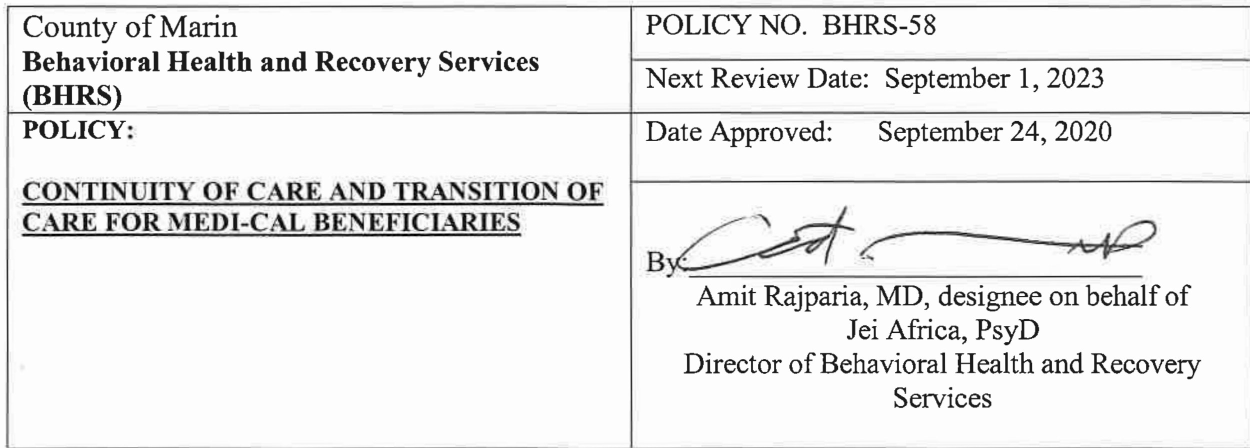

| County of Marin<br>**Behavioral Health and Recovery Services (BHRS)** | POLICY NO. BHRS-58<br>Next Review Date: September 1, 2023 |
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| **POLICY:**<br><br>**CONTINUITY OF CARE AND TRANSITION OF CARE FOR MEDI-CAL BENEFICIARIES** | Date Approved: September 24, 2020<br><br>By<br>Amit Rajparia, MD, designee on behalf of Jei Africa, PsyD<br>Director of Behavioral Health and Recovery Services |

**POLICY: CONTINUITY OF CARE AND TRANSITION OF CARE FOR MEDI-CAL BENEFICIARIES**

## I. PURPOSE:

The purpose of this policy is to define the continuity of care and transition of care procedure to be used by:

A. County of Marin Behavioral Health and Recovery Services (BHRS) – Mental Health Plan (MHP) and to ensure continued access to services to Medi-Cal beneficiaries when they transition from a Medi-Cal Fee-For-Service provider to a Managed Care Program (MCP), or from one MCP to another.
B. County of Marin BHRS –Drug/Medi-Cal Organized Delivery System (DMC-ODS) to ensure continued access to services during a transition from State Plan Drug Medi-Cal (DMC) to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization

## II. REFERENCES:

- 42 CFR Section 438.10 (d)
- 42 CFR Section 438.62
- California State Department of Health Care Services (DHCS), MHSUDS Information Notice 18-059: Federal Continuity of Care Requirements for Mental Health Plans
- California State Department of Health Care Services (DHCS), MHSUDS Information Notice 18-051: DMC-ODS Transition of Care Policy
- BHRS Policy 45: Out-of-Network Access

## III. POLICY:

It is the policy of BHRS to follow the Federal Continuity of Care mandate to:

A. Provide Medi-Cal beneficiaries who meet medical necessity criteria for specialty mental health services (SMHS) their right to request Continuity of Care for a period

of up to twelve (12) months with a provider who the beneficiary has seen at least once in the previous twelve (12) months.

B. Allow the beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. DMC-ODS treatment services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months.

## IV. AUTHORITY/RESPONSIBILITY:

BHRS Access Team
BHRS Program Managers/Supervisors
BHRS Contract Managers
BHRS Quality Management
BHRS County Alcohol and Drug Administrator
HHS Finance Department

## V. PROCEDURE FOR THE MHP:

A. A beneficiary, a beneficiary's authorized representative or a beneficiary's provider may make a direct request to BHRS for Continuity of Care. Beneficiaries may request Continuity of Care in person, in writing, or by telephone and shall not be required to submit an electronic or written request.

B. BHRS shall provide reasonable assistance to beneficiaries in completing requests for Continuity of Care, including oral interpretation and auxiliary aids and services.

C. BHRS shall inform beneficiaries of their Continuity of Care protections and shall include information about these protections in beneficiary informing materials and handbooks. The information shall include how the beneficiary and provider initiate a Continuity of Care request with any county's mental health plan (MHP). BHRS shall provide these documents in threshold languages and make them available in alternative formats upon request.

