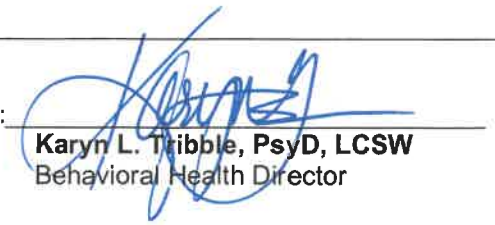
alameda county behavioral health MENTAL HEALTH & SUBSTANCE USE SERVICES	By:  **Karyn L. Tribble, PsyD, LCSW** Behavioral Health Director
OUT OF NETWORK ACCESS AND CONTINUITY OF CARE FOR MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES AND SUBSTANCE USE DISORDER SERVICES	**Policy No: 100-2-1** **Date of Original Approval**: 1/24/20 **Date(s) of Revision(s):**

PURPOSE

The intent of this policy is to outline the out-of-network access and continuity of care requirements for Alameda County Behavioral Health (ACBH) under Medi-Cal for Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) Treatment Services.

AUTHORITY

42 CFR 438.206(b)(4); California Department of Health Care Services (DHCS) Intergovernmental Agreement #17-94062 with ACBH; California DHCS MHP Agreement #17-94572 with ACBH; California DHCS MHSUDS Information Notices 18-011 and 18-059.

SCOPE

ACBH as well as entities, individuals and programs providing Specialty Mental Health Services (SMHS) and Substance use disorder (SUD) treatment services, and/or the administration related to such services, under a contract or subcontract with ACBH shall adhere to this policy.

POLICY

As a county Medi-Cal Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), ACBH is required to comply with federal network adequacy standards for services. These standards include time, distance, and timely access standards; continuity of care standards; service availability and network certification requirements; and monitoring and reporting activities.

Out of Network Access
The California Department of Health Care Services (DHCS) is responsible for establishing the applicable network adequacy standards for ACBH and has based those standards on the population density in Alameda County. Under these standards, ACBH must maintain and monitor a provider network (within applicable scopes of practice) that is adequate to serve its client capacity, for both adults and children/youth.

If the ACBH provider network is unable to provide timely access to medically-necessary service benefits under the MHP or DMC-ODS within the applicable time and distance standards, ACBH must cover these services out of network for the client.

- ACBH must permit out-of-network access for as long as its provider network is unable to provide the services in accordance with the applicable Network Adequacy standards.

- Out-of-network providers must coordinate with ACBH for payment and ensure that the cost to the client is no greater than it would be if the services were furnished within the ACBH provider network.
- If an exception to presumptive transfer exists, ACBH ensures access to services for foster care children outside its county of adjudication.

- All eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS or SUD treatment under DMC-ODS, have a pre-existing relationship with a provider, and makes a continuity of care request to ACBH will be given the option to continue treatment for up to 12 months with an eligible out-of-network Medi-Cal provider.

NOTE: Network providers include county- operated providers/sites, as well as any provider, group of providers, or entity that has a network provider agreement with ACBH and receives Medi-Cal or Drug Medi-Cal funding directly or indirectly to provide covered services.

Continuity of Care

ACBH and its contracted providers offer care coordination and ensure continuity of care in collaboration with partner organizations and agencies. Continuity of care extends to beneficiaries who receive SMHS or SUD treatment services in the DMC-ODS, as well as those who require care coordination between levels of care within the DMC-ODS, and/or with mental health service providers, hospitals, health care clinics and others. For those beneficiaries served by treatment services outside Alameda County's network, continuity of care includes appropriate transition services to facilitate care during the transition to an in-network provider.

This policy applies to all Medi-Cal beneficiaries who are transitioning as follows:

- The provider has voluntarily terminated employment or the contract with ACBH;
- 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;
- Transitioning from one county MHP or DMC-ODS Program to another county MHP or DMC-ODS Program due to a change in the beneficiary's county of residence;
- Transitioning from an MCP to ACBH; or,
- Transitioning from Medi-Cal Fee-for-Service (FFS) to ACBH.

PROCEDURE

Out of Network Access

1. All Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) Substance Use Disorder treatment services are authorized according to ACBH policy.
2. If a client requires SMHS or DMC services the ACBH provider network is unable to provide, ACBH will arrange timely provision of the services out of network.

3. ACBH will coordinate out-of-network services and monitor service provision to ensure quality of care and compliance with timeliness and documentation standards.

Continuity of Care

1. A client, their authorized representative or the client's provider may request continuity of care or out of network access in person, in writing, or via telephone and are not required to submit an electronic or written request. ACBH must provide reasonable assistance to clients in completing requests for continuity of care, including oral interpretation and auxiliary aids and services.

2. Should a client make a continuity of care or out of network access request, ACBH staff or contracted network providers must inform designated ACBH unit for review of the request as soon as possible.

3. All continuity of care and out of network requests received will be tracked and monitored by ACBH to ensure that requests meet requirements for continuity of care or out of network access.

4. ACBH will be responsible for contacting the identified unit for assessing whether identified provider meets minimum network requirements.

