Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Medi-Cal Managed Care Access 09.01.01 ☐New ☒Revised
	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	_Signature on File_ ___	_1/19/2022____

SUBJECT: Mental Health Plan Out-of-Network Services

PURPOSE:

To establish a procedure for requesting and processing requests for out-of-network Specialty Mental Health Services (SMHS) for Medi-Cal beneficiaries in the Medi-Cal Mental Health Plan (MHP).

POLICY:

Medi-Cal beneficiaries may be eligible to receive medically necessary Specialty Mental Health Services under the MHP from out-of-network providers in certain circumstances. It is the policy of Mental Health and Recovery Services (MHRS) that all out-of-network providers meet specified requirements, including but not limited to those required by the Department of Health Care Services (DHCS) for Medicaid Managed Care Plans.

SCOPE:

All Medi-Cal Managed Care beneficiaries receiving or requesting services from the MHP.

REFERENCES:

MHSUDS Information Notice 18-011- Federal Network Adequacy Standards for Mental Health Plans (MHPS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

MHSUDS Information Notice 18-059 – Federal Continuity of Care Requirements for Mental Health Plans

FORMS:

Notice of Adverse Benefit Determination (NOABD) About Your Treatment Request

PROCEDURE:

I. Situations eligible for medically necessary out-of-network services:

A. American Indians

1. It is required that American Indians be permitted to receive MHP services from an American Indian Health Facility if so desired.

2. American Indian Health Facilities shall not be required to contract to become an in-network provider with County.

3. There are no American Indian Health Facilities in Orange County.

4. Orange County shall invite, but not require, any American Indian Health Facilities that may open in Orange County to join the MHP.

5. American Indians wishing to receive services from an American Indian Health Provider may do so, whether or not that provider chooses to become part of the MHP network.

B. Alternate Access Standards

1. The MHP is required to provide services within established time and distance standards. When an area of the county does not fall within those standards, persons in the area that does not meet the standards may be approved (depending on any alternative standard that may be approved by DHCS) to receive out-of-network services from a non-network provider.

C. Continuity of Care

1. Beneficiaries with pre-existing provider relationships must be given the option to continue treatment with an out-of-network Medi-Cal provider or a terminated network provider.

2. Continuity of Care arrangements shall not exceed 12 months in duration.

3. Continuity of Care requirements apply to all Medi-Cal beneficiaries who are transitioning into the SMHS delivery system, as follows:

   a) From Medi-Cal Fee-for-Service (FFS),

   b) From one county MHP to another county MHP due to a change in the beneficiary's county of residence, or

   c) From a Managed Care Plan (MCP) to an MHP.

4. To be eligible for Continuity of Care arrangements, multiple criteria must be met, including:

   a) A documented pre-existing relationship between the beneficiary and provider.

   b) The provider is eligible under State Plan and State law.

c) The provider agrees, in writing:

i) To be subject to the same contractual terms and conditions that are imposed upon currently contracting network providers.

ii) To comply with State requirements for SMHS, including documentation requirements.

d) The provider supplies the MHP with all relevant treatment information, for the purposes of determining medical necessity.

e) The provider is willing to accept the higher of either the MHP's provider contract rates for existing network providers or Medi-Cal FFS rates.

f) The MHP has not 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.

D. Medically necessary services are not available/provided in network.

1. When the MHP has made a determination that a requested service is medically necessary and authorized and these services are not available/provided in network.

E. Direction by the Department of Health Care Services (DHCS)

1. When the MHP has not met network adequacy standards set by DHCS, DHCS may directed the MHP to allow beneficiaries to use out of network providers.

a) Depending on the specific direction from DHCS that is in place at any given time, the requirement to allow out of network providers may apply to only a subset of the services provided by the MHP.

b) The Director of Authority and Quality Improvement Services may be consulted to determine what, if any, services fall into this out of network requirement at the time a request comes in.

II. Request Processing Procedures

A. Requesting Approval:

1. Request out-of-network services by:

a) For Children and Youth, call MHRS Children, Youth and Prevention (CYP) Administration at (714) 834-2125.

b) For Adult and Older Adults, call MHRS Adult and Older Adult (AOA) Administration at (714) 834-4707.

B. Request Review Process:

1. Determine if situation meets requirements for out-of-network services (see I A-E, above).

2. Determine if Medical Necessity for SMHS is met.

3. Give the prospective provider an information sheet which outlines the specific detailed provider requirements.

4. Develop a letter agreement with the provider.

C. Denial of request to receive out-of-network services:

1. If a request for out-of-network services is denied, an appropriate NOABD is required. (See MHRS P&P Notice of Adverse Benefit Determination.) If services by an alternative in-network provider are offered, specify this on the NOABD.