Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Medi-Cal Managed Care Access 09.01.08 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	_Signature on File_	___9/30/19_____

SUBJECT:	Continuity of Care for Medi-Cal beneficiaries receiving Specialty Mental Health Services (SMHS) within the County of Orange Mental Health Plan (MHP)

PURPOSE:

To establish a procedure for requesting and processing continuity of care requests for Medi-Cal beneficiaries receiving Specialty Mental Health Services (SMHS) in the County of Orange Mental Health Plan (hereby referred to as Orange MHP).

POLICY:

Medi-Cal beneficiaries may be eligible to receive continued access to medically necessary Specialty Mental Health Services (SMHS) under the Orange MHP from out-of-network providers in certain circumstances. It is the policy of Behavioral Health Services (BHS) that all out-of-network providers meet specified requirements, including but not limited to those required by the Department of Health Care Services (DHCS) for Medicaid Managed Care Plans.

SCOPE:

All Medi-Cal beneficiaries requesting continuity of care for SMHS from Orange MHP.

REFERENCES:

BHS 09.01.01. Mental Health Plan Out-of-Network Services

MHSUDS Information Notice No. 18-059 - Federal Continuity of Care Requirements for Mental Health Plans

Medicaid Mental Health Parity Final Rule Federal Register

FORMS:

AQIS Continuity of Care Request Form

DEFINITIONS:

Adverse benefit determination:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Authority and Quality Improvement Services (AQIS) – Is an administrative unit providing oversight and coordination of quality improvement and compliance activities across the Divisions of BHS.

Beneficiary – A person with Orange County Medi-Cal coverage. For the purposes of this policy and procedure, "beneficiary" includes a parent, guardian, conservator, or other authorized representative, unless otherwise specified.

Notice of Adverse Benefit Determination (NOABD) - Form used to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. There are multiple versions of this form, to be used depending on the situation.

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist beneficiaries and family members with grievances. The Provider Representative is the person designated to provide information to the beneficiary about the status of a grievance upon request.

Termination – The provider voluntarily terminated employment or contact; or the MHP terminated employment or the provider's contract for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medicaid program.

PROCEDURES:

I. Continuity of Care requirements apply to all:

A. Medi-Cal beneficiaries who are transitioning into the SMHS delivery system, as follows:

1. From one county MHP to another county MHP due to a change in the beneficiary's county of residence;

2. From Medi-Cal Fee-for-Service (FFS) to the MHP.

3. From a Managed Care Plan (MCP) to an MHP.

B. All Medi-Cal beneficiaries whose:

1. Provider has voluntarily terminated employment;

2. Provider organizational/employer has terminated their contract with the Mental Health Plan (MHP);

3. Provider's employment or whose organizational employer's 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.

II. Beneficiaries with pre-existing provider relationships who make a continuity of care request to Orange MHP will have the option to continue treatment with an individual out-of-network Medi-Cal provider or a terminated network provider subject to the conditions specified in this P&P. No beneficiary shall be subject to discrimination or any other penalty for requesting continuity of care.

III. Continuity of Care arrangements shall not exceed 12 months in duration. At the request of the beneficiary, Orange MHP shall continue to provide SMHS necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by Orange MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice.

IV. The beneficiary may make a direct request to Orange MHP for continuity of care in writing or via telephone and shall not be required to submit an electronic or written request.

V. Orange MHP shall provide reasonable assistance to beneficiaries in completing requests for continuity of care including oral interpretation and auxiliary aids and services, including but not limited to, interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

VI. The beneficiary may choose an authorized Representative to act on his/her behalf. This person can be a family member, significant other or other person of his/her choice. The beneficiary's authorized Representative may make a continuity of care request on the beneficiary's behalf. The beneficiary shall provide written confirmation of the authorization of a Representative by completing an Authorization to Use and Disclose (ATD) Protected Health Information (PHI). The beneficiary will complete all necessary sections and document the representative's name, address and phone number and indicate under Part 4 Other: "Acting as representative for continuity of care request."

VII. Authority and Quality Improvement Services (AQIS) shall process all continuity of care requests whether in writing, fax, email, or phone. If a continuity of care request is received by phone, the AQIS representative shall complete a Continuity of Care Request Form on behalf of the beneficiary. If the request is received from an authorized Representative, the AQIS representative will obtain an ATD, as noted in VI, prior to contacting the authorized Representative.

A. The AQIS representative will send an acknowledgement letter to the beneficiary regardless of how the request is received, confirming receipt of the beneficiary's continuity of care request.

B. The AQIS representative shall log receipt of the request in the internal Continuity of Care Tracking Log.

VIII. To be eligible for Continuity of Care arrangements, multiple criteria must be met, including all of the below:

A. A documented pre-existing relationship between the beneficiary and the individual provider. The beneficiary has received SMHS from an individual out-of-network provider at least once during the 12 months prior to their initial enrollment in Orange MHP.

B. The provider is eligible under State Plan and State law.

C. The provider agrees, in writing:

1. To be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers.

2. To comply with State requirements for SMHS, including documentation requirements.

D. The provider supplies Orange MHP with all relevant treatment information, for the purpose of determining medical necessity.

E. The provider is willing to accept the higher of either Orange MHP's provider contract rates for existing network providers or Medi-Cal FFS rates.

F. Orange MHP has not documented disqualifying quality of care issues to the extent that the provider would not be eligible to provide services to any other beneficiaries of the MHP.

