BHS Policies and Procedures	
City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES	1380 Howard Street, 5th Floor San Francisco, CA 94103 (415) 255-3400 FAX (415) 255-3567
Policy or Procedure Title: **San Francisco Continuity-of-Care Requirements for Medi-Cal Specialty Mental Health Services**	
Issued By: Imo Momoh, MPA BHS Director of Managed Care DocuSigned by: imo momoh 360E6E598F1D468... Date: April 25, 2023	Manual Number: 3.04-09 References: DHCS MHSUDS Information Notice No.: 18-059; Federal Continuity of Care Requirements for Mental Health Plans

(Technical Revision. Replaces 3.04-09 March 6, 2019)

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, leads with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Purpose:
On December 17, 2018, the California Department of Health Care Services (DHCS) issued MHSUDS Information Notice (IN) #18-059, "Federal Continuity of Care Requirements for Mental Health Plans," setting forth the continuity-of-care requirements that county mental health plans have to comply with for Specialty Mental Health Services they provide to Medi-Cal beneficiaries.

These new DHCS continuity-of-care requirements align with the Parity in Mental Health and Substance Use Disorder Services Final Rule issued in the Federal Register, and with the Medicaid and Children's Health Insurance Program Managed Care Final Rule incorporated in Title 42 of the Code of Federal Regulations, by the Centers for Medicare and Medicaid Services.

Effectively immediately, DHCS IN #18-059 requires county mental health plans to give Medi-Cal beneficiaries the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider (organizational provider, provider group, or individual practitioner) with whom the beneficiary has a pre-existing provider relationship, upon the beneficiary's request for such continuity-of-care.

DHCS IN #18-059 requires county mental health plans to provide beneficiaries the requested continuity- of-care specialty mental health services with pre-existing providers 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 within the mental health plan's network.

The full DHCS information notice is available online at:
https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN 18-059 Continuity of Care/MHSUDS Information Notice 18-059 Continuity of Care.pdf

Scope: This policy applies to all BHS providers of both children and adult mental health services.

Policy:
This San Francisco Behavioral Health Services (BHS) policy details the procedures to be followed by BHS Mental Health Access (MH Access), Private Provider Network Unit (PPN), Quality Management, Billing Unit, all SF BHS providers, and Office of Compliance and Privacy Affairs (OCPA), Behavioral Health Compliance Office (BHCO) in order to comply with DHCS IN #18-059.

The following is the complete list of situations, stipulated in DHCS IN #18-059, for which a San Francisco Medi-Cal beneficiary may request BHS for continuity-of-care with an out-of-network pre- existing provider:

- When the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian requests that the beneficiary continue to receive mental health services under continuity-of-care from a provider who has been terminated from the provider network of BHS, and from whom the beneficiary has been receiving mental health services, for as long as the termination was for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medi-Cal program;
- When the beneficiary is transitioning from another county mental health plan into BHS, due to a change of residency to San Francisco, and the beneficiary requests continuity-of-care with their pre-existing provider from the previous county;
- When the beneficiary is transitioning from obtaining their mental health care from a Managed Care Plan (MCP) into obtaining Medi-Cal Specialty Mental Health Services from BHS, and the beneficiary requests continuity-of-care with their pre-existing mental health provider from the MCP; and
- When the beneficiary is transitioning from Medi-Cal fee-for-service to the BHS Medi-Cal specialty Mental Health Plan.

