



**Health Care Agency
Behavioral Health Services
Policies and Procedures**

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Sub Section: Access
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	SIGNATURE	DATE APPROVED
Deputy Director Behavioral Health Services	<u>Signature on File</u>	<u>10/17/2025</u>

SUBJECT: Behavioral Health Plan (BHP) Out of Network Services and Continuity of Care Requests

PURPOSE:

To establish a procedure for accessing, requesting and processing requests for out-of-network services, and continuity of care, within the Orange County Behavioral Health Plan (BHP).

POLICY:

Medi-Cal members may be eligible to receive medically necessary Specialty Mental Health Services (SMHS) or Substance Use Disorder (SUD) services under the Drug Medi-Cal Organized Delivery Systems (DMC-ODS) within the BHP from out-of-network providers in certain circumstances. Medi-Cal members may also be eligible to receive continued access to Orange County BHP services from out of network providers in certain circumstances for a limited time. It is the policy of Behavioral Health Services (BHS) 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 members receiving or requesting services from the Orange County BHP.

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](#) and subsequent releases

[MHSUDS Information Notice 18-059 - Continuity of Care](#) and subsequent releases

Intergovernmental Agreement between DHCS and the County of Orange for the provision of Behavioral Health Plan (BHP) services

[Medicaid Mental Health Parity Final Rule Federal Register](#)

FORMS:

[Notice of Adverse Benefit Determination - NOABD](#)

[QMS Continuity of Care Request Form](#)

DEFINITIONS:

Adverse benefit determination -

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (2) The reduction, suspension, or termination of a previously authorized service.
- (3) The denial, in whole or in part, of payment for a service.
- (4) The failure to provide services in a timely manner, as defined by the State.
- (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Quality Management Services (QMS) – An administrative service area providing oversight and coordination of quality improvement and compliance activities across the Divisions of BHS.

Member – A person with Orange County Medi-Cal coverage. For the purposes of this policy and procedure, “member” includes a parent, guardian, conservator, or other authorized representative, unless otherwise specified.

Notice of Adverse Benefit Determination (NOABD) - Form used to notify the requesting provider, and give the enrollee written notice of any decision by the Plan to deny or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. There are multiple versions of this form, to be used depending on the situation.

Provider Representative – The individual assigned at each clinic and treatment site to educate and assist beneficiaries and family members with grievances. The Provider Representative is the person designated to provide information to the member about the status of a grievance upon request.

Termination – The provider voluntarily terminated employment or contact; or the BHP terminated employment or the provider's contract for a reason other than issues related to quality of care or eligibility of the provider to participate in the Medicaid program.

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 BHP services from a Tribal Health Provider from whom the member is eligible to receive services from, if so desired.
 2. Tribal Health Provider shall not be required to contract to become an in-network provider with County.
 3. There are no Tribal Health Provider 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 BHP.
 5. American Indians wishing to receive services from an Indian Health Care Provider (IHCP) may do so, whether that provider chooses to become part of the BHP network or not.
 - B. Alternate Access Standards
 1. The BHP 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. Medically necessary covered services are not available/provided in network.
 1. When the BHP has made a determination that a requested covered service is medically necessary and authorized, and these services are not available/provided in network.
 - D. Direction by the Department of Health Care Services (DHCS)
 1. 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 BHP.

- a) The Director of Quality Management Services (QMS) 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 of Out-of-Network Services:

1. Members may request out-of-network services by contacting the QMS Utilization Management Complex Care Coordination (UMCCC) team by sending a request via email at BHPUMCCC@ochca.com. The request must include the member's name, contact information and the provider's name and contact information.

B. Request Review Process by UMCCC:

1. Determine if the request meets requirements for out-of-network services (see I A-E, above).
2. Determine if Medical Necessity for SMHS or Medical Necessity for DMC-ODS at the requested Level of Care (LOC) is met, based on clinical justification.
3. Identify a BHP Medi-Cal certified provider in the surrounding counties who is able to provide services to the member to fulfill access standards until an "in-network" provider is available.
4. If no BHP Medi-Cal certified provider is available, identify a non-BHP provider in the County who is able to provide services to the member to fulfill access standards, until an "in-network" or BHP certified provider has availability to provide services to the member.
5. Provide the prospective provider an information sheet which outlines the specific detailed provider requirements that apply.
6. Develop a letter/single case agreement to provide services for the member with the provider.

