SANTA CRUZ COUNTY
Behavioral Health Services

POLICIES AND PROCEDURE MANUAL

Subject: Transition (Continuity) of Care	**Policy Number: 3229**
Date Effective: 6/17/2019	**Pages: 7**
Replaces: None	**Responsible for Updating:** Quality Improvement
Approval: _____ Behavioral Health Director	6-20-2019 Date

PURPOSE:
This policy describes the Santa Cruz County Behavioral Health Services (SCCBHS) procedures for ensuring safe transfers of care and continuity of care for Medi-Cal beneficiaries (MHP and DMC-ODS).

SCOPE:
Transition (Continuity) of Care applies to all Santa Cruz County Medi-Cal beneficiaries who Meet medical necessity for SUDS or SMHS from SCCBHS. It applies to beneficiaries whose treatment will be provided by employees, contractors and Network Providers.

BACKGROUND:
SCCBHS's Drug Medi-Cal Organized Delivery System (DMC-ODS) and Mental Health Plan (MHP) operate as a type of managed care organization to authorize, provide and/or arrange for all Substance Use Disorder Services (SUDS) and Specialty Mental Health Services (SMHS) for Santa Cruz Medi-Cal beneficiaries.

To accomplish its mission as the DMC-ODS and MHP, SCCBHS maintains a network of Providers that includes employees, contract providers, and individual Network Providers to deliver a broad array of services in a variety of levels of care. The service array and provider network consider the needs for different types of services and providers as well as the cultural and linguistic needs of Santa Cruz Medi-Cal beneficiaries.

SCCBHS encourages collaborative treatment relationships between providers and beneficiaries to support effective mental health and substance use disorders services. Abrupt ending to treatment may result in impaired outcomes. SCCBHS will implement a Transition (Continuity) of Care policy that will allow eligible beneficiaries the opportunity to maintain Treatment relationships with their eligible existing providers, which supports continued access to services during a transition.

POLICY:
SCCBHS will authorize and pay for medically necessary SUDS or SMHS for eligible Medi-Cal beneficiaries who have an existing treatment relationship with an eligible out-of-network provider when, in the absence of continued services with the provider, the beneficiary would suffer serious detriment to their health, or be or risk of hospitalization or institutionalization.

SCCBHS' time-limited Transition (Continuity) of Care authorizations will allow the beneficiary to complete a course of treatment, and/or arrange for a safe transfer to a provider within SCCBHS's provider network.

DEFINITIONS/CRITERIA:

1. Client Eligibility Criteria
    a. Client must meet medical necessity criteria for the SUDS or SMHS for which transition of care is requested.
    b. SCCBHS must determine that change of provider to an in-network provider would result in "serious detriment to client's health or place client at risk of hospitalization or institutionalization."

2. Existing Treatment Relationship Criteria
    a. SUDS: Evidence (not just client self-report) that the beneficiary received services from the provider prior to the date of beneficiary's "transition to the DMC-ODS county" (i.e. the date eligible for Santa Cruz County Drug Medi-Cal)
    b. SMHS: One or more of the following
        i. Evidence that the beneficiary received mental health services at least once during the 12 months prior to the date of client's "initial enrollment in the MHP" (i.e. the date eligible for Santa Cruz County Medi-Cal)
        ii. Evidence that the beneficiary was receiving SMHS from the provider at the time SCCBHS or the provider terminated a contract or employee relationship
        iii. Evidence that the beneficiary was receiving SMHS from the provider at the time of the client's move to Santa Cruz County from another MHP's jurisdiction
        iv. Evidence that, at the time of the client's transition to the MHP, (i.e. at the time the beneficiary meets medical necessity for SMHS), the beneficiary was receiving non-SMHS from:
            1. A Medi-Cal Fee-for-Service provider
            2. A Beacon provider - Managed Care Plan's (MCP) [mild-to-moderate services]

