Behavioral Health

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Continuity of Care Procedure

Approval Date	07/07/2022	DocuSigned by: Dr. Georgina Yoshioka, Interim Director 7DF8077EFA674B2...
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Purpose

To provide procedural guidance to Department of Behavioral Health (DBH) staff, contract agencies and Fee For Service (FFS) providers regarding the process for Continuity of Care requests received from clients for Specialty Mental Health Services (SMHS) by an out of network provider. Requests for Continuity of Care are only applicable for SMHS.

Right to Request Continuity of Care

DBH clients have the right to request Continuity of Care and DBH is required to notify clients of this right. Clients seeking to continue receiving SMHS with an out of network or terminated network provider must make a request for Continuity of Care.

Clients may be approved to continue receiving those services for up to twelve (12) months when DBH determines through its assessment that, in the absence of continued services, the client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

Requests

Clients, their authorized representatives, or their current provider may submit a request for Continuity of Care with their current SMHS provider/clinic or by calling the DBH Access Unit at 888-743-1478 (TTY 711) to make the request.

In accordance with the Department of Health Care Services (DHCS), the request may be in person, in writing or be taken via telephone; however, DBH cannot require the request be submitted electronically or in writing by the client. Therefore, for tracking purposes, DBH is requesting clinics and providers complete the form on behalf of clients or assist clients with completion, which may include providing oral interpretation and auxiliary aids and services in completing the requested (not client required): Out of Network Services Request form (QM039).

How to Submit Requests

DBH clinics, contract agencies and FFS Providers shall upon receipt of a Continuity of Care request submit to the following DBH mailbox: DBH-OutofNetwork@dbh.sbcounty.gov.

Upon receipt of the request, DBH's Quality Management (QM) division shall send the client written acknowledgement regarding receipt of the request. QM shall log the request and begin processing of the request.

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Eligibility

In order to be eligible for Continuity of Care with an out of network provider, the client must be transitioning as follows:

- Client's SMHS provider has voluntarily terminated employment or ended their contract with DBH;
- Client's SMHS 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;
- Client moving from one county MHP to another county MHP due to a change in the client's county of residence;
- Client changing level of services from a Managed Care Plan (MCP) to DBH; or
- Client changing level of services and Medi-Cal systems from Medi-Cal FFS to DBH.

Criteria

DBH as the MHP must provide Continuity of Care if the client meets one of the transitioning criteria listed above with an eligible out of network Medi-Cal provider and all the following conditions are met:

1. DBH is able to determine that the client has an existing relationship with the out of network provider (i.e., the client has received mental health services from an out of network provider at least once during the twelve (12) months prior to their initial enrollment in DBH;
2. The out of network provider type is consistent with the State Plan 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 supplies DBH 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, to the extent allowed under federal and state privacy laws and regulations;
5. The provider is willing to accept the higher of DBH's FFS provider contract rates or Medi-Cal FFS rates, and
6. DBH 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 clients.

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Criteria, continued

Once DBH confirms there is a pre-existing relationship with an out of network provider, DBH is required to 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 client.

Important Note: If a provider is not willing or unable to accept the aforementioned requirements, then DBH cannot approve the Continuity of Care request.

Approval Process

When approving a Continuity of Care request, DBH agrees that it must allow the client to have access to that provider for a period up to 12 months, depending on the needs of the client and the agreement between DBH and the out of network provider. Additionally, DBH must work with the out of network provider to establish a client plan and transition plan for the client. When issuing an approval for the Continuity of Care request, DBH must notify the client and/or their authorized representative, in writing of the following:

- Approval of the request;
- Duration of the continuity of care arrangement;
- Process that will occur to transition the client's care at the end of the Continuity of Care period, and
- Client's right to choose a different provider from DBH's provider network.

