Reaching the 95 Percent "R95" FAQ

	QUESTIONS	ANSWERS
General R95 Capacity Building and Reimbursement Questions		
1.	Has there been a consideration to create a community outreach services structure that is billable, allowing programs to bill for outreaching prospective clients as part of 'reaching the 95'?	Yes. Currently, the 30- and 60-day (d) policy allows for reimbursable outreach and engagement activities prior to a diagnosis or assessment, though this is only available in non-residential settings, per State policy. Outreach services, billed as counseling and care coordination, are claimed once the patient's financial eligibility for services has been established. For patients who are not ready to complete the full ASAM, providers can take advantage of the 30d/60d initial engagement policy for non-residential services and provide ongoing recovery support services until the patient is ready for more intensive treatment services. While CalOMS should be completed on schedule, the 30d/60d initial engagement policy for non-residential services can serve as the basis for billing for community outreach services. R95 Focus Area 1: Outreach and Engagement and Capacity Building 2A-1, 2A-2 & 2A-3 - Formalizing New Partnerships are intended to support an agency in part to divert staff from direct services and instead cover salary expenses to find and build new referral partnerships and begin to increase the number of R95 patient admissions who do not currently have abstinence goals but want services, which is a mechanism for building these community outreach services initially outside of Medi-Cal billing. Capacity Building 2B - Expanding Field Based Services can build upon relationships established under Capacity Building 2A –Formalizing New Partnerships and leverages new community-based locations that already attract the focus population to deliver SUD treatment services. Capacity Building 2C – 30d/60d Engagement in part enables agencies to go outside of their treatment programs to engage individuals in the community and perform limited services (e.g., Individual sessions, care coordination).
2.	Why the templates are being created after the implementation?	All templates will be created before the due dates associated with each respective capacity deliverable. Templates will serve as a point of reference for SAPC when evaluating agency's implementation in alignment with agency attestations and template submissions. It was a priority to launch the Capacity Building and Incentives (CBI) initiative with payment reform which necessitated creating forms and processes during the FY 23-24.
R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT Preparation and Planning – 2A-1, 2A-2, 2A-3		

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R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT Field-Based Service (FBS) Expansion - 2B1, 2B-2		
3.	Re: Workgroup 1: Have the deadlines for 2A-1 thru 2B-1 been adjusted? Most of the meetings for Workgroup 1 are after the original deadline for partnership development (MOU's) and meetings (12/31/23)	The adjustment of deadlines for 2A-1 through 2B-1 is currently under review and consideration. Workgroup meetings will be adjusted accordingly to align with any newly adjusted deadlines.
4.	Does FBS need to be added to our Master Contract before we can participate in 2B?	Yes, a Field Based Services Application including a memorandum of understanding with the site operator must be submitted and approved by SAPC to participate in 2B. (see SAPC Bulletin 19-06 for application information).
5.	What is the turn-around approval process for FBS? We are awaiting approval for one submitted back in July/August.	The turnaround time to approve complete FBS applications is 15 business days. However, incomplete applications may take longer to review, because additional information will be requested from the submitting provider. Please email SAPCMonitoring@ph.lacounty.gov if you would like a status update on your application.
6.	When would the new FBS policy be in place?	The updated Field Based Policy is expected to be completed by early December 2023. However, providers should continue to utilize the existing FBS policy as outlined under SAPC Bulletin 19-06.
7.	Would telehealth be acceptable for community referrals and potentially field-based services?	Telehealth and field-based services are different methods of delivering substance used disorder services. Establishing Memorandum of Understandings (MOU) with local health and social service providers for referral processes that result in telehealth or field-based services could be done for 2A-3. However, since telehealth and field-based services are different, telehealth may NOT be utilized to verify claims for new admissions for field-based services (2-B2).
R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT 30- and 60-Day Engagement Policy - 2C1, 2C2		
8.	Has there been any further consideration about extending the initial engagement auth flexibilities to residential LOC's?	No, State policy does not currently permit initial engagement authorizations for residential LOCs, so that is not a flexibility that SAPC can offer our provider network.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Admissions & Discharge (A&D) Policies - 2D1, 2D2, 2D3		
9.	What is the definition of Same Day Admission?	Same Day Admission is defined as admitting someone the same day they seek services. For example, they call on Thursday and receive their first service on same Thursday.
10.	How can this be implemented with a criminal justice client with timeline deadlines from the	Similar to implementation of DMC-ODS, SAPC's position is that while treatment may be mandated by courts, the specifics of that treatment (what setting, how