3. Provider Eligibility Criteria
    a. Rate Agreement:
        i. SUDS: Provider must agree to accept the higher of DMC-ODS or DMC rates.
        ii. SMHS: Provider must agree to accept the higher of SCCBHS Network Provider contract rates or MC FFS rates (or previous contract rate with MHP rate if applicable).
    b. Provider must meet applicable professional standards for their discipline.
    c. Provider must be free from disqualifying quality of care concerns. If SSCBHS verifies and documents quality of care concerns about the provider such that the

provider would be ineligible to provide services to other beneficiaries, the provider does not meet this criterion.

d. Provider must be willing to enter a contract with SCCBHS for provision of services to the beneficiary.
e. Provider must give SCCBHS all relevant treatment information to the SCCBH to determine medical necessity, including the current Treatment Plan, Progress Notes and Assessment.
f. Additional provider requirements:
    i. SUDS:
        1. Provider must be verified as a current DMC provider.
        2. Provider must give SCCBHS all outcome data (ASAM and CalOMS).
        3. Provider agrees in writing to adhere to DHCS/SCCBHS DMC-ODS documentation standards.
        4. Provider must agree in writing not to refer the beneficiary to another out-of-network provider.
    ii. SMHS:
        1. Provider type must be consistent with State Plan (i.e. must be a provider type who can provide SMHS).
        2. Provider agrees in writing to adhere to DHCS/SCCBHS documentation standards.
        3. Provider must agree in writing not to refer the beneficiary to another out-of-network provider.
        4. Provider must agree in writing to adhere to the same contractual terms and conditions that are imposed upon currently contracted network providers, including, but not limited to, credentialing, utilization review and quality assurance.

PROCEDURES:

1. Request for Transition (Continuity) of Care
    a. A Medi-Cal beneficiary, authorized representative, or provider may submit a request for transition of care authorization to SCCBHS by phone, in person, or in writing. A request is not required to be submitted electronically or in writing.
    b. When needed, SCCBHS will make reasonable assistance available, for example, using bilingual staff or Language Line, transcribing the beneficiary or provider's request, etc.
    c. Requests for Transition of Care will be forwarded to Quality Improvement (QI) on the day received.
    d. QI staff will acknowledge receipt of the request in writing within three (3) business days of the request. The acknowledgement letter will be sent to the beneficiary and the provider.

2. Evaluation Process
    a. SCCBHS QI staff, or delegate, will complete the Transition (Continuity) of Care Authorization assessment to document the results of the evaluation.
    b. SCCBHS QI staff, or delegate, must determine that the beneficiary meets the Client Criteria identified in this policy.
        i. Assessment to determine medical necessity and risk without the Transition of Care authorization may vary depending on the type of request and the information available to SCCBHS staff.

1. In some circumstances, as when the client is new to SCCBHS, a face-to-face contact with the client and completion of the comprehensive assessment may be required.
2. At other times, as when the client asks to continue a course of treatment with a terminated employee, a review of records obtained from SCCBHS EHR and a telephone contact with the beneficiary may be sufficient.

ii. SCCBHS QI staff, or delegate, will apply current medical necessity criteria for the service requested to make their determination. For additional information about medical necessity, refer to SCCBHS the applicable policy and Documentation Manual for the service requested.

iii. In addition to meeting medical necessity criteria, the beneficiary must be at risk of "serious detriment" to the beneficiary's health or risk of hospitalization or institutionalization if treatment with the current provider is not continued.

c. SCCBHS QI staff, or delegate, must determine that Existing Treatment Relationship Criteria is met.

d. SCCBHS QI staff, or delegate, must determine if Provider Eligibility Criteria are met.

i. SCCBHS staff will contact the provider to evaluate provider's willingness to treat beneficiary under the terms of this policy (i.e. rate acceptance, etc.).

ii. SCCBHS staff will begin a good faith effort to expedite credentialing/contract development:

1. QI credentialing staff will complete credentialing steps.
2. Administrative fiscal contract staff, or delegate, will coordinate with the appropriate division leadership to complete contracting and rate agreement steps.