C. Guidelines for identifying and retaining out-of-network providers

1. The cost to beneficiaries shall not be greater than it would be if the services were furnished in-network, and out-of-network providers shall coordinate payment with the County only.
2. No providers shall be utilized that are located outside of the United States.

D. Monitoring Responsibility

1. Monitoring of out-of-network BHP providers in the surrounding counties shall remain the responsibility of the county/ies with which the provider holds a contract as network provider.
2. Monitoring that all requirements are met for non-BHP certified providers shall remain the responsibility of County monitoring staff responsible for coordinating access.

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

1. If a request for out-of-network services is denied, an appropriate Notice of Adverse Benefit Determination (NOABD) is required. (See BHS P&P 02.02.04 Notice of Adverse Benefit Determination). If services by an alternative in-network provider are offered, specify this on the NOABD.

III. Interim or alternate services

A. Other appropriate services shall be offered to members while arrangements are made to secure services in or out-of-network, including:

1. SUD Residential placement requests:
 - a) Members may be offered appropriate outpatient or intensive outpatient services in combination with recovery residences, if eligible.
2. Outpatient requests:
 - a) Members may be offered case management and other appropriate supportive services.

B. It is the policy of BHS to process out-of-network service requests expeditiously to ensure proper access.

IV. Continuity of Care requirements apply to all:

A. Medi-Cal members who are transitioning into the BHP delivery system, as follows:

1. From one county BHP to another county BHP due to a change in the member's county of residence;
2. From Medi-Cal Fee-for-Service (FFS) to the BHP;
3. From a Managed Care Plan (MCP) to an BHP.

B. All Medi-Cal members whose:

1. Provider has voluntarily terminated employment;

2. Provider organizational/employer has terminated their contract with the Behavioral Health Plan (BHP);
 3. Provider's employment or whose organizational employer's 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.
- C. Members with pre-existing provider relationships who make a continuity of care request to Orange BHP will have the option to continue treatment with an individual out-of-network Medi-Cal provider or a terminated network provider subject to the conditions specified in this Policy and Procedure (P&P). No member shall be subject to discrimination or any other penalty for requesting continuity of care.
- D. Continuity of Care arrangements shall not exceed 12 months in duration. At the request of the member, Orange BHP shall continue to provide SMHS necessary to complete a course of treatment and to arrange for a safe transfer to another provider as determined by Orange BHP, in consultation with the member and the provider, and consistent with good professional practice.
- E. The member may make a direct request to Orange BHP for continuity of care in writing or via telephone and shall not be required to submit an electronic or written request.
- F. Orange BHP shall provide reasonable assistance to members in completing requests for continuity of care including oral interpretation and auxiliary aids and services, including but not limited to, interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
- G. The member may choose an authorized Representative to act on his/her behalf. This person can be a family member, significant other or other person of his/her choice. The member's authorized Representative may make a continuity of care request on the member's behalf. The member shall provide written confirmation of the authorization of a Representative by completing an Authorization to Use and Disclose (ATD) Protected Health Information (PHI). The member shall complete all necessary sections and document the Representative's name, address and phone number and indicate under Part 4, Purpose of This Authorization: check "Other" and write "Acting as representative for continuity of care request."
- H. Quality Management Services (QMS) UMCCC shall process all continuity of care requests whether in writing, fax, email, or phone. If a continuity of care request is received by phone, the QMS representative shall complete a Continuity of Care Request Form on behalf of the member. If the request is received from an authorized Representative, the QMS representative shall obtain an ATD, as noted in IV.G above, prior to contacting the authorized Representative
1. The QMS representative shall send an acknowledgement letter to the member regardless of how the request is received, confirming receipt of the member's continuity of care request.

