State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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DATE: February 19, 2021

Behavioral Health Information Notice No: 21-008

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Federal Out-of-Network Requirements for Mental Health Plans

PURPOSE: To advise the Mental Health Plans (MHP) of out-of-network (OON) provider requirements. These requirements are to ensure that a beneficiary receives covered services from an OON provider when the MHP does not have a network provider available to offer the services.

REFERENCE: Behavioral Health Information Notice 20-012

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule), which revised Part 438 of Title 42 of the Code of Federal Regulations (42 CFR Part 438). These changes aligned Medicaid managed care regulations with federal managed care requirements. MHPs are classified as Prepaid Inpatient Health Plans and must therefore comply with federal managed care

requirements (with some exceptions),[1] including time and distance standards.[2] However, the Managed Care Rule permits states to grant exceptions to the time and distance standards.[3] If a MHP cannot meet the time and distance standards set forth in the chart below for all coverage areas, it shall submit to DHCS a completed Alternative Access Standards Request (AAS).[4] To obtain the most recent AAS template, please contact MHSDFinalRule@dhcs.ca.gov. Every MHP must also maintain and monitor an adequate network of providers sufficient to provide adequate access to all covered services for all beneficiaries,[5] and ensure that all covered services are available and accessible to beneficiaries in a timely manner.[6]

POLICY:
MHPs must have an adequate network meeting the requirements set forth in Behavioral Health Information Notice (BHIN) 20-012. If the MHP is unable to provide necessary services to a beneficiary within the time, distance and timely access standards using a network provider, the MHP must allow beneficiaries to access services out of network, as required by State and federal law, the MHP contract, and DHCS guidance, including any applicable Information Notices. [7] OON provider means a provider or group of providers without a network provider or subcontractor agreement with the MHP responsible for the service.[8] A provider may be "out-of-network" for one MHP but in the network of another MHP.[9]

Time and Distance Standards and Out-of-Network Requirement[10]
Certain Specialty Mental Health Services (SMHS), specifically Mental Health Services, Targeted Case Management, Crisis Intervention, and Psychiatrist Services, are subject to time and distance standards.[11] All beneficiaries must have access to those SMHS within the established time and distance standards, unless DHCS has authorized the MHP to use an alternate time or distance standard through an approved AAS Request.[12] See table on page 3 for details.

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[1] See 42 CFR. § 438.2
[2] Welfare & Institutions Code (W&I) § 14197, subd. (a) & (b); 42 CFR § 438.68, subd. (a) & (c)
[3] 42 CFR. § 438.68, subd. (d)(1)
[4] W&I, § 14197, subd. (e)(2)
[5] 42 CFR § 438.206(b)(1); MHP Contract, Exhibit A, Attachment 8, sections 3.B, p. 1 of 11.
[6] 42 CFR §§ 438.68(d), 438.206(a); MHP Contract, Exhibit A, Attachment 8, sections 3.A and 3.D, p. 1 and 2 of
[7] 42 CFR § 438.206 (b)(4)
[8] MHP Contract, Exhibit E, Attachment 1, section 1.P., p. 2 of 4
[9] *Id.*
[10] W&I § 14197, subd. (i), authorizes the department to implement requirements related to time and distance by bulletin.
[11] W&I § 14197, subd. (c)(1) & (3)
[12] W&I § 14197, subd. (e)

When a MHP is unable to provide SMHS with an in-network provider that is within time and distance standards, the MHP must refer the beneficiary to an OON provider for SMHS, within the time and distance standards.[13]

Network Adequacy Time and Distance Standards	
Time and Distance[16]	Up to **15 miles and 30 minutes** from the beneficiary's place of residence for the following counties: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
	Up to **30 miles and 60 minutes** from the beneficiary's place of residence for the following counties: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura.
	Up to **45 miles and 75 minutes** from the beneficiary's place of residence for the following counties: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba.
	Up to **60 miles and 90 minutes** from the beneficiary's place of residence for the following counties: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

In cases where an OON provider is not available within the time and distance standards, the MHP must arrange for telehealth or transportation to an in-person visit.[14] DHCS' telehealth policy ensures that beneficiaries have the right to an in-person visit if they do not want to accept a telehealth visit. SMHS rendered by in-network or OON providers, including those provided within a DHCS approved alternative access standard, must comply with timely access standards as well.[15]

MHPs are required to notify DHCS by email to MHSDFinalRule@dhcs.ca.gov within 10 business days any time there has been a significant change in the MHP's operations that would render the MHP non-compliant with standards for network adequacy and capacity including, but not limited to, the composition of the MHP's provider network. For more details, see BHIN 20-012.

