



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



EDMUND G. BROWN JR.
GOVERNOR

DATE: December 17, 2018

MHSUDS INFORMATION NOTICE NO.: 18-059

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS
CALIFORNIA STATE ASSOCIATION OF COUNTIES

SUBJECT: FEDERAL CONTINUITY OF CARE REQUIREMENTS FOR MENTAL HEALTH PLANS

PURPOSE

The Department of Health Care Services (DHCS) is issuing this Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) to set forth continuity of care requirements for Medi-Cal beneficiaries who receive specialty mental health services (SMHS) from county mental health plans (MHPs).

BACKGROUND

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule)¹, which revised Title 42 of the Code of Federal Regulations. These changes aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans (PIHPs) and must therefore comply with applicable federal managed care requirements.

¹ Managed Care Final Rule, Federal Register, Vol. 81, No. 88:
<https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>

Effective July 1, 2018, Title 42 of the Code of Federal Regulations, part 438.62 requires the State to have in effect a transition of care policy 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.²

This IN also addresses compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule). On March 30, 2016, CMS issued the Parity Rule in the Federal Register³ (81.Fed.Reg. 18390) to strengthen access to mental health (MH) and substance use disorder (SUD) services for Medicaid beneficiaries. It aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program. The Parity Rule requires states to ensure that limitations imposed for Medicaid MH and SUD services are no more restrictive than the predominant limitations imposed for substantially all medical and surgical services within a benefit classification⁴. In addition, the Parity Rule prohibits an MHP from applying a non-quantitative treatment limitation (a requirement that limits the scope or duration of a benefit) to a mental health benefit unless the limitation is comparable to, and applied no more stringently, that it is applied to corresponding medical benefits⁵. As such, DHCS' continuity of care policy for SMHS is consistent with existing requirements for Medi-Cal managed care plans (MCP).

POLICY

Effective immediately, all eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS⁶ have the right to request continuity of care⁷. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the county MHP must 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 (i.e., an employee of the MHP or a contracted organizational provider, provider group, or individual practitioner)⁸.

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

² 42 C.F.R. § 438.62(b)

³ Medicaid Mental Health Parity Final Rule Federal Register: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

⁴ 42 C.F.R. § 438.910(b)(1)

⁵ 42 C.F.R. § 438.910(d)(1)

⁶ Cal. Code. Regs., tit.9, §§ 1820.205, 1830.205, and 1830.210

⁷ 42 C.F.R. § 438.62(b)(1)(i)

⁸ Health & Safety Code, §§ 1373.96(a) and 1373.96(c)(2)

consultation with the beneficiary and the provider, and consistent with good professional practice⁹.

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

- The provider has voluntarily terminated employment or the contract with the MHP;
- 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 to another county MHP due to a change in the beneficiary's county of residence;
- Transitioning from an MCP to an MHP; or,
- Transitioning from Medi-Cal FFS to the MHP.

Out-of-Network Providers

An MHP shall, at the request of a beneficiary, or the beneficiary's authorized representative¹⁰, provide for the completion of SMHS by a non-participating (i.e., out-of-network) provider, for a period of up to 12-months, in accordance with this IN. An MHP must provide continuity of care with an eligible out-of-network Medi-Cal provider if all of the following conditions are met:

1. 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);
2. The provider type is consistent with the State Plan¹¹ 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, including documentation requirements in accordance with the MHPs contract with DHCS;
5. The provider supplies the MHP with all relevant treatment information, for the purposes of determining medical necessity, including documentation of a current

⁹ Health & Safety Code, § 1373.96(c)(2)

¹⁰ A provider may be designated, by the beneficiary, as the authorized representative.

¹¹ State Plan, Section 3, Supplements 1 and 3 to Attachment 3.1-A, and Supplement 2 to Attachment 3.1-B

assessment, a current treatment plan, and relevant progress notes, as long as it is allowable under federal and State privacy laws and regulations;¹²

6. The provider is willing to accept the higher of the MHPs provider contract rates or Medi-Cal FFS rates; and,
7. 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.