IX. Orange MHP shall provide continuity of care with an eligible out-of-network Medi-Cal provider if the following conditions are met:

A. Orange MHP is able to determine that the beneficiary has an existing relationship with the provider (i.e., the beneficiary has received SMHS from an out-of-network provider at least once during the 12 months prior to their initial enrollment in Orange MHP);

B. The provider type is consistent with the State Plan and the provider meets the applicable professional standards under State law;

C. The provider agrees, in writing, to be subject to the same contractual terms and conditions imposed upon currently contracting network providers, including, but not limited to, credentialing, utilization review, and quality assurance;

D. The provider agrees, in writing, to comply with State requirements for SMHS, including documentation requirements in accordance with Orange MHPs contract with Department of Health Care Services (DHCS);

E. The provider supplies Orange MHP with all relevant treatment information including documentation of a current assessment, a current treatment plan, and relevant progress notes as long as it is allowable under federal and State privacy laws and regulations;

F. The provider is willing to accept the higher of Orange MHPs provider contract rates of Medi-Cal FFS rates, and

G. Orange MHP has not identified, verified, and documented disqualifying quality of care issues to the extent that the provider would not be eligible to provide services to any other beneficiaries of Orange MHP.

H. If a non-participating network provider does not agree to comply or does not comply with these contractual terms and conditions, Orange MHP is not required to approve the continuity of care request. If the continuity of care request is denied

for any reason, Orange MHP shall notify the beneficiary and or the beneficiary's authorized representative.

X. Orange MHP shall provide continuity of care with an eligible terminated network provider if the following conditions are met:

A. The completion of SMHS shall be provided by a terminated network provider to a beneficiary who, at the time of the contract's termination, was receiving SMHS from that provider.

B. Orange MHP may require the terminated provider, whose services are continued beyond the contract termination date, to agree, in writing, to be subject to the same contractual terms and conditions, including rates of compensation, that were imposed upon the provider prior to termination.

C. If a terminated network provider does not agree to comply or does not comply with these contractual terms and conditions, Orange MHP is not required to approve the continuity of care request. If the continuity of care request is denied for any reason, Orange MHP shall notify the beneficiary and or the beneficiary's authorized representative.

XI. Validating Pre-existing Provider Relationships

A. 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:

1. The beneficiary establishing residence in the county;

2. Upon referral by another MHP or MCP; and/or,

3. Orange MHP making a determination that the beneficiary meets medical necessity criteria for SMHS.

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

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

XII. Timeline Requirements

A. The following timeline requirements must be followed for Orange MHP processing of the Continuity of Care request:

1. Thirty calendar days from the date Orange MHP received the request;

2. Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,

3. Three calendar days if there is a risk of harm to the beneficiary.

B. Upon verification that all Coordination of Care criteria requirements are met, Orange MHP shall retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:

1. Services were provided after a referral was made to Orange MHP (this includes self-referrals made by the beneficiary); and,

2. The beneficiary is determined to meet medical necessity criteria for SMHS.

C. A continuity of care request is considered complete when:

1. Orange MHP informs the beneficiary and/or the beneficiary's authorized representative, that the request has been approved; or,

2. Orange MHP and the out-of-network provider are unable to agree to a rate and Orange MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,

3. Orange 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,

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

XIII. Requirements Following Completion of Continuity of Care Request

A. If the provider meets all of the required conditions and the beneficiary's request is granted, Orange MHP shall allow the beneficiary to have access to that provider

for a period of up to 12-months, depending on the needs of the beneficiary and the agreement made between Orange MHP and the out-of-network provider. When the continuity of care agreement has been established, the MHP shall work with the provider to establish a Client Plan and transition plan for the beneficiary.

B. Upon approval of a continuity of care request, AQIS will notify the beneficiary and/or the beneficiary's authorized representative within the required timeframe, in writing, of the following:

1. Orange MHPs approval of the continuity of care request;

2. The duration of the continuity of care arrangement;

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

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

C. Upon denial of a continuity of care request, AQIS will notify the beneficiary and/or the beneficiary's authorized representative within the required timeframe, in writing. A Notice of Adverse Benefit Determination (NOABD) – Continuity of Care Request Denial letter will be mailed to the beneficiary and will include the following:

1. Orange MHPs denial of the beneficiary's continuity of care request;

2. A clear explanation of the reasons for the denial;

3. The availability of in-network SMHS;

4. How and where to access SMHS from Orange MHP;

5. The beneficiary's right to file an appeal based on the notice of adverse benefit determination; and,

6. Orange MHPs beneficiary handbook and provider directory.

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

E. Orange MHP shall notify the beneficiary, and/or the beneficiary's authorized representative, 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.

XIV. Repeated Requests for Continuity of Care

A. After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in Orange 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 Orange MHP for SMHS, the 12-month continuity of care period may start over one time.

B. If a beneficiary changes county of residence more than once in a 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 shall communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

XV. Beneficiary and Provider Outreach and Education

A. Orange MHP will inform beneficiaries of their continuity of care protections and include information about these protections in Orange MHP Beneficiary Medi-Cal Handbook. This information will include how the beneficiary and provider initiate a continuity of care request with Orange MHP. Orange MHP will translate these documents into threshold languages and make them available in alternative formats, upon request. Orange MHP will provide training to staff who come into regular contact with beneficiaries about continuity of care protections.

B. Reporting Requirements

1. AQIS will monitor and maintain an internal tracking log that will include the following information:

a) The date of the request;

b) The beneficiary's name;

c) The name of the beneficiary's pre-existing provider;

d) The address/location of the provider's office; and,

e) Whether the provider has agreed to the MHPs terms and conditions; and,

f) The status of the request, including the deadline for making a decision regarding the beneficiary's request.

2. Orange MHP will report to DHCS all requests, and approvals, for continuity of care. Orange MHP will submit a continuity of care report, with Orange MHPs quarterly network adequacy submissions that will include the above information (1a-1f).