Procedure:
Effective immediately, upon receipt by MH Access of a continuity-of-care request from a San Francisco Medi-Cal beneficiary, or from the beneficiary's authorized representative or parent/legal guardian, or from the beneficiary's provider, and upon determination by MH Access that the beneficiary meets eligibility criteria for Specialty Mental Health Services, MH Access will obtain a consent-to-release- information from the beneficiary in order for MH Access to immediately contact, by phone and/or by email, the out-of-network pre-existing provider identified by the requesting beneficiary, to immediately request and obtain written confirmation from that out-of-network pre-existing provider (on a standard form that MH Access will send them to complete) of the following attestations:

CONFIRMATIONS NEEDED FROM OUT-OF-NETWORK PRE-EXISTING PROVIDER

1. That the out-of-network pre-existing provider *has been providing* mental health services to the requesting beneficiary (for at least once during the past 12 months), as evidenced by relevant treatment information, such as documentation of current assessment, treatment plan, and/or relevant progress notes;
2. That the pre-existing provider is consistent with a *provider type eligible* to provide services under the county Mental Health Plan;
3. That the pre-existing provider is *willing to continue providing* mental health services to the requesting beneficiary, under the framework of continuity-of-care;
4. That the pre-existing provider is *willing to contract* with BHS, under the *standard rates and contract terms and conditions* (including credentialing, documentation, utilization review, and quality assurance requirements) *set by BHS,* for the provision of continuity-of-care mental health services to the requesting beneficiary; and
5. That the pre-existing provider, based upon their knowledge and assessment of the requesting beneficiary, *attests* that the requesting beneficiary will likely suffer serious detriment to their health or be at risk of hospitalization or institutionalization if continuity-of-care is not provided.

If the pre-existing provider does not comply with the list of above written confirmations, then MH Access will have to disapprove the continuity of care request, and appropriately notify the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian in writing, accordingly. The written notice of denial must contain a clear explanation of the reasons for the denial; the availability of in-network BHS specialty mental health services; how and where to access BHS Specialty Mental Health Services; the beneficiary's right to file an appeal based on the adverse benefit determination, the Beneficiary Handbook, and the Provider Directory. (see BHS policy 3.11-04: *Issuing Notices of Adverse Benefit Determination to Medi-Cal Beneficiaries Receiving Specialized Mental Health Services or Drug Medi-Cal Organized Delivery System Services*).

Upon receipt of the above written confirmations from the pre-existing provider, MH Access will then contact the PPN, which will coordinate with OCPA/BHCO, to immediately expedite the 1) verification and credentialing of, and 2) the contracting with, the pre-existing provider for the provision of continuity- of-care services to the requesting beneficiary.

The PPN will instruct the pre-existing provider to furnish all the necessary documents within an expedited timeframe in order for OCPA/BHCO to be able to verify the pre-existing provider's credentials, and thereby enable MH Access to have everything that it needs to complete the response to the continuity-of- care request within the required calendar days from the date the request was received.

VERIFICATION OF PRE-EXISTING PROVIDER'S CREDENTIALS

OCPA/BHCO must minimally verify the following (from the required documents and information solicited and received from the pre-existing provider) before MH Access can complete the response to the continuity-of-care request:

- That the pre-existing provider's license is clear of any formal actions, formal decisions, or 805

reports, in the records of the state licensing board;
- That the pre-existing provider's certificate of insurance is verified;
- That there have been no adverse actions, including malpractice claims paid, against the pre- existing provider in the National Practitioner Data Bank;
- That the pre-existing provider is not ineligible to provide Medi-Cal-funded services in the Medi- Cal Suspended and Ineligible Provider List;
- That there are no sanctions or adverse actions against the pre-existing provider in the Office of Inspector General (OIG) List of Excluded Individuals/Entities; and
- That there are no sanctions of adverse actions against the pre-existing provider in the federal System for Award Management.

If OCPA/BHCO is unable to verify the above validities of the pre-existing provider's credential, then MH Access will have to disapprove the continuity of care request, and appropriately notify the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian in writing, accordingly. The

written notice of denial must contain a clear explanation of the reasons for the denial; the availability of in-network BHS Specialty Mental Health Services; how and where to access BHS Specialty Mental Health Services; and the beneficiary's right to file an appeal based on the adverse benefit determination (see BHS policy 3.11-04: Issuing Notices of Adverse Benefit Determination to Medi-Cal Beneficiaries Receiving Specialized Mental Health Services or Drug Medi-Cal Organized Delivery System Services).