	court and probation officers' requirements of abstinence?	long, what type of treatment, etc) are based on clinical determinations made by substance use disorder (SUD) providers and not courts/judges. This is the approach taken with mental health (MH) services and there should be an equal approach taken with SUD services. If SUD agencies are asked to abide by court mandates on specifics of treatment, SAPC suggests highlighting this position with them and contacting SAPC so we can assist with these communications. While we expect some courts to question this approach, we have made progress after DMC-ODS implementation and also anticipate being able to achieve this more appropriate approach to SUD care delivery.
11.	We have those elements in other P&Ps (some in admissions, some in other documents) will that be okay for submission?	It is the intention that each required element in SAPC's Admission and Discharge (A&D) policy is explicitly included in participating agencies updated A&D P&P to be compensated for Capacity Building deliverables 2D-1 and 2D-2. This is because it is important that direct service staff understand each of these elements and how these key components fit together to more comprehensively engage the R95 population and other patients. If there are further agency specific questions, please direct to sapc-cbi@ph.lacounty.gov with subject "A&D Policy".
12.	How do we balance serving those who are not committed to abstinence while ensuring a drug-free environment for others in a **residential setting**?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Even clients in long-term recovery experience moments where they question their desire to maintain their abstinence, and clients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around not wanting to create barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with its R95 efforts focused on Admissions and Discharge policies. While there are unique considerations in residential settings that need to be individualized according to the circumstances of individual clients, the reality is that providers often mix these populations every day, so providers are already admitting people who are not currently practicing full sustained abstinence into their programs today. The aim in these situations is to provide pathways for clients to feel open, comfortable, and trusting with providers to share with providers where they are in their readiness for abstinence so that providers can try to move them along the readiness continuum. As is the case with all levels of care, the "R95" approach to this situation would be to: 1. Ensure that there are policies in place that not only avoid creating barriers to care, but widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services)

		2. Addressing instances of problematic use of substances during treatment on a case-by-case basis that considers both the treatment of the client using substances as well as the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual client as well as their peers to demonstrate that clients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and, in these instances, it is important for provider agencies to consider connecting them with another level of care and/or care coordination or other services, as appropriate, so as not to disconnect the client from treatment all together. For example, even if a client who used/relapsed needs to be discharged from a residential setting, an agency needs to attempt to discharge them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the client's discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a client who recently relapsed to a lower level of care or having the client be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those clients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together. These are complex considerations that are challenging to fully address in an FAQ and will be further discussed in R95 workgroup meetings.
13.	How does one distinguish what **a non-abstinence focused withdrawal management** system might look like?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Even clients in long-term recovery experience moments where they question their desire to maintain their abstinence, and clients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around not wanting to create barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with its R95 efforts focused on Admissions and Discharge policies. For withdrawal management, clients typically will be seeking to withdraw from the substances they are using, which often influences and may reduce the likelihood of clients using certain substances while receiving withdrawal

		management services. Use of substances while people are withdrawing from substances, including when medications are used as part of the withdrawal management services, can be counterproductive and even may be harmful to clients. It is important that this is meaningfully discussed with clients. Nonetheless, there will be instances when withdrawal management clients may use substances or relapse, as is the case in all other levels of care. And as is the case with all levels of care, the “R95” approach to this situation would be to: 1. Ensure that there are policies in place that not only avoid creating barriers to care, but actually widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services) 2. Addressing instances of problematic use of substances during treatment on a case-by-case basis that considers both the treatment of the client using substances as well as the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual client as well as their peers to demonstrate that clients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and, in these instances, it is important for provider agencies to consider connecting them with another level of care and/or care coordination or other services, as appropriate, so as not to disconnect the client from treatment all together. For example, even if a client who used/relapsed needs to be discharged from a residential setting, an agency should consider discharging them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the client’s discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a client who recently relapsed to a lower level of care or having the client be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those clients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together. These are complex considerations that are challenging to fully address in an FAQ and will be further discussed in R95 workgroup meetings.
14.	Is the option instead to say we want to continue to keep engaging with clients so we’re going to link them to outpatient services and is that sufficient? Or is the focus the housing condition that is linked to the	Please see response to #13 above.

	residential treatment environment?	
15.	How do A&D policy changes impact Class A deficiencies (the fine for those deficiencies is about $500.00 per day)?	SAPC has reviewed this State-level issue and believes there are various options to address this. While it will take time, we anticipate working with the State to make progress on this issue. Please inform SAPC Contracts and Compliance Chief, Marika Medrano, if the State issues a citation for this reason. In the meanwhile, Class A deficiencies do not conflict with the operationalization of R95 and there are ways to operationalize R95 in nuanced ways without triggering Class A concerns. For example, having policies that accept clients who are not ready for abstinence as a pre-requisite of admission or policies that do not result in automatic discharges for lapses.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Service Design - 2E1, 2E2, 2E3		
16.	Are treatment providers who are also harm reduction sites still eligible for this incentive?	Yes, when the site(s) used as part of service design is also a treatment site.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Bidirectional Referrals – 2F1, 2F2		

Links provided:

- **Shared in chat by Dr. Hurley: SAPC Utilization Management Meeting – December 15, 2021**
  http://publichealth.lacounty.gov/sapc/NetworkProviders/qiumpm/121521/UMProviderMeeting.pdf