3. Notification of Approval or Denial

a. Approval:

i. SCCBHS QI staff will notify the beneficiary and the provider in writing of the conclusion of the evaluation within the timeframes set below.

ii. If the Transition (Continuity) of Care Request is approved, the notification will:

1. Specify the duration of the authorization period
   a. SUDS (whichever is shorter):
      i. Until medical necessity criteria are no longer met
      ii. 90 days (may be extended to up to 12 months if medically necessary)
   b. SMHS (whichever is shorter):
      i. Until medical necessity criteria are no longer met
      ii. Until the course of treatment is completed
      iii. Until safe transition to an in-network provider can be arranged
      iv. Not to exceed 12 months
2. Describe the transition process back to SCCBHS
3. State that the beneficiary may request a transition back to SCCBHS at any time during the authorization period

4. State that continuous Medi-Cal eligibility is a requirement for the Transition of Care authorization. SCCBHS is not responsible to pay for services that are rendered during a lapse in Medi-Cal eligibility.

b. Denial:
   i. Denial Reasons:
      1. Beneficiary does not meet Client Criteria (i.e. does not meet medical necessity criteria, no evidence of risk without treatment by requested provider)
      2. No evidence of Existing Treatment Relationship Criteria
      3. Provider declines to continue treatment
      4. Provider does not meet Provider Criteria
         a. SCCBHS verifies and documents disqualifying quality of care issues
         b. Provider does not meet criteria
         c. SCCBHS and the provider are not able to enter into contract (includes when SCCBHS makes a good faith effort to enter into contract and the provider is non-responsive for 30 days)
   ii. Denial Process
      1. SCCBHS QI staff will issue a NOABD – Denial
         See **3224: Grievance & Appeal Policy**
         a. The NOABD will describe in plain language the reason for the adverse decision.
         b. The NOABD will be mailed to the beneficiary, authorized representative, and provider and will explain the appeal options.
      2. SCCBHS will offer the beneficiary at least one in-network alternative.
      3. SCCBHS will describe how the beneficiary can access services within SCCBHS' network.
      4. SCCBHS will make available the Beneficiary Handbook and the Provider Directory.

c. Timeliness for evaluation and written notification (Approval Letter or NOABD)
   i. Written notification of the authorization decision will be mailed within the following timeliness, from the date the request was received:
      1. SUDS (all requests) and SMHS (routine requests): 30 calendar days
      2. SMHS (urgent requests – includes situation when upcoming appointments have already been scheduled for services and a delay would negatively affect the beneficiary): 15 calendar days
      3. SMHS (crisis requests – includes situations when a delay would cause serious harm to the beneficiary: three (3) calendar days

   Note: A contract does not need to be fully executed before the Authorization decision is made. Services may begin after the Credentialing Attestation and contract are signed by the provider while awaiting final execution and approval of the contract by the Board of Supervisors.

4. Transition to SCCBHS for ongoing care
    a. Unless a client is open for services at a SCCBHS provider location, transition back to SCCBHS in-network providers will be coordinated by the QI Team.
    b. If the beneficiary remains in treatment for the duration of the authorization, SCCBHS QI staff will:
        i. Notify the beneficiary and provider in writing 30 calendar days before the end of the authorization
        ii. Describe the transition process
        iii. Engage the beneficiary and provider by phone to ensure a smooth transition
    c. If during the Transition (Continuity) of Care authorization period the beneficiary elects to or the provider determines that the beneficiary must transfer care to SCCBHS, QI staff will facilitate the transfer. This may involve an Access re-assessment to determine the most appropriate level of care.

5. Medical Necessity and Documentation
    a. SCCBHS QI staff will complete periodic documentation reviews to ensure that documentation meets medical necessity standards for claiming.
    b. The provider will make available to SCCBHS staff any records requested to complete quality management activities.
    c. As described in the contract between SCCBHS and the provider, SCCBHS will neither pay a provider for nor claim to Medi-Cal any services that do not meet applicable documentation standards. In all instances, the provider is responsible for reimbursing SCCBHS for services that were claimed and paid but are not documented to SCCBHS standards.