D. BHRS Access Team Supervisor will provide staff who come into regular contact with beneficiaries with training about Continuity of Care protections.

E. Continuity of Care requests may be made under any one of the following conditions:

1. The beneficiary would suffer a serious detriment to their health or be at risk of hospitalization or institutionalization if they are not allowed to continue

with their existing provider, or the beneficiary is making significant progress with their current provider.

2. The beneficiary's provider has voluntarily terminated their employment or their contract with BHRS.

3. The beneficiary's 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.

4. The beneficiary is transitioning from another county's MHP to BHRS due to a change in the beneficiary's residence

    a. If the beneficiary is an out-of-county foster child/youth for whom a Presumptive Transfer has been completed, see Policy and Procedure BHRS-56, Guidelines for Presumptive Transfer (AB 1299), for how to arrange for Continuity of Care.

5. The beneficiary is transitioning from an MCP to an MHP.

6. The beneficiary is transitioning from Medi-Cal Fee-For-Service (unassigned) to BHRS.

F. Continuity of Care requests for Out-of-Network Providers.

1. BHRS shall, at the request of the beneficiary, provide SMHS with an eligible out-of-network Medi-Cal provider for a period up to 12 months if all the following conditions are met:

    a. BHRS is able to determine that the beneficiary has received mental health services from the out-of-network provider at least once during the 12 months prior to the initial enrollment with BHRS.

    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 adhere to the same conditions imposed on contracted providers; such as credentialing, utilization review, and quality assurance.

    d. The provider agrees in writing to comply with State requirements for SMHS, including documentation requirements.

    e. The provider supplies BHRS with all the relevant treatment information for the purpose of determining medical necessity; such as current assessment, current treatment plan, and relevant progress notes.

    f. The provider is willing to accept BHRS provider contract rates.

g. BHRS has not identified any disqualifying quality-of-care issues.

G. Continuity of Care requests due to Terminated Providers.

1. At the request of the beneficiary, BHRS shall provide SMHS by a terminated network provider for a period of up to twelve (12) months if the beneficiary was receiving services from that provider at the time of the contract's termination and either:

   a. The provider voluntarily terminated their employment or contract.

   or

   b. BHRS terminated the provider's employment or contract for reasons ***not*** related to either quality of care or eligibility of the provider to participate in the Medi-Cal program.

2. BHRS may require the terminated provider to agree in writing to the same contractual terms and conditions, including rates, that were included in the provider's previous contract prior to termination.

H. For both Out-of-Network and Terminated Providers, if the provider does not agree to comply or does not comply with these contractual terms and conditions, BHRS shall not be required to approve the beneficiary's Continuity of Care request.

I. Processing Continuity of Care Requests.

1. Validate Pre-Existing Provider Relationship. An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the twelve (12) months prior to one or more of the following:

   a. The beneficiary establishing residence in Marin County.

   b. Upon referral by another MHP or MCP.

   c. BHRS is making the determination that the beneficiary meets medical necessity criteria for SMHS.

2. A beneficiary or provider shall provide information to BHRS that demonstrates verification of their pre-existing relationship with a provider.

3. Following the identification of a pre-existing relationship with an out-of-network provider, BHRS must contact the provider and make a good-faith effort to enter into a contract, single case agreement or other formal relationship.

4. Timeline requirements.

a. Each Continuity of Care request must be completed within the following timelines:

i) Thirty (30) calendar days from the date BHRS received the request.

ii) Fifteen (15) calendar days from the date BHRS received the request, if the beneficiary's condition requires more immediate attention.

iii) Three (3) calendar days from the date BHRS received the request, if there is a risk of harm to the beneficiary.

5. BHRS shall retroactively approve a Continuity of Care request and reimburse providers for services already provided under the following circumstances:

a. The provider meets the Continuity of Care requirements outlined in MHSUDS Information Notice 18-059.

b. A provider to whom the beneficiary was referred requests retroactive Continuity of Care reimbursement for services that were provided after the Continuity of Care request was made.

c. The beneficiary meets medical necessity criteria for SMHS.

6. Requirements following completion of Continuity of Care requests:

a. Upon approval of the Continuity of Care request, BHRS shall provide notification in writing to the beneficiary of the following:

i) Approval of the request.

ii) The duration of the approved request/authorization.

iii) The process that will occur to transition the beneficiary's care at the end of the Continuity of Care period.

iv) The beneficiary's right to choose a different provider from BHRS's provider network.

b. If the request is denied, BHRS shall provide the beneficiary with written notification, through the Notice of Adverse Benefit Determination (NOABD) process, that shall comply with Title 42 of the Code of Federal Regulations, part 438.10 (d), and include the following:

i) BHRS's denial of the beneficiary's Continuity of Care request, including a clear explanation of the reason(s) for denial, which shall be limited to the following:

a) BHRS and the out-of-network provider are not able to agree to a rate.

b) BHRS has documented quality of care issues with the provider.

c) BHRS has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

ii) The availability of in-network providers and/or services.

iii) How and where to access SMHS.

iv) The beneficiary's right to file an appeal based on the adverse benefit determination.

v) BHRS beneficiary handbook and provider directory.