2. The QMS representative shall log receipt of the request in the internal Continuity of Care Tracking Log.
- I. Orange BHP shall provide continuity of care with an eligible out-of-network Medi-Cal provider if the following conditions are met:
 1. Orange BHP is able to determine that the member has an existing relationship with the provider (i.e., the member has received SMHS or DMC-ODS services from an out-of-network provider at least once during the 12 months prior to their initial enrollment in Orange BHP);
 2. The 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 imposed upon currently contracting network providers, including, but not limited to, credentialing, utilization review, and quality assurance;
 4. The provider agrees, in writing, to comply with State requirements for SMHS or DMC-ODS services including documentation requirements in accordance with Orange BHPs contract with Department of Health Care Services (DHCS);
 5. The provider supplies Orange BHP with all relevant treatment information including documentation of a current assessment, a current treatment plan, and relevant progress notes as allowable under federal and State privacy laws and regulations;
 6. The provider is willing to accept the higher of Orange BHP's provider contract rates of Medi-Cal FFS rates;
 7. Orange BHP has not identified, verified, or documented disqualifying quality of care issues to the extent that the provider would not be eligible to provider services to any other members of Orange BHP.
 8. If a non-participating network provider does not agree to comply or does not comply with these contractual terms and conditions, Orange BHP is not required to approve the continuity of care request. If the continuity of care request is denied for any reason, Orange BHP shall notify the member and/or the member's authorized representative.
 - K. Orange County BHP shall provide continuity of care with an eligible terminated network provider if the following conditions are met:
 1. The completion of SMHS or DMC-ODS services shall be provided by a terminated network provider to a member who, at the time of the contract's

termination, was receiving SMHS or DMC-ODS services from that provider.

2. Orange BHP may require the terminated provider, whose services are continued beyond the contract termination date, to agree, 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. If a terminated network provider does not agree to comply or does not comply with these contractual terms and conditions, Orange County BHP is not required to approve the continuity of care request. If the continuity of care request is denied for any reason, Orange County BHP shall notify the member an/or the member's authorized representative.

L. Validating Pre-existing Provider Relationships

1. An existing relationship with a provider may be established if the member has seen the out-of-network provider at least once during the 12-months prior to the following:
 - a) The member establishing residence in the county;
 - b) Upon referral by another BHP or MCP; and/or,
 - c) Orange County BHP making a determination that the member meets medical necessity criteria for SMHS or DMC-ODS.
2. A member or provider may make available information to Orange County BHP that provides verification of their pre-existing relationship with a provider.
3. Following identification of a pre-existing relationship with an out-of-network provider, Orange County BHP shall 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 member.

M. Timeline Requirements for Continuity of Care

1. The following timeline requirements must be followed for Orange County BHP processing of the Continuity of Care request:
 - a) Thirty calendar days from the date Orange County BHP received the request;
 - b) Fifteen calendar days if the member's condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

- c) Three calendar days if there is a risk of harm to the member
- 2. Upon verification that all continuity of care criteria requirements are met, Orange County BHP shall retroactively approve a continuity of care request and reimburse providers for services that were already provided to the member under the following circumstances:
 - a) Services were provided after a referral was made to Orange County BHP (this includes self-referrals made by the member); and,
 - b) The member is determined to meet medical necessity criteria for SMHS or DMC-ODS services.
- 3. A continuity of care request is considered resolved when:
 - a) Orange County BHP informs the member and/or the member's authorized representative, that the request has been approved; or,
 - b) Orange County BHP and the out-of-network provider are unable to agree to a rate and Orange BHP notifies the member and/or the member's authorized representative that the request is denied; or,
 - c) Orange County BHP has documented quality of care issues with the provider and the BHP notifies the member and/or the member's authorized representative that the request is denied; or,
 - d) Orange County BHP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days and Orange County BHP notified the member and/or the member's authorized representative that the request is denied.