Denial Process

If DBH is denying a Continuity of Care request, it must provide written notice to the client and/or the authorized representative or provider via the appropriate Notice of Adverse Benefit Determination (NOABD) with the following required information:

- Denial of the request;
- Clear explanation of the reasons for denial;
- Availability of in-network SMHS;
- How and where to access SMHS from DBH's network;
- Client's right to file an appeal based on the adverse benefit determination, and
- DBH Handbook and Provider Directory.

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Notification Requirements

Other requirements associated with the Continuity of Care request that DBH must provide, notify or advise, include the following:

- Right of the client to change their provider to an in-network provider whether or not a Continuity of Care relationship has been established;
- Advisement to the client that DBH must provide SMHS and/or refer clients to appropriate network providers without delay and within the established appointment time standards outlined in the QM6041 Timely Access Policy;
- Notification to the client and/or authorized representative 30 calendar days before the end of the Continuity of Care period about the process that will occur to transition the client's care at the end of the Continuity of Care period;
- Advisement that the client must choose a SMHS provider in the DBH network when the Continuity of Care period ends; and
- Repeated requests for Continuity of Care may be possible based on subsequent transfers and changes regarding the county of residence.

Timelines

The timelines for DBH to adhere to regarding Continuity of Care requests are as indicated in table below:

Circumstances	Timeframe
Upon receipt of the Continuity of Care request	Complete request within but no longer than 30 calendar days
Should the client's condition require more immediate attention, such as upcoming appointments or other pressing care needs	Complete request within but no longer than 15 calendar days from the request
If there is risk of harm to the client	Complete the request within but no longer than 3 calendar days

Completion of Request

A Continuity of Care request is considered complete when one the following applies:

- DBH informs the client and/or their authorized representative that the request has been approved; or
- DBH and the out of network provider are unable to agree on a rate and DBH notifies the client and/or their authorized representative that the request is denied; or
- DBH has documented quality of care issues with the out of network provider and notifies the client and/or their authorized representative that the request is denied; or
- DBH makes good faith effort to contact the out of network provider and the provider is non-responsive for 30 calendar days and DBH notifies the client and/or their authorized representative that the request is denied.

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Reimbursement

The reimbursement procedures and the roles and responsibilities of DBH staff for Continuity of Care requests if the provider chooses not to join DBH's network of care are as indicated in table below:

Role	Responsibility
Applicable DBH QM staff	• Contacts the out of network provider to obtain invoice and supporting documents; • Reviews and approves or requests correction of the invoice and supporting documents once received from provider; and • Provides written notification to Fiscal staff to process payment to an out of network provider.
Fiscal Staff	• Processes payment upon receipt of approved documents from QM.

Outreach and Education

DBH is required to inform clients of their Continuity of Care protections and must include information about these protections in client informing materials and handbooks. This information must include how the client and provider initiate a Continuity of Care request with DBH. DBH must translate these documents into threshold languages and make them available in alternative formats, upon request. Additionally, DBH must provide training to staff who come into regular contact with clients about Continuity of Care protections.

Reporting Requirements

DBH is required to report to DHCS all requests, and approvals, for Continuity of Care. DBH must submit a continuity of care report with its annual network adequacy submissions, that includes the following information:

- Date of the request;
- Client's name;
- Name of the client's pre-existing provider;
- Address/location of the provider's office; and,
- Whether the provider has agreed to DBH's terms and conditions and,
- Status of the request, including the deadline for making a decision regarding the client's request.

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Related Policy or Procedure

DBH Standard Practice Manual and Departmental Forms:

- Out of Network Services Request form (QM039)
- Timely Access Policy (QM6041)
- Timely Access Procedure (QM6041-1)
- Network Adequacy Monitoring Policy (QM6043)
- Network Adequacy Monitoring Procedure (QM6043-1)
- Out of Network Access Policy (QM6044)
- Out of Network Procedure (QM6044-1)
- Transition of Care (QM6044-3)
- Service Availability Policy (QM6046)

Reference(s)

- California Department of Health Care Services Mental Health and Substance Use Disorder Services Information Notice No. 18-059
- DBH mailbox: DBH-OutofNetwork@dbh.sbcounty.gov.