7. Repeated Requests for Continuity of Care.

a. After the beneficiary's Continuity of Care period ends, the beneficiary must choose a BHRS mental health provider for SMHS in network. If the beneficiary later transitions to another county's MHP or Medi-Cal FFS for ***non***-specialty mental health services and subsequently transitions back to BHRS for SMHS, the twelve (12)-month Continuity of Care period may start over one (1) time.

b. If the beneficiary changes county of residence more than once in a twelve (12)-month period, the twelve (12)-month Continuity of Care period may start over with the second and third MHPs, after which the beneficiary may not be granted additional Continuity of Care requests with the same pre-existing provider. In these cases, BHRS shall communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing Continuity of Care request.

8. BHRS shall notify the beneficiary, and/or the beneficiary's authorized representative, thirty (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. The process shall include engaging the beneficiary and the provider to ensure continuity of services through the transition to a new provider.

J. Procedure for beneficiaries requesting Continuity of Care with a BHRS provider when transitioning from BHRS to another county's MHP due to a change in the beneficiary's residence.

1. A representative from either BHRS or the treating mental health clinic provider shall identify a request by the beneficiary to continue services and inform the clinic's Program Manager.
2. The Program Manager shall complete a referral packet and submit to the Access Team for centralized tracking and outreach to the new county of residence.
3. The Access Team shall coordinate with the HHS Finance Department regarding the out-of-network provider's proposed contractual rates and conditions for continued care with the beneficiary. This information shall be included in the referral packet for the other county's MHP.
4. The Access Team shall communicate the beneficiary's Continuity of Care request to the other county's MHP via submission of the referral packet.
5. Upon transfer of Medi-Cal to the new county of residence, that county of residence must either decline or accept the beneficiary's Continuity of Care request and notify the beneficiary of the request status.
    a. If the Continuity of Care request is approved and contractual rates and conditions are accepted by the county of residence's MHP, BHRS shall continue services for a period not to exceed 12 months, necessary to arrange for a safe transition of care and consistent with good professional practice, including ensuring sufficient medications until services are transferred to the county of residence's MHP.
    b. If the Continuity of Care request is declined by the county of residence's MHP, BHRS shall arrange for a safe transition of care and consistent with good professional practice, including ensuring sufficient medications until Medi-Cal is transferred to the county of residence.

K. Reporting Requirements.

1. BHRS shall provide DHCS a log of all requests received, including all approvals and denials for Continuity of Care, with the quarterly Network Adequacy Certification submission. The log shall include:
    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 BHRS terms and conditions.

f. The status of the request, including the deadline for making a decision regarding the beneficiary's request.

## VI. PROCEDURE FOR DMC-ODS (Transition of Care):

A. Transition of Care Requests for Out-of-Network Providers
1. Transition of Care requests may be made under any one of the following conditions:
2. The beneficiary would suffer a serious detriment to their health or be at risk of hospitalization or institutionalization if they are not allowed to continue with their existing provider.
3. The beneficiary is transitioning from another county's DMC-ODS or State Plan DMC due to a change in the beneficiary's residence

B. A beneficiary, a beneficiary's authorized representative or a beneficiary's provider may make a direct request to BHRS for Transition of Care. Beneficiaries may request Transition of Care in person, in writing, or by telephone and shall not be required to submit an electronic or written request. BHRS shall provide reasonable assistance to beneficiaries in completing requests for Continuity of Care, including oral interpretation and auxiliary aids and services.

C. BHRS shall provide a beneficiary with a transition of care with an eligible out-of-network Medi-Cal provider when all of the following criteria are met:
1. BHRS determines through its assessment that moving a beneficiary to a new provider would result in a serious detriment to the health of the beneficiary, or would produce a risk of hospitalization or institutionalization;
2. BHRS is able to determine that the beneficiary has an existing relationship with an out-of-network provider prior to the date of his or her transition to the Marin BHRS (self-attestation is not sufficient to provide proof of a relationship with a provider);
3. The out-of-network provider is willing to accept the higher of Marin's DMC-ODS contract rates or DMC rates for the applicable DMC-ODS service(s);
4. The out-of-network provider meets the Marin DMC-ODS applicable professional standards and has no disqualifying quality of care issues;
5. The provider is verified as a current DMC certified provider; and

6. The out-of-network provider supplies BHRS with all relevant treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations. Additionally, the provider supplies Marin BHRS with all relevant outcomes data.

