CONTINUITY OF CARE DISCLOSURE

In order to coordinate continuity of care as required by the State of California for Medi-Cal beneficiaries, who receive specialty mental health services, Trinity County Behavioral Health Services (TCBHS) will work with the beneficiary to transition from Medi-Cal fee-for-service (FSS) to a managed care program or transition from one managed care entity to another, when the beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The goal is to arrange for a safe transfer to another provider in consultation with the beneficiary and the provider and consistent with good professional practice.

All eligible Medi-Cal beneficiaries who meet medical necessity criteria for SMHS have the right to request continuity of care. Beneficiaries with a pre-existing provider relationship who make a continuity of care request to TCBHS will be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider or a terminated network provider (i.e. an employee of TCBHS or a contract organizational provider, provider group, or individual practitioner).

For a transfer to be completed, the beneficiary or beneficiary's representative must request for continuity of care. This request can be made in person, by phone or in writing to the Deputy Director of Clinical Services (DDCS). TCBHS shall provide reasonable assistance to beneficiaries in completing the request for continuity of care, including oral interpretation, auxiliary aids or services. Each continuity of care request must be completed within thirty (30) calendar days from the date of the request received by TCBHS or fifteen (15) calendar days