6. Tracking
    a. The QI staff will log all DMC-ODS "Transition of Care" requests and MHP SMHS "Continuity of Care" requests, evaluation outcome, sent NOABDs and the date ranges for approved authorization periods and outcome of the request (if known)
    b. Each approved Transition (Continuity) of Care authorization period will be scheduled to alert the SCBHS staff that the transition planning must begin no later than eleven (11) months after the final approval of the Transition (Continuity) of Care request.

7. Retroactive Requests
    a. SCCBHS will retroactively approve transition of care requests and will reimburse out-of-network providers for services already provided under the following circumstances:
        i. SUDS:
            1. Must be submitted in writing within 30 calendar days of the first service to which the request applies
            2. Must have dates of services that occurred after the beneficiary became eligible for Santa Cruz County Medi-Cal
            3. Provided documentation meets DMC-ODS requirements.

ii. SMHS:
    1. Must have dates of services that occurred after the beneficiary became eligible for Santa Cruz County Medi-Cal
    2. Must have dates of services that occurred after the beneficiary was referred (or self-referred) to SCCBHS and after the beneficiary was determined to meet medical necessity for SMHS
    3. Provided documentation meets MHP SMHS requirements

b. SCCBHS QI staff will mail a NOABD – Payment Denial to the beneficiary and provider to deny a request for retroactive payment for a transition (continuity) of care service.

8. Outreach and Informing Requirements
SCCBHS will include information about transition (continuity) of care in its informing materials, including information made available on the SCCBHS website and an easily displayed Transition (Continuity) of Care brochure at provider locations.

9. DHCS Reporting
    a. SUDS: Designated QI staff will report DMC-ODS transition of care requests to DHCS in the quarterly Grievance and Appeal log reporting.
    b. SMHS: Designated QI staff will report MHP continuity of care requests to DHCS in quarterly Network Adequacy submissions.
    c. Reporting will include:
        i. Beneficiary's name
        ii. Date of Request
        iii. Provider name and address
        iv. Status update – whether the provider agreed to contract, timeliness for approval/denial, outcome of the request (if known at the time of submission)

10. Other Requirements
    a. SUDS: SCCBHS must submit DMC-ODS Provider Form to Master Provider File unit
    b. SMHS: Repeated Requests for Continuity of Care
        i. After the beneficiary's transition of care period ends, the beneficiary must choose a mental health provider in the MHP network for SMHS.
        ii. If the beneficiary later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to the MHP for SMHS, the 12-month transition of care period may start over one (1) time.
        iii. If a beneficiary changes county of residence more than once in a 12-month period, the 12-month transition of care period may start over with the second MHP and third MHP, after which, the beneficiary may not be granted additional transition of care requests with the same pre-existing provider.
            1. In these cases, QI staff, or delegate, will outreach and communicate with the MHP in the beneficiary's new county of residence to share information about the beneficiary's existing transition of care requests.

2. SCCBHS QI staff will deny additional request and conduct the denial process described in the above Notification Section.

PRIOR VERSIONS: N/A

REFERENCES: Code of Federal Regulations (CFR) Title 42, 438.08 Coordination and continuity of care; 42 CFR 438.62(b)1-2 Continued services to beneficiaries; 42 CFR 438.3(l) Choice of Provider; 42 CFR 438.114(d)(3) Emergency and Post-stabilization Services; 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records; 45 CFR 160 and 164 HIPAA; CCR 1810.370 Memorandum of Understanding (MOU) with Medi-Cal Managed Care Plans; 9 CCR 1810.425 Hospital Selection Criteria. California Health & Safety Code, Division 2, Chapter 2.2, 1373.96; Department of Health Care Services (DHCS) MHSUDS Information Notices 18-051 & 18-059

FORMS/ATTACHMENTS: Brochure; Acknowledgement Letter; Approval Letter, Transition (Continuity) of Care Form