

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

POLICY NO. :	Policy Title: CONTINUITY OF CARE	EFFECTIVE DATE:
0704.875	(Replaces Access to Courtesy Providers)	3/27/1998
PROGRAM:	Performance Management Unit – Quality Improvement	REVISION DATES: 3/25/19, 2/18/20
AFFECTS:	ALL	REVIEW DATES: 11/2/98;12/21/99; 1/3/01; 2/22/02; 9/20/04; 9/5/08; 12/11/10; 12/20/13; 1/14/14; 10/27/16; 5/31/17

POLICY All Medi-Cal beneficiaries who meet medical necessity criteria for Specialty Mental Health Services (SMHS) have the right to request continuity of care. Beneficiaries with pre-existing provider relationships who make a continuity of care request to the Humboldt County Mental Health Plan (MHP), also known as the Humboldt County Department of Health and Human Services - Behavioral Health (DHHS-BH), will be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider or a terminated network provider. SMHS will continue to be provided, at the request of the beneficiary, for a period of time, not to exceed twelve (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.

DEFINITION(S) Continuity of Care: A transition of care 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.

Out-of-Network Providers: A Medi-Cal provider that is not currently under contractual agreement with the MHP or a terminated network provider.

Terminated Network Providers: A past employee of the MHP or a previously contracted provider, provider group, or individual whose employment or contract has either been voluntarily terminated thereby or terminated by the MHP for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program.

Pre-Existing Provider Relationship: An existing relationship with a provider may be established if the Medi-Cal beneficiary has seen the out-of-network provider at least once during the twelve (12) months prior to: the beneficiary establishing residence in the county; upon referral by another Mental Health Plan or Managed Care Plan (MCP); and/or the MHP making a determination that the beneficiary meets medical necessity criteria for SMHS.

- PROCEDURE**
1. Eligibility Requirements:
 - 1.1. All Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care if they are transitioning between providers due to one (1) of the following scenarios:
 - 1.1.1. The beneficiary's provider has voluntarily terminated employment or the contract with the MHP;

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

- 1.1.2. The beneficiary's provider's employment or contract has been terminated by the MHP for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program;
- 1.1.3. The beneficiary is transitioning to the MHP from another county Mental Health Plan due to a change in the beneficiary's county of residence;
- 1.1.4. The beneficiary is transitioning from a MCP to the MHP; or
- 1.1.5. The beneficiary is transitioning from Medi-Cal FFS to the MHP.

2. Out-of-Network Providers:

- 2.1. At the request of a beneficiary, or the beneficiary's authorized representative, the MHP will provide for the completion of SMHS by an out-of-network provider, for a period of up to twelve (12) months, in accordance with the California Department of Health Care Services' (DHCS) Mental Health and Substance Use Disorder Services Information Notice (IN) No.18-059. The MHP will provide continuity of care with an eligible out-of-network provider if all of the following conditions are met:
 - 2.1.1. The MHP is able to determine that the provider has a pre-existing relationship with the beneficiary;
 - 2.1.2. The provider type is consistent with California's Medicaid State Plan and the provider meets the applicable professional standards under state law;
 - 2.1.3. 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;
 - 2.1.4. The provider agrees, in writing, to comply with state requirements for SMHS, including documentation requirements in accordance with the MHP's contract with DHCS;
 - 2.1.5. 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;
 - 2.1.6. The provider is willing to accept the higher of the MHP's provider contract rates or Medi-Cal FFS rates; and
 - 2.1.7. The MHP has not identified, verified, or documented any quality of care issues that would exclude the provider from being eligible to provide services to any other beneficiaries of the MHP.
- 2.2. 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 request. If the continuity of care request is denied for any reason, the MHP will notify the beneficiary, and/or the beneficiary's authorized representative, in accordance with the requirements detailed in Section 4.4.4.

3. Terminated Providers:

- 3.1. At the request of a beneficiary or the beneficiary's authorized representative, the MHP will authorize continued SMHS for a period of up to twelve (12) months with a terminated
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COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

network provider in order for the beneficiary to complete treatment with that provider if the following conditions are met:

- 3.1.1. The provider was rendering SMHS to the beneficiary at the time of the termination of the contract or employment;
- 3.1.2. The provider's employment or contract was either voluntarily terminated thereby or terminated by the MHP for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program; and
- 3.1.3. The provider agrees, 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.