N. Requirements Following Completion of Continuity of Care Request

- 1. If the provider meets all of the required conditions and the member's request is granted, Orange County BHP shall allow the member to have access to that provider for a period of up to 12-months, depending on the needs of the member and the agreement made between Orange County BHP and the out-of-network provider. When the continuity of care agreement has been established, the BHP shall work with the provider to establish a Client Plan and transition plan for the member.
- 2. Upon approval of a continuity of care request, QMS will notify the member and/or the member's authorized representative within the required timeframe, in writing, of the following:
 - a) Orange County BHP approval of the continuity of care request;
 - b) The duration of the continuity of care arrangement;

- c) The process that will occur to transition the member's care at the end of the continuity of care period; and
 - d) The member's right to choose a different provider from Orange County's BHP provider network.
 - 3. Upon denial of a continuity of care request, QMS will notify the member and/or the member's authorized representative within the required timeframe, in writing. A Notice of Adverse Benefit Determination (NOABD) letter will be mailed to the member and will include the following:
 - a) Orange County BHP denial of the member's continuity of care request;
 - b) A clear explanation of the reasons for the denial;
 - c) The availability of in-network SMHS or DMC-ODS services;
 - d) How and where to access SMHS or DMC-ODS services from Orange County BHP;
 - e) The member's right to file an appeal based on the notice of adverse benefit determination; and,
 - f) Orange County BHPs member handbook and provider directory.
 - 4. At any time, members may change their provider to an in-network provider whether or not a continuity of care relationship has been established. Orange County BHP shall provide SMHS or DMC-ODS services and/or refer members to appropriate network providers without delay and within established appointment time standards.
 - 5. Orange County BHP shall notify the member, and/or the member's authorized representative, 30-calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.
- O. Repeated Requests for Continuity of Care
- 1. After the member's continuity of care period ends, the member must choose a provider in Orange County's BHP network for SMHS or DMC-ODS. If the member later transitions to a MCP or Medi-Cal FFS for non-specialty mental health services, and subsequently transitions back to Orange County BHP for SMHS or DMC-ODS services, the 12-

month continuity of care period may start over one time.

2. If a member 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 BHP and third BHP, after which, the member may not be granted additional continuity of care requests with the same pre-existing provider. In these cases, the BHP shall communicate with the BHP in the member's new county of residence to share information about the member's existing continuity of care request.

P. Member and Provider Outreach and Education

1. Orange County BHP will inform members of their continuity of care protections and include information about these protections in Orange County BHP Member Handbook. This information will include how the member and provider may initiate a continuity of care request with Orange County BHP. Orange County BHP will translate these documents into threshold languages and make them available in alternative formats, upon request, Orange County BHP will provide training to staff who come into regular contact with members about continuity of care protections.
2. Reporting Requirements
 - a) QMS will monitor and maintain an internal tracking log that will include the following information:
 - 1) The date of the request;
 - 2) The member's name;
 - 3) The name of the member's pre-existing provider;
 - 4) The address/location of the provider's office; and,
 - 5) Whether the provider has agreed to the BHPs terms and conditions; and,
 - 6) The status of the request, including the deadline for making a decision regarding the member's request.
 - b) Orange County BHP will report to DHCS all request and approvals, for continuity of care. Orange County BHP will submit a continuity of care report, with Orange BHPs annual network adequacy submissions that will include the above information (a1-a6).

V. Required Data Reporting for DMC-ODS services

- A. For out-of-County providers, DMC-ODS certified or not, QMS shall complete the Drug Medi-Cal Organized Delivery System Provider Form and submit to DHCS at dhcsmpf@dhcs.ca.gov
- B. For currently contracted in-County, non-DMC-ODS providers, QMS shall complete the Existing Provider Information Update/Change Form and submit to DHCS at dhcsmpf@dhcs.ca.gov
- C. For new in-County, non-DMC-ODS certified providers, QMS shall complete the Non-Drug Medi-Cal New Provider Information Form and submit to DHCS at dhcsmpf@dhcs.ca.gov