SECTION 5, CHAPTER 10, POLICY 008

CONTINUITY OF CARE

POLICY NUMBER:	5-10-008
SYSTEM OF CARE:	MENTAL HEALTH
FINALIZED DATE:	03.15.2021
EFFECTIVE:	07.01.2021
SUPERSEDES # :	Supersedes Policy #'s: N/A

A. PURPOSE: To establish uniform guidelines, requirements, and timelines for continuity of care requests for beneficiaries that meet medical necessity criteria for Specialty Mental Health Services (SMHS), to ensure Yolo County Health and Human Services Agency (HHSA) Behavioral Health (BH) and Network Providers follow federal and state requirements.

B. RELATED DOCUMENTS: N/A

C. DEFINITIONS:

1. **Mental Health Plan (MHP):** Yolo County HHSA BH.

2. **Network Providers:** Any provider, group of providers, or entity that has a network provider agreement with the Select appropriate ones: Yolo County HHSA BH/ Administrator) and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2).

3. **Managed Care Organization (MCO)**: An entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is:

a. A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or

b. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
    i. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
    ii. Meets the solvency standards of § 438.116.

4. **Terminated Provider**: defined as the provider voluntarily terminated employment or contract; 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.

D. POLICY: The MHP and its Network Providers shall ensure eligible Medi-Cal beneficiaries who meet medical necessity have the right to request continuity of care in accordance with 42 C.F.R. § 438.62(b)(1)(i). A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to the MHP or a Network Provider for continuity of care which may be made in person, in writing, or via telephone. The beneficiary shall not be required to submit an electronic or written request.

Beneficiaries with pre-existing provider relationships who make a continuity of care request shall be given the option to continue treatment for up to 12 months with an out of network Medi-Cal provider or a terminated network provider. Beneficiaries may request continuity of care when:

a. A provider has voluntarily terminated employment of a contract with the MHP;

b. A provider's employment of contract has been terminated, for a reason other than issues related to quality of care or eligibility of the provider to participate on the Medi-Cal program;

c. The beneficiary is transitioning from one county MHP to another county MHP due to a change in the beneficiary's county of residence;

d. The beneficiary is transitioning from a MCO to an MHP; or

e. The beneficiary is transitioning from Medi-Cal Fee for Service (FFS) to the MHP.

The MHP and its Network Providers shall provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services. (MHSUDS IN 18-059)

SMHS shall continue to be provided, at the request of the beneficiary, for a period of time, not to exceed 12 months, necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by the MHP, in consultation with the beneficiary and the provider, and consistent with good professional practice.

MHPs shall inform beneficiaries of their continuity of care protections and shall include information about these protections in beneficiary informing materials and handbooks. This information shall include how the beneficiary and provider initiate a continuity of care request with the MHP. The MHP shall make these documents available in the MHP's threshold languages in addition to making them available in alternative formats, upon request. MHPs and Network Providers shall provide training to staff who come into regular contact with beneficiaries about continuity of care protections.

E. PROCEDURE:

1. **Timeline Requirements:** Each continuity of care request must be completed within the following timelines:
    a. Thirty (30) calendar days from the date the MHP or Network Provider 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. (MHSUDS IN 18-059);

    d. Upon a request for continuity of care Yolo County HHSA BH Quality Management (QM) shall be notified within one (1) business day.

2. **Out of Network Providers**: The MHP shall provide continuity of care with an eligible out-of-network Medi-Cal provider if all of the following conditions are met:
    a. The MHP is able to 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 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 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, including documentation requirements in accordance with the MHPs contract with the Department of Health Care Services (DHCS);

e. 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;

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

g. The 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 the MHP.

h. If the provider does not agree to comply or does not comply with these contractual terms and conditions, the MHP shall not be required to approve the beneficiary's continuity of care request.

i. Following identification of a pre-existing relationship with an out-of-network provider, the 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. (MHSUDS IN 18-059)

3. **<u>Terminated Providers:</u>** 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. The MHP shall 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.

4. **<u>Continuity of Care Authorization</u>**: Any continuity of care request shall be authorized by the Deputy Mental Health Director or authorized designee, when applicable. A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request for continuity of care to the MHP or a Network Provider, consistent with the policy stated above.
    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:
        i. The beneficiary establishing residence in the county;
        ii. Upon referral by another MHP or MCP; and/or,
        iii. The MHP making a determining the beneficiary meets medical necessity criteria for SMHS.

    b. A beneficiary or provider may make available information to the 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, the 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.

    d. A continuity of care request shall be considered complete when:
        i. The MHP informs the beneficiary and/or the beneficiary's authorized representative, that the request has been approved; or,
        ii. The MHP and the out-of-network provider are unable to agree to a rate and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied; or,
        iii. The 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,
        iv. The MHP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days and the MHP notifies the beneficiary and/or the beneficiary's authorized representative that the request is denied.

    e. If the provider meets all of the required conditions and the beneficiary's request is granted, the 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 the 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. (MHSUDS IN 18- 059).

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

5. <u>Beneficiary Notification Requirements</u>:

a. Upon approval of a continuity of care request, the MHP shall notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:
   i. The MHP's approval of the continuity of care request;
   ii. The duration of the continuity of care arrangement;
   iii. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and,
   iv. The beneficiary's right to choose a different provider from the MHP's provider network. (MHSUDS IN 18-059)

b. The written notification to the beneficiary shall comply with Title 42 of the Code of Federal Regulations, part 438.10(d) and include the following:
   i. The MHP's denial of the beneficiary's continuity of care request;
   ii. A clear explanation of the reasons for the denial;
   iii. The availability of in-network SMHS;
   iv. How and where to access SMHS from the MHP;
   v. The beneficiary's right to file an appeal based on the adverse benefit determination; and,
   vi. The MHP's beneficiary handbook and provider directory. (MHSUDS IN 18-059)

c. If the continuity request was approved the 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 care at the end of the continuity of care period. (MHSUDS IN 18-059)

d. If the continuity of care request is denied for any reason, the MHP must notify the beneficiary and/or the beneficiary's authorized representative in accordance with the requirements of DHCS Mental Health and Substance Use Disorder Services Information Notice No.: 18-059.

6. <u>Reporting Requirements:</u>

a. **<u>Individual Provider Reporting responsibilities:</u>** A beneficiary may choose to request continuity of care directly to an individual provider. It shall be the responsibility of the individual provider to follow policies and procedures in accordance with the organization of employment. Upon a

request for continuity of care, the following shall be reported to the MHP Quality Management (QM) department within one (1) business day of the request:

i. The date of the request;
ii. The beneficiary's name;
iii. The name of the beneficiary's pre-existing provider;
iv. The address/location of the provider's office; and,
v. The beneficiary's request.
vi. Supporting evidence verifying a pre-existing relationship with the provider.

b. **MHP Reporting Responsibilities** The MHP shall report to DHCS all requests, and approvals, for continuity of care and shall submit a continuity of care report with the MHPs network adequacy submissions, that includes the following information:

i. The date of the request;
ii. The beneficiary's name;
iii. The name of the beneficiary's pre-existing provider;
iv. The address/location of the provider's office; and,
v. Whether the provider has agreed to the MHPs terms and conditions; and,
vi. The status of the request, including the deadline for making a decision regarding the beneficiary's request.

F. REFERENCES:

1. 42 C.F.R. § 438.62(b)(1)(i)
2. Health & Safety Code, §§ 1373.96
3. MHSUDS IN 18-059

Approved by:

Karen Larsen

3/24/2021

Karen Larsen, Director **Date**
Yolo County Health and Human Services Agency