Monterey County Behavioral Health Policies and Procedures

Policy Number	152
Policy Title	Continuity of Care
References	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
Form	Continuity of Care Request Form
Effective	08/01/2021

Policy

Monterey County Behavioral Health Bureau (MCBHB) provides mental health and substance use treatment to a diverse population, directly and through contracted partners. The purpose of this policy is to establish the procedures related to Information Notice18-059, for Medi-Cal beneficiaries who meet medical necessity for specialty mental health services (SMHS) to exercise their right to make a Continuity of Care Request. Beneficiaries with a pre-existing relationship with an out- of- network provider may request the option to continue treatment with an out-of-network provider for up to 12 months.

Definitions

I. Continuity of Care: A transition of care to ensure continued access to services during a beneficiary's transition from Medi-Cal Fee-for-Service (FFS) to a managed care program or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

II. Out-of-Network Providers: A Medi-Cal provider that is not currently under contractual agreement with the MHP or a terminated network provider.

III. Terminated Network Providers: A past employee of the MHP or a previously contracted provider, provider group, or individual whose employment or contract has either been voluntarily terminated thereby or terminated by the MHP for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.

IV. Pre-Existing Provider Relationship: An existing relationship with a provider may be established if the Medi-Cal beneficiary has seen the out-of-network provider at least once during the twelve (12) months prior to the beneficiary establishing residence in the county; upon referral by another Mental Health Plan or Managed Care Plan (MCP); and/or the MHP deciding that the beneficiary meets medical necessity criteria for SMHS.

V. Eligibility Requirements: All MediCal Beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care if they are transitioning between providers due to one (1) of the following reasons:

a. The provider has voluntarily terminated employment or the contract with MCBH;
b. 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;
c. The beneficiary is transitioning from one County Mental Health Program to another County Mental Health Program due to a change in the beneficiary's county of residence;
d. The beneficiary is transitioning from a Managed Care Plan (Mild to Moderate) to an MHP; or
e. The beneficiary is transitioning from Medi-Cal FFS to the MHP.

Requests for Continuity of Care:

1. **Out-of-Network Providers**

Upon request by the beneficiary, or their authorized representative, MCBH 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:

a. MCBH 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);
b. The provider type is consistent with State requirements 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 that are 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 or appropriate program, including documentation requirements in accordance with MCBH's contract with DHCS;
e. The provider supplies MCBH 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;

f. The provider is willing to accept the higher of MCBH's provider contract rates or Medi-Cal FFS rates; and

g. MCBH 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 MCBH.

If the provider does not agree to the above conditions or comply these conditions, MCBH is not required to approve the continuity of care request and shall notify the beneficiary and/or the beneficiary's authorized representative that the request is denied.

2. Terminated Providers

a. At the request of a beneficiary or the beneficiary's authorized representative, the MHP will authorize continued SMHS for a period of up to twelve (12) months with a terminated network provider in order for the beneficiary to complete treatment with that provider if the following conditions are met: The provider was rendering SMHS to the beneficiary at the time of the termination of the contract or employment;

b. The provider's employment or contract was either voluntarily terminated thereby or terminated by the MHP for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program; and

c. The provider agrees, 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.

If the provider does not agree to the terms and conditions listed in Section C, MCBH is not required to approve the beneficiary's request and will notify the beneficiary and/or the authorized representative.

Procedure:

Submission and Tracking of Continuity of Care Requests: A beneficiary or their authorized representative may make a direct request to MCBH for continuity of care through the Plan's Quality Improvement Department via telephone, in person, or in writing at the following:

Monterey County Behavioral Health
Quality Improvement Department
1611 Bunker Hill Wy. Suite 120, Salinas, Ca, 93906
(831) 755-4545

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

The MHP shall use the Continuity of Care Request Form (attached) to track continuity of care requests which may be completed by the beneficiary or program staff. Once this form is completed, it will be forwarded to the MHP's quality improvement division for tracking.

1. Validating Pre-existing Provider Relationships:

Upon receipt of continuity of care request, MCBH Quality Improvement Department or designee will validate whether a pre-existing provider relationship exists and meets the applicable standards for Mei-Cal services. 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:

a. The beneficiary establishing residence in the county;
b. Upon referral by another county Mental Health Plan or MCP; and/or
c. The MHP making a determining the beneficiary meets medical necessity criteria for SMHS

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

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

If during the contracting process, any of the requirements are not met, the MHP will deny the continuity of care request and the MHP will notify the beneficiary and/or the beneficiary's authorized representative.

2. Timeline Requirements:

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

a. Thirty (30) calendar days from the date the MHP received the request;
b. Fifteen (15) calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
c. Three (3) calendar days if there is a risk of harm to the beneficiary.
d. MCBH will retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under

the following circumstances:

I. The provider meets the continuity of care requirements outlined in this policy;
II. Services were provided after a referral was made to MCBH (this includes self-referrals made by the client); and,
III. The beneficiary is determined to meet medical necessity criteria for SMHS.

A continuity of care request is considered complete when:

1. MCBH informs the beneficiary and/or the beneficiary's authorized representative, that the request has been approved; or
2. MCBH 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; or
3. MCBH 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. MCBH 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.

3. Requirements Following Completion of Continuity of Care Request:

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

a. The approval of the continuity of care request;
b. The duration of the continuity of care arrangement;
c. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
d. 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:

e. The denial of the beneficiary's continuity of care request;
f. A clear explanation of the reasons for the denial;

g. The availability of in-network providers for SMHS;
h. How and where to access SMHS services through the ACCESS Call Center;
i. The beneficiary's right to file an appeal based on the adverse benefit determination; and
j. The beneficiary handbook and provider directory.

At any time, beneficiaries may change their provider to an in-network provider whether a continuity of care relationship has been established. MHPs must provide SMHS and/or refer beneficiaries to appropriate network providers without delay and within established appointment time standards.

MCBH 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.

4. Repeated Requests for Continuity of Care:

After the beneficiary's continuity of care period ends, the beneficiary must choose a mental health provider in the MCBH network for SMHS. 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 MCBH 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 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 should communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

5. Reporting Requirements

MCBH will report to DHCS all requests, and approvals for continuity of care with the quarterly Network Adequacy submission and will keep a reporting log of all requests and approvals. The report will contain 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;
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.