[13] 42 CFR § 438.206, subd. (b)(4)
[14] Exhibit A, Att. 11, Information Requirements (page 5 of 10), section 4 C.2)
[15] 42 CFR 438.206(b)(4).
[16] W&I, § 14197, subd. (c)(1), (3)

Special Requirements for Mental Health Plans with an Approved Alternate Time Standard or Alternate Distance Standard for Psychiatry Services

The following requirements apply to MHPs with approval from DHCS to use an alternative time standard or an alternative distance standard for psychiatry services (e.g., medication support services).[17] These requirements only apply in the zip codes in which the alternate access standard applies.[18]

In accordance with W&I section 14197 (c)(1) for psychiatry service specialists, upon the request of the beneficiary, the MHP must do either 1 or 2:

(1) Arrange an appointment for the requesting beneficiary with a psychiatrist within the applicable time and distance standards in W&I section 14197 (c)(1) and within 15 business days of the beneficiary's request for an appointment.

OR

(2) Make its best effort to establish a beneficiary-specific case agreement, at the Medi-Cal fee-for-service rate or a rate mutually agreed upon between the psychiatrist and MHP, with an OON psychiatrist to provide services to the requesting beneficiary within the applicable time and distance standards in W&I section 14197 (c)(1) and within 15 business days of the beneficiary's request for an appointment.

This requirement does not apply if there is not a psychiatrist within the applicable time and distance standards of the requesting beneficiary or if the MHP unsuccessfully attempted to enter into a beneficiary-specific case agreement with the psychiatrist within the last 12 months.[19] If the MHP is unable to arrange an appointment for the beneficiary as provided in paragraphs 1 and 2 above, the MHP must coordinate with the beneficiary's managed care plan if the beneficiary resides in an excluded ZIP code or is otherwise enrolled in fee-for-service Medi-Cal to arrange non-emergency medical transportation or non-medical transportation for the beneficiary to his or her appointment outside the coverage area.[20]

As above, with beneficiary consent, telehealth may be used to meet this requirement.

[17] W&I § 14197.04
[18] W&I § 14197.04, subd (a)(3)
[19] W&I § 14197.04, subd. (a)(2)(A)
[20] W&I § 14197.04, subd. (b)

Timely Access and Out-of-Network Requirement[21]

In addition to the time and distance standards above, and in accordance with W&I section 14197, subdivision (d)(1), MHPs must comply with the timely access to care standards (title 28, California Code of Regulations (CCR) section 1300.67.2.2), ensuring that the directly operated and/or contracted provider network has adequate capacity and maintains a network of licensed providers able to offer beneficiaries appointments that meet the timeframes in the table below.[22]

Appointment Type	Standard
Urgent care[23] appointment for services that do not require prior authorization	Within 48 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Urgent care appointments for services that require prior authorization	Within 96 hours of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G)
Non-urgent appointments with specialist physicians (i.e., psychiatrists)	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments with a non- physician mental health care provider	Within 10 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of the request for appointment, except as provided in CCR §1300.67.2.2(c)(5)(G) and (H)

[21] W&I § 14197, subd. (i), authorizes the department to implement requirements related to timely access by bulletin.

[22] W&I § 14197, subd. (d)(1); Cal. Code Regs., tit. 28, § 1300.67.2.2(c)(5)

[23] "Urgent care" means health care for a beneficiary whose "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

Section 1300.67.2.2(c)(5)(G) of Title 28 of CCR provides that an appointment time "may be extended if the referring or treating [licensed health care] provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the beneficiary's record that a longer waiting time will not have a detrimental impact on the health of the beneficiary."

In addition, CCR, title 28, section 1300.67.2.2(c)(5)(H) provides that periodic office visits to monitor and treat mental health conditions may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed mental health provider acting within the scope of his or her practice.

When a MHP is unable to arrange an appointment for a beneficiary with a network provider (for the appropriate level of care, as determined by an assessment) that meets the timely access standards in the table, the MHP must arrange an appointment for the beneficiary with an OON provider that meets those standards, either in-person or by telehealth.[24]

Telehealth Services

MHPs utilizing telehealth to comply with the network adequacy components outlined above (e.g., time and distance, timely access) must submit supporting documentation and evidence of contracting efforts within providers that are physically located to DHCS for review and approval. However, in the absence of an emergency that would preclude in-person service delivery, MHPs cannot require a beneficiary to access services via telehealth.

Out-of-Network Requirements for American Indians

MHPs are required to allow American Indians to obtain SMHS from OON American Indian Health Facilities, if the beneficiaries meet the medical necessity and other requirements to receive SMHS.[25]

Out-of-Network Requirements for Continuity of Care

MHPs are also required to cover services OON when necessary to meet federal continuity of care requirements. For more details, see MHSUDS Information Notice 18-059.

[24] W&I, § 14197, subd. (c)(1), (3)
[25] 42 CFR 438.14(b)(4)

MHPs that are unable to meet network adequacy standards as outlined above will be required to comply with a corrective action plan (CAP). When a CAP is not adhered to, the MHP may be subject to administrative or financial sanctions.

For questions regarding this BHIN, please contact the Medi-Cal Behavioral Health Division at MHSDFinalRule@dhcs.ca.gov.

Sincerely,

Original signed by

Shaina Zurlin, PsyD, LCSW, Chief
Medi-Cal Behavioral Health Division