If the provider does not agree to comply or does not comply with these contractual terms and conditions, the MHP is not required to approve the continuity of care request¹³. 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 detailed in this IN.

Terminated Providers

An MHP shall, at the request of a beneficiary or the beneficiary's authorized representative, provide for the completion of SMHS by a terminated network provider, for a period of up to 12-months, in accordance with this IN¹⁴. 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 provider¹⁵. For the purposes of this IN, termination means the following:

- 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.

The MHP 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 termination¹⁶. If the provider does not agree to comply or does not comply with these contractual terms and conditions, the MHP is not required to approve the beneficiary's continuity of care request.

¹² 42 C.F.R. § 438.62(b)(1)(iv)

¹³ Health & Safety Code, § 1373.96(e)(1)

¹⁴ Health & Safety Code, § 1373.96(b)(1)

¹⁵ Health & Safety Code, § 1373.96(b)(1)

¹⁶ Health & Safety Code, § 1373.96(d)(1)

CONTINUITY OF CARE PROCEDURES

A beneficiary, the beneficiary's authorized representatives, or the beneficiary's provider may make a direct request to an MHP for continuity of care. Beneficiaries may request continuity of care in person, in writing, or via telephone and shall not be required to submit an electronic or written request. MHPs must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services¹⁷.

Validating Pre-existing Provider Relationships

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:

- The beneficiary establishing residence in the county;
- Upon referral by another MHP or MCP; and/or,
- The MHP making a determination the beneficiary meets medical necessity criteria for SMHS.

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

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

Timeline Requirements

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

- Thirty calendar days from the date the MHP received the request;
- Fifteen calendar days if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is a risk of harm to the beneficiary.

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

- The provider meets the continuity of care requirements outlined in this IN;

¹⁷ 42 C.F.R. § 438.10(d)(4)

- Services were provided after a referral was made to the MHP (this includes self-referrals made by the beneficiary); and,
- The beneficiary is determined to meet medical necessity criteria for SMHS.

A continuity of care request is considered complete when:

- The MHP informs the beneficiary and /or the beneficiary's authorized representative, that the request has been approved; or,
- 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,
- 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,
- 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.

Requirements Following Completion of Continuity of Care Request

If the provider meets all of the required conditions and the beneficiary's request is granted, the MHP must 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 must work with the provider to establish a Client Plan and transition plan for the beneficiary. Upon approval of a continuity of care request, the MHP must notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:

- The MHPs approval of the continuity of care request;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
- The beneficiary's right to choose a different provider from the MHPs 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:

- The MHPs denial of the beneficiary's continuity of care request;

- A clear explanation of the reasons for the denial;
- The availability of in-network SMHS;
- How and where to access SMHS from the MHP;
- The beneficiary's right to file an appeal based on the adverse benefit determination;¹⁸ and,
- The MHPs beneficiary handbook and provider directory.¹⁹

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 must provide SMHS and/or refer beneficiaries to appropriate network providers without delay and within established appointment time standards^{20 21}.

The MHP 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.

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 MHPs network for SMHS. If the beneficiary later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the MHP for SMHS, the 12-month continuity of care period may start over one time.

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.

¹⁸ The definition of adverse benefit determination includes the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 C.F.R. § 438.400(b)

¹⁹ 42 C.F.R. § 438.10(e)(2)(vi)

²⁰ 42 C.F.R. § 438.62(b)(1)(ii)

²¹ [MHSUDS Information Notice No. 18-011](#)

BENEFICIARY AND PROVIDER OUTREACH AND EDUCATION

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

REPORTING REQUIREMENTS

MHPs are required to report to DHCS all requests, and approvals, for continuity of care. The MHP must submit a continuity of care report, with the MHPs quarterly network adequacy submissions, that includes 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; and,
- Whether the provider has agreed to the MHPs terms and conditions; and,
- The status of the request, including the deadline for making a decision regarding the beneficiary's request.

If you have questions regarding this IN, please contact the Mental Health Services Division at MHSDFinalRule@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services