3.2. If the provider does not agree to comply or does not comply with these contractual terms and conditions, the MHP will not approve the beneficiary's continuity of care request and will notify the beneficiary and/or the beneficiary's authorized representative as detailed in Section 4.4.4.

4. Continuity of Care Procedures:

4.1. Submission and Tracking of Continuity of Care Requests.

- 4.1.1. A beneficiary, the beneficiary's authorized representative, or the beneficiary's provider may make a request to the MHP for continuity of care in person, in writing, or via telephone and will not be required to submit an electronic or written request.
- 4.1.2. The MHP must provide reasonable assistance to beneficiaries in completing requests for continuity of care, including oral interpretation and auxiliary aids and services (see MHP policy no. [0704.881 – Accessible Client Materials](#)).
- 4.1.3. The MHP shall use MHP form no. [1232 – Continuity of Care Request Form](#) to track continuity of care requests which may be completed by the beneficiary or program staff. Once this form is completed, it will be forwarded to the MHP's quality improvement division for tracking.

4.2. Validating Pre-Existing Provider Relationships.

- 4.2.1. Upon receipt of a continuity of care request, the MHP will validate whether a pre-existing provider relationship exists and meets the applicable professional standards for Medi-Cal services.
 - 4.2.1.1. A pre-existing relationship with a provider must be established prior to the continuity of care request being approved. If the MHP cannot verify the pre-existing provider relationship, the continuity of care request will be denied.
 - 4.2.1.2. The requestor must make information available to the MHP that provides verification of the beneficiary's pre-existing relationship with the provider.
 - 4.2.2. Following verification of a pre-existing relationship with an out-of-network or terminated provider, the MHP will 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.
 - 4.2.2.1. If during the contracting process, any of the requirements are not met, the MHP will deny the continuity of care request and the MHP will notify the
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COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

beneficiary and/or the beneficiary's authorized representative as detailed in Section 4.4.4.

- 4.2.2.2. Providers entering into a contractual agreement with the MHP must meet any and all applicable organizational provider standards, including, without limitation, the site certification requirements set forth in MHP [policy no. 0704.341](#), provider certification requirements set forth in MHP [policy no. 0704.878](#) and documentation requirements set forth in MHP [policy no. 0704.879](#).

4.3. Timeline Requirements.

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

- 4.3.1.1. Thirty (30) calendar days from the date the MHP receives the request;
- 4.3.1.2. Fifteen (15) calendar days from the date the MHP receives the request, if the beneficiary's condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- 4.3.1.3. Three (3) calendar days from the date the MHP receives the request, if there is a risk of harm to the beneficiary.

4.3.2. The MHP will retroactively approve a continuity of care request and reimburse providers for services that were already provided to a beneficiary under the following circumstances:

- 4.3.2.1. The provider meets the continuity of care requirements outlined in this policy;
- 4.3.2.2. Services were provided after a referral was made to the MHP, including self-referrals made by the beneficiary; and
- 4.3.2.3. The beneficiary is determined to meet medical necessity criteria for SMHS.

4.3.3. A continuity of care request shall be considered complete upon the occurrence of any of the following conditions:

- 4.3.3.1. The MHP notifies the beneficiary, and/or the beneficiary's authorized representative, in writing, that the request has been approved;
 - 4.3.3.2. The MHP and the out-of-network provider are unable to agree to a service rate and the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, in writing, that the request is denied;
 - 4.3.3.3. The MHP has documented quality of care issues with the provider and the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, in writing, that the request has been denied;
 - 4.3.3.4. The MHP makes a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days and the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, in writing, that the request has been denied; or
 - 4.3.3.5. The provider does not agree to comply or does not comply with the contractual terms and conditions set forth in the single case agreement
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COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

and the MHP notifies the beneficiary, and/or the beneficiary's authorized representative, in writing, that the request has been denied.