MH ACCESS' AUTHORIZATION OF CONTINUITY-OF-CARE SERVICES

Upon verification by OCPA/BHCO of the validity of the credentials of the pre-existing provider, 1) MH Access will then authorize in writing the continuity-of-care services to the beneficiary, and, at the same time, 2) the PPN will then complete the contracting process with the pre-existing provider for the provision of such services.

The BHS claims payment unit (Billing Unit) will reimburse pre-existing providers for all continuity-of- care services that were provided to the beneficiary after the request or referral to continuity-of-care services was made, and so, the written authorization of continuity-of-care services to be sent by MH Access to the pre-existing provider will be backdated to the request or referral date. The written authorization of services will also contain the clinical documentation required to be maintained by the provider, including the completion of a client treatment and transition plan for the beneficiary's continuity-of-care service. The written authorization will also instruct the provider to engage with the beneficiary, 30-calendar days before the end of the continuity-of-care period, in a process with MH Access to transition care to a new BHS in-network provider.

Concurrent with the issuance by MH Access to the provider of the written authorization for continuity-of-care services, the PPN will proceed to put into place the standard BHS contract for Specialty Mental Health Services with the provider (individual, group, or organization), following the standard contracting processes for PPN individual providers and for single-case-agreements with provider organizations, and following any current or future processes involving contracting for services between counties (for pre- existing organizational providers that are part of the system-of-care of another county other than San Francisco).

Upon approval and authorization of the continuity-of-care request, MH Access will also notify the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian, in writing, of 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 BHS' provider network.

At any time during the period of receiving continuity-of-care services, beneficiaries may request MH Access to change their provider to an in-network BHS provider, and if so, MH Access will refer beneficiaries to appropriate network providers following established standards for responding to requests for services.

All requests for continuity-of-care services must be made to the MH Access Unit, and BHS will inform all providers and all Medi-Cal beneficiaries (via the beneficiary informing materials) accessing services, of the continuity-of-care option and how to initiate such a request.

COMPLETION OF RESPONSE TO CONTINUITY-OF-CARE REQUEST

MH Access must respond to the continuity-of-care request within 30 calendar days from the date the continuity-of-care request was received, or within 15 calendar days if the beneficiary's condition requires more immediate attention, or 3 calendar days if there is a risk of harm to the beneficiary.

BHS's response to a continuity-of-care request is considered complete when:

- MH Access informs the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian, that the request has been approved; or
- The PPN and the pre-existing provider are unable to agree to a rate, and MH Access notifies the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian that the request is denied; or
- Compliance Unit has documented quality of care issues with the pre-existing provider, and MH Access notifies the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian that the request is denied; or
- BHS (MH Access, OCPA/BHCO, or PPN) makes a good faith effort to contact the pre-existing provider, and the pre-existing provider is non-responsive for 30 calendar days, and the MH Access notifies the beneficiary and/or the beneficiary's authorized representative or parent/legal guardian that the request is denied.

RECORD-KEEPING OF CONTINUITY-OF-CARE REQUESTS

Because BHS Quality Management is required to submit to DHCS a quarterly continuity-of-care report (along with the quarterly Network Adequacy Certification Tool report), MH Access will keep a log of all requests, and approvals, for continuity-of-care, that includes the following information:

- Date of the request;
- Beneficiary's name;
- Name of beneficiary's pre-existing provider;
- Address/location of the pre-existing provider's office;

- Whether the provider has agreed to BHS' terms and conditions; and
- Status of the request, including the deadline for making a decision regarding the beneficiary's request.

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 BHS provider network. If the beneficiary later transitions to a MCP or Medi-Cal fee-for-service for non-specialty mental health services, and subsequently transitions back to the BHS for Specialty Mental Health Services, 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 county Mental Health Plan and third county Mental Health Plan, after which, the beneficiary may not be granted additional continuity-of-care requests with the same pre-existing provider.

Contact Person:
Director of Managed Care
Director of Quality Management
System of Care Directors

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