D. Processing Transition of Care Requests

1. Upon receipt of the request, Marin BHRS shall send the beneficiary written acknowledgement and begin to the process the request within three (3) working days following the receipt of the request.
2. Assess Risk: Marin BHRS shall assess the beneficiary for risk of serious detriment to the health of the beneficiary, or a risk of hospitalization or institutionalization. This can be performed by reviewing a recent ASAM assessment or conducting a new assessment using the ASAM criteria.
3. Validate Pre-Existing Provider Relationship: If either risk exists, BHRS shall validate whether the beneficiary has a pre-existing relationship with a provider. An existing relationship with a provider may be established if the beneficiary has seen the out-of-network provider at least once during the twelve (12) months prior to one or more of the following:
   a. The beneficiary establishing residence in Marin County.
   b. Upon referral by another DMC-ODS or State Plan DMC Plan
   c. BHRS is making the determination that the beneficiary meets medical necessity criteria for DMC-ODS services.
4. A beneficiary or provider shall provide information to BHRS that demonstrates verification of their pre-existing relationship with a provider.
   a. Following the identification of a pre-existing relationship with an out-of-network provider, BHRS must determine if the provider is qualified and if so, contact the provider and make a good-faith effort to enter into a contract, single case agreement or other formal relationship. Considerations to determine if the provider is qualified include:
      i. Provider is verified as a current DMC certified provider
      ii. Provider is willing to accept the higher of the Marin DMC-ODS contract rates or DMC rates for the applicable DMC-ODS service(s)
      iii. Provider meets the DMC-ODS applicable standards outlined in the County's Professional Services Contract, including Exhibits A and I

iv. There are no documented concerns with the provider's quality of care to the extent that the provider would not be eligible to provide service to any other DMC-ODS beneficiaries

v. The provider supplies BHRS with all relevant: 1) outcomes data; and 2) treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations.

E. Retroactive Transition of Care Request Process

1. BHRS shall retroactively approve a Transition of Care request and reimburse providers for services already provided under the following circumstances:

   a. The provider meets the Transition of Care requirements outlined above and in MHSUDS Information Notice 18-051.

   b. Services that are the subject of the request: occurred after the member's enrollment into the DMC-ODS; and have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive Transition of Care reimbursement

   c. Retroactive continuity of care reimbursement requests shall be submitted in writing within 30 calendar days of the first service to which the request applies.

F. Approvals and Denials of Transition of Care Requests

2. Each transition of care request shall be completed within thirty (30) calendar days from the date Marin DMC-ODS received the request.

3. Within seven (7) calendar days of approval of the Transition of Care request, BHRS shall provide notification in writing to the beneficiary of the following:

   a. Approval of the request.

   b. The duration of the approved request/authorization. BHRS shall allow a beneficiary to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the beneficiary for a shorter timeframe. In this case, Marin DMC-ODS shall allow the beneficiary to have access to that provider for the

shorter period of time, as established by the out-of-network provider.

c. The process that will occur to transition the beneficiary's care at the end of the continuity of care period.

d. The beneficiary's right to choose a different provider from BHRS's DMC-ODS provider network.

3. Marin DMC-ODS can deny a beneficiary's request to retain their current provider if Marin DMC-ODS has documented quality of care issues with the DMC provider. If the beneficiary's request is denied, then BHRS shall issue a Notice of Adverse Benefit Determination to the beneficiary, offer the beneficiary at least one in-network alternative provider that offers the same level of services as the out-of-network provider, and inform the beneficiary of their right to file a grievance if they disagree with the denial. If BHRS offered the beneficiary multiple in-network provider alternatives and the beneficiary does not make a choice, then Marin DMC-ODS shall refer or assign the beneficiary to an in-network provider and notify the beneficiary of that referral or assignment in writing.

G. Termination of Transition of Care Process

1. Marin BHRS shall notify the beneficiary in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition the beneficiary's care to an in-network provider at the end of the transition of care period. This process includes engaging with the beneficiary and affected provider(s) before the end of the transition of care period to ensure continuity of services through the transition to an in-network provider.

H. Member and Provider Outreach

1. BHRS shall inform beneficiaries of their Continuity of Care protections and shall include information about these protections in beneficiary informing materials and handbooks. The information shall include how the beneficiary and provider initiate a Continuity of Care request with Marin BHRS. BHRS shall translate these documents into threshold languages and make them available in alternative formats upon request.

2. BHRS shall provide staff who come into regular contact with beneficiaries with training about Continuity of Care protections.

I. Reporting Requirements

1. BHRS shall provide DHCS a log of all requests received, including all approvals and denials for Continuity of Care, with the quarterly Grievance and Appeals Log submission to ODSSubmissions@dhcs.ca.gov.

   For approved out-of-network providers, BHRS shall submit the required DMC-ODS Provider Form to the DHCS Master Provider File Unit.