SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Policy:	**20-01**
Subject:	**Continuity of Care for Specialty Mental Health and Drug Medi-Cal Organized Delivery System**
Authority:	Mental Health Parity and Addiction Equity Act of 2008; Medicaid/CHIP Final Rule; CFR Title 42, Section 438.62; California Health and Safety Code 1373.96, California DHCS Information Notice 18-059, Delegation Agreements with the Health Plan of San Mateo; Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for The Period of 2022-2026
Original Policy Date:	January 10, 2020
Amended:	Renamed and Technical Edit September 4, 2024
Supersedes:	N/A
Attachments:	N/A

PURPOSE

This policy establishes procedures, as outlined in Information Notice 18-059, for Medi-Cal beneficiaries who meet medical necessity criteria for Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal Organized Delivery System (DMC-ODS) to exercise their right to make a Continuity of Care Request. Beneficiaries with a pre-existing relationship with a provider may request the option to continue in treatment with an out-of-network provider for up to 12 months.

POLICY

Specialty Mental Health Services and Drug Medi-Cal Organized Delivery System services will continue to be provided, at the request of the beneficiary or their authorized representative, for a period not to exceed 12 months, that is necessary to either complete the course of treatment, or safely transfer the beneficiary to a Behavioral Health and Recovery Services (BHRS) provider. BHRS will make a determination to grant the request in consultation with the beneficiary and their provider that will be consistent with good professional practices.

This policy pertains to Medi-Cal beneficiaries who are transitioning care for the following reasons:

- The provider has voluntarily terminated employment or the contract with BHRS;
- The provider's employment or 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;
- The beneficiary is transitioning from one County Mental Health Program or DMC-ODS Program to another County Mental Health or DMC-ODS Program due to a change in the beneficiary's county of residence;

- The beneficiary is transitioning from the Health Plan of San Mateo (Mild to Moderate) to BHRS (SMHS); or
- The beneficiary is transitioning from Medi-Cal FFS to the BHRS specialty mental health.

A. Requests for Continuity of Care

1. For those beneficiaries that have a pre-existing relationship with a provider, they will have the option to continue treatment for up to twelve months if their provider is out-of-network, a terminated contracted provider, or a BHRS provider that is no longer employed.

2. Care will be allowed to continue at the request of the beneficiary for the amount of time necessary (up to 12 months unless otherwise noted) to complete the course of treatment and BHRS will, in consultation with the beneficiary, safely transfer the beneficiary to another provider offered by BHRS, that is consistent with appropriate clinical practice.

B. Out-of-Network Providers

Upon request by the beneficiary, or their authorized representative, BHRS shall provide for the continuity of care for an out-of-network provider, for a period up to 12 months, if the following are met:

1. BHRS can determine that the beneficiary has an existing relationship with the provider (i.e., the beneficiary has received mental health services from an out-of-network provider at least once during the 12 months prior to their initial enrollment in the MHP or DMC-ODS program);
2. The provider type is consistent with State requirements and the provider meets the applicable professional standards under State law;
3. The provider agrees, in writing, to be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers, including, but not limited to, credentialing, utilization review, and quality assurance;
4. The provider agrees, in writing, to comply with State requirements for SMHS or appropriate program, including documentation requirements in accordance with BHRS' contract with DHCS;
5. The provider supplies BHRS with all relevant treatment information, for the purposes of determining medical necessity, 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;
6. The provider is willing to accept the higher of BHRS provider contract rates or Medi-Cal FFS rates; and
7. BHRS 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 BHRS.

If the provider does not agree to the above conditions or comply these conditions, BHRS is not required to approve the continuity of care request and shall notify the beneficiary that the request is denied.

C. Terminated Providers

At the request of a beneficiary or the beneficiary's authorized representative, BHRS shall provide, for a period of up to 12 months, the completion of treatment by a terminated network provider. This request will only be granted if the beneficiary was receiving services within the last 12 months at the time of the termination of the provider's contract.