4.4. Requirements Following Completion of Continuity of Care Request.

- 4.4.1. If the provider meets all of the required conditions and the beneficiary's request is granted, the MHP will authorize the beneficiary to receive services from that provider for a period of up to twelve (12) months, depending on the needs of the beneficiary and the agreement made between the MHP and the out-of-network provider.
 - 4.4.2. Once the continuity of care agreement has been established, the MHP will work with the provider to establish client and transition plans for the beneficiary.
 - 4.4.3. Upon approval of a continuity of care request, the MHP will notify the beneficiary and/or the beneficiary's authorized representative, in writing, of the following:
 - 4.4.3.1. The MHP's approval of the continuity of care request;
 - 4.4.3.2. The duration of the continuity of care arrangement;
 - 4.4.3.3. The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
 - 4.4.3.4. The beneficiary's right to choose a different provider from the MHP's provider network.
 - 4.4.4. If the beneficiary's request is denied for any reason, the MHP will notify the beneficiary, and/or the beneficiary's authorized representative, in writing, of all the following in accordance with Part 438.10(d) of Title 42 of the Code of Federal Regulations:
 - 4.4.4.1. The MHP's denial of the beneficiary's continuity of care request;
 - 4.4.4.2. A clear explanation of the reasons for the denial;
 - 4.4.4.3. The availability of in-network SMHS;
 - 4.4.4.4. How and where to access SMHS from the MHP;
 - 4.4.4.5. The beneficiary's right to file an appeal based on the adverse benefit determination; and
 - 4.4.4.6. The MHP's beneficiary handbook and provider directory
 - 4.4.5. At any time, beneficiaries may change their provider to an in-network provider whether or not a continuity of care relationship has been established. The MHP will provide SMHS and/or refer beneficiaries to appropriate network providers without delay and within established appointment time standards (see MHP policy no. [0100.600 – Request for Access to Mental Health Services](#)).
 - 4.4.6. The MHP will notify the beneficiary, and/or the beneficiary's authorized representative, within thirty (30) calendar days before the end of the continuity of care period about the process that will occur to transition their 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
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COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

services through the transition to a new provider.

4.5. Repeated Requests for Continuity of Care.

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

4.5.2. If a 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 Mental Health Plan, after which, the beneficiary may not be granted additional continuity of care requests with the same pre-existing provider. In such cases, the Mental Health Plan should communicate with the Mental Health Plan in the beneficiary's new county of residence to share information about the beneficiary's existing continuity of care request.

5. Beneficiary and Provider Outreach and Education:

5.1. The MHP shall inform beneficiaries of their continuity of care protections by including information about these protections in the informational materials and handbooks provided to beneficiaries. Such information must include how the beneficiary and provider initiate a continuity of care request with the MHP. The MHP shall translate these documents into threshold languages and makes them available in alternative formats, upon request (see MHP policy no. [0704.881 – Accessible Client Materials](#)). The MHP shall provide continuity of care training to access staff in order to help inform beneficiaries about these protections.

6. Reporting Requirements:

6.1. The MP shall report to DHCS all requests, and approvals, for continuity of care with the MHP's quarterly network adequacy submissions. In addition, the MHP shall submit a continuity of care report that includes the following information:

6.1.1. The date of the request;

6.1.2. The beneficiary's name;

6.1.3. The name of the beneficiary's pre-existing provider;

6.1.4. The address or location of the provider's office;

6.1.5. Whether the provider has agreed to the MHP's terms and conditions; and

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

FORM(S)/
ATTACHMENTS

[1232 – Continuity of Care Request Form](#)

REFERENCE

[DHCS IN 18-059](#)
[Title 42 of the Code of Federal Regulations, part 438.10\(d\)](#)
[0704.881 Accessible Client Materials](#)
[0100.600 Request for Access to Mental Health Services](#)
[0704.341 Medi-Cal Site Certification/Recertification](#)
[0704.878 Provider Selection, Certification and Re-Certification](#)

COUNTY OF HUMBOLDT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH

0704.879 Required Documents by Contract Providers
California's Medicaid State Plan, Section 3 Supplements 1 and 3 to Attachment 3.1-A, and
Supplement 2 to Attachment 3.1-B
