceding three months, by responding *"Yes this person has a medical expense in the last 3 months that he or she needs help paying for"* in Step 2 of the application; and enrolling individuals in services while the application is being processed. The application should be signed and submitted even if all of the information is not available at the time of submission.

No Medi-Cal or My Health LA eligible individual can be turned away by a network provider, if the application process is incomplete or pending approval. Network providers need to use the Case Management benefit to assist patients to obtain and maintain their health benefits.

Medi-Cal managed care plans in LAC include (1) L.A. Care and its delegated partners Kaiser Foundation Health Plan, Anthem Blue Cross and Care 1st Health Plan; and (2) Health Net and its delegated partner Molina Health Care. If a Medi-Cal beneficiary has a member card from one of these health plans, the individual can be served under DMC.

LAC Residency and Benefits Transfer

All patients need to be residents of LAC, and have their Medi-Cal benefits assigned to LAC (if Medi-Cal eligible), with the exception of Opioid Treatment Program patients who have until July 1, 2018 to transition back to the County of residence for services.

If a prospective patient resides in LAC (LA County Code=19), but has Medi-Cal benefits assigned to another California county, the patient, with the provider's assistance, needs to call the public social services office in the originating county to authorize the transfer; this process is referred to as an Inter-County Transfer (ICT). The patient needs to provide the receiving county (DPSS) with their new physical address. If the patient has benefits in one county for a day or more, the benefit in that county will remain for the entire month.

Using the Case Management Benefit

Once medical necessity has been established, and the individual has been admitted to the appropriate level of care, the case management benefit needs to be used to support patients in completing the enrollment process, following-up monthly to ensure the benefits remain active, and supporting patients through the redetermination process. Up to 7 hours of case management services can be claimed monthly (in most levels of care) to support connections with health and social service needs, including benefits acquisition and maintenance.

Verifying Medi-Cal Enrollment

The provider has the option to verify Medi-Cal enrollment through the Department of Health Care Services (DHCS) at http://www.medi-cal.ca.gov/signup.asp. To obtain access to this system, the provider must complete the Medi-Cal Point of Service (POS) network/internet agreement form which can be found on the website listed above.

Medi-Cal Automated Eligibility Verification Process

The provider can also obtain Medi-Cal enrollment verification by calling 1-800-541-5555. The provider will be instructed to enter their Provider Identification Number (PIN) or be walked through the process of establishing a PIN number.

Your Benefits Now! (YBN)

Another method of verifying Medi-Cal eligibility is through the Your Benefits Now! web application. The system requires the patient customer ID and PIN to verify enrollment via the YBN system.

Providers can access this feature at:
https://www.dpssbenefits.lacounty.gov/ybn/SignInPage.html

Verifying My Health LA Enrollment

Providers can verify My Health LA enrollment by calling the My Health LA helpdesk number at 1-844-744-6452. Individuals who qualify for My Health LA but who refuse to or are unable to enroll can still receive treatment services, and the network provider will be reimbursed as long as My Health LA eligibility is documented in the County's data collection system.

Sliding Scale Fees

Fees cannot be charged to eligible Medi-Cal beneficiaries or My Health LA participants, even during the benefits acquisition process. This includes, but is not limited to, waitlist fees, assessment fees, and sliding scale fees. The only exception is Medi-Cal beneficiaries who have a required share-of-cost up to a predetermined amount before services are fully covered. Sliding scale fees are only allowable for individuals who have commercial insurance, or who do not qualify for Medi-Cal or My Health LA.

Reimbursable Services

Substance Abuse Prevention and Control will only reimburse network providers for the delivery of medically necessary SUD treatment services for (1) active Medi-Cal beneficiaries and My Health LA eligible individuals who are verifiable residents of LAC, and (2) individuals who are mandated to participate in certain criminal justice programs such as AB 109 and Drug Court who are verifiable residents of LAC. Claims will be denied for individuals who do not meet eligibility criteria. SAPC network providers are still required to accept and serve patients with pending Medi-Cal and My Health LA applications, and claims need to be held until Medi-Cal enrollment is obtained, including an active Client Identification Number (CIN). If Medi-Cal is approved, DMC claims can be submitted and reimbursed back to the date of completed application.

Submitting Applications

In LAC, Medi-Cal applications are generally processed within 30 to 45 days (this includes approval and activation). The applicant will receive a Notice of Action (NOA) concerning the application. If the application is rejected the person can appeal. If the person is accepted the NOA will outline when coverage will start and include the ID number. The beneficiary will also receive a Beneficiary ID card and a PIN number in separate envelopes to ensure privacy is maintained. If the person is a previous Medi-Cal beneficiary (e.g. a 40-year-old who had Medi-Cal as a young child) the old card will be reactivated; if the person needs a new card a request to DPSS is required.

Reimbursement Procedures

During this transition period, network providers will be reimbursed for delivered treatment services for up to 45 days after admission, including establishment of medical necessity (including ASAM assessment) and entry of the required data elements (LACPRS), for: (1) patients who are likely eligible for Medi-Cal and whose complete Medi-Cal application is submitted with a Client Identification Number (CIN) number assigned but who are awaiting a determination of eligibility by the State; and (2) patients who need current Medi-Cal benefits re-assigned to Los Angeles County due to a permanent move. This reimbursement policy also applies to individuals who are eligible for My Health LA regardless of whether or not enrollment is complete, provided attempts are documented in the patient's chart. Proof of application and case management assistance is required for reimbursement in denied cases.

Monthly Verification of Active Benefits

Network Provider staff need to verify Medi-Cal eligibility at least monthly to ensure that the individual still qualifies for publicly funded services and to ensure services are reimbursable based on current eligibility. Assigned case managers need to track due dates for required updates/renewals, and assist patients to submit required documentation on-time.