1. Termination is defined as when the provider voluntarily ended employment or contract; or
2. BHRS ended the provider's 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 Medi-Cal Program.

If the provider does not agree to the terms and conditions listed in Section C, BHRS is not required to approve the beneficiary's request.

PROCEDURE/PROTOCOL

A beneficiary or their authorized representative may make a direct request to BHRS for continuity of care through the ACCESS Call Center. If applicable, the ACCESS Call Center will also collaborate with the BHRS AOD Residential Treatment Team (RTX).

Beneficiaries may request continuity of care in person, in writing, or via telephone and are not required to submit an electronic or written request. BHRS must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

BHRS will inform beneficiaries of their continuity of care protections and will include information about these protections in beneficiary informing materials and handbooks.

A. Validating Pre-existing Provider Relationships:

An existing relationship with a provider may be established if the beneficiary has seen their existing 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 county Mental Health Plan or MCP; and/or Drug Medical Organized Delivery Program
3. The MHP or DMC-ODS making a determining the beneficiary meets medical necessity criteria.

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

Following identification of a pre-existing relationship with an out-of-network provider, BHRS must 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.

B. <u>Timeline Requirements:</u>

Each continuity of care request must be completed within the following timelines:

1. Thirty (30) calendar days from the date the MHP or DMC-ODS program received the request;
2. Fifteen (15) calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
3. Three (3) calendar days if there is a risk of harm to the beneficiary.
4. BHRS will retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:
    a. The provider meets the continuity of care requirements outlined in this policy;
    b. Services were provided after a referral was made to BHRS (this includes self-referrals made by the client); and,
    c. The beneficiary is determined to meet medical necessity criteria.

A continuity of care request is considered complete when:

1. BHRS informs the beneficiary and/or the beneficiary's authorized representative, that the request has been approved;
2. BHRS and the out-of-network provider are unable to agree to a rate and notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied;
3. BHRS has documented quality of care issues with the provider and notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or
4. BHRS makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days and notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied.

C. <u>Requirements Following Completion of Continuity of Care Request:</u>

If the provider meets all of the required conditions and the beneficiary's request is granted, BHRS will 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 BHRS and the out-of-network provider. When the continuity of care agreement has been established, BHRS will work with the provider to establish a Client Plan and transition plan for the beneficiary. Upon approval of a continuity of care request, BHRS will notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

1. The 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 the provider network.

The written notification to the beneficiary must comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:

1. The 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 providers;
4. How and where to access services through the ACCESS Call Center;
5. The beneficiary's right to file an appeal based on the adverse benefit determination; and
6. The beneficiary handbook and provider directory.

BHRS must 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.

D. <u>Repeated Requests for Continuity of Care:</u>

After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in the BHRS network. The exceptions to this standard are:

1. If the beneficiary later transitions to a Managed Care Program or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to BHRS for SMHS, the 12-month continuity of care period may begin again only one time. At the end of the subsequent period the beneficiary must pick an in-network provider.

2. 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 or DMC-ODS and third MHP or DMC-ODS, after which, the beneficiary may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the MHP or DMC-ODS should communicate with the MHP or DMC-ODS in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

E. Reporting Requirements

BHRS will report to DHCS all requests, and approvals for continuity of care with the quarterly Network Adequacy submission. The report will contain the following information:

- The date of the request;
- The beneficiary's name;
- The name of the beneficiary's pre-existing provider;
- The address/location of the provider's office;
- Whether the provider has agreed to the MHPs or DMC-ODS programs terms and conditions; and
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

Approved: *Signature on File*
Scott Gruendl, MPA
Assistant Director
Compliance Officer

Approved: *Signature on File*
Dr. Jei Africa, PsyD, FACHE
BHRS Director

ANNUAL REVIEW OF COMPLIANCE POLICY			
Next Review Due:	October 2025		
Last Reviewed by:	Scott Gruendl, Compliance Officer	**Date:**	10/11/2024