Validating Pre-existing Provider Relationships

An existing relationship with a provider may be established if the client has seen the out-of-network provider under continuity of care at least once during the 12-months prior to the following:

1. The client establishing residence in the county;

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

3. ACBH making a determining the client meets medical necessity criteria for SMHS or DMC ODS SUD treatment.

A client or provider may make available information to ACBH that provides verification of their pre-existing relationship with a provider. Following identification of a pre-existing relationship with an out-of-network provider, ACBH Network Office staff 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 client.

Timeline Requirements

Each continuity of care or out of network request must be processed within the following timelines:

1. Thirty calendar days from the date the ACBH received the request;

2. Fifteen calendar days if the client'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 client.

ACBH must retroactively approve a continuity of care request and reimburse providers for services that were already provided to a client under the following circumstances:

1. The provider meets the continuity of care requirements outlined in this policy;
2. Services were provided after a referral was made to ACBH, including self-referrals made by the client, and;
3. The client is determined to meet medical necessity criteria for SMHS.
4. This request cannot exceed 12 months.

A continuity of care or out of network request is considered complete when:

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

Requirements Following Completion of Continuity of Care Request

When the continuity of care or out of network agreement has been established, ACBH must work with the provider to establish a Treatment Plan and transition plan for the client. Upon approval of a continuity of care request, ACBH staff or designee must notify the client and/or the client's authorized representative, in writing, of the following:

1. Approval of the continuity of care or out of network request;
2. The duration of the continuity of care or out of network arrangement;
3. The process that will occur to transition the client's care at the end of the continuity of care or out of network period; and
4. The client's right to choose a different provider from the ACBHs provider network

If a Request is Denied

If the request for continuity of care is denied, ACBH staff or designee must notify the client in writing of the following:

1. Denial of the client's continuity of care request;
2. A clear explanation of the reason(s) for the denial;
3. The availability of in-network SMHS or SUD treatment;
4. How and where to access SMHS or SUD treatment from ACBH;
5. The client's right to file an appeal based on the adverse benefit determination;18 and,
6. ACBH's beneficiary handbook and provider directory.

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

ACBH must notify the client, and/or the client's authorized representative, 30-calendar days before the end of the continuity of care period about the process what will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the client and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

All written notices to the client must comply with Title 42 of the Code of Federal Regulations, part 438.10(d)

Repeated Requests for Continuity of Care

After the client's continuity of care period ends, the client must choose a mental health provider in ACBH's network for SMHS or SUD. If the client later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the ACBH for SMHS or SUD, the 12-month continuity of care period may start over one time. If a client 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 client may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, ACBH will communicate with the MHP or SUD DMC in the client's new county of residence to share information about the client's existing continuity of care request.

Beneficiary and Provider Outreach and Education

ACBH must notify beneficiaries and providers of continuity of care via informing materials, beneficiary and provider handbooks, postings, and training of all staff and subcontractors who come into contact with clients. All informing materials must be available in Alameda County threshold languages and alternative formats must be available upon request.

A. **Beneficiary Eligibility Criteria**

1. Beneficiary must meet medical necessity criteria for the SMHS or SUD ASAM level services for which transition of care is requested.
2. ACBH must determine that the change of provider to an in-network provider would result in "serious detriment to beneficiary's health or place beneficiary at risk of hospitalization or institutionalization"

B. **Provider Eligibility Criteria**

1. Provider must agree to accept higher of SMHS DMC-ODS or DMC rates depending on the services provided) or Medi-Cal FFS rates.
2. Provider must meet applicable professional standards for the discipline
3. Provider must be free from disqualifying quality of care concerns. If ACBH verifies and documents quality of care concerns about the provider such that the provider would be ineligible to provide services to other beneficiaries, the provider does not meet this criterion.
4. 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.
5. The provider agrees, in writing, to comply with State requirements for SMHS, including documentation requirements in accordance with the MHPs contract with DHCS.
6. The provider supplies the MHP 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.
7. Provider must be verified as a current SMHS or DMC provider.
8. Provider must supply ACBH all outcomes data (ASAM and CalOMS)
9. Provider must agree in writing not to refer the beneficiary to another out-of-network provider.

If the provider does not agree to comply or does not comply with these contractual terms and conditions, ACBH is not required to approve the continuity of care request. If the continuity of care request is denied for any reason, ACBH must notify the beneficiary and/or the beneficiary's authorized representative.

Terminated Providers

An MHP shall, at the request of a beneficiary or the beneficiary's authorized representative, provide for the completion of SMHS or DMC services by a terminated network provider, for a period of up to 12-months. 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 or DMC from that provider. For the purposes of this policy and procedure, termination means the following:

The provider voluntarily terminated employment or contract; or,
ACBH 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.
ACBH may require the terminated network 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. If the provider does not agree to comply or does not comply with these contractual terms and conditions, ACBH is not required to approve the beneficiary's continuity of care request.

CONTACT

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DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff

ISSUANCE AND REVISION HISTORY

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Term	Definition
Behavioral Health	The term "Behavioral Health" is inclusive of both mental health and substance use disorder (services, treatment, programs, etc....)
Consumer	Anyone currently receiving BHCS care or services, or who has received BHCS care or services in the last 12 months. The term 'consumer' is also synonymous with 'beneficiary,' 'patient,' or 'client'.
Medi-Cal	The name of California's Medicaid program which provides health coverage to people with low-income, the aged or disabled and those with asset levels who meet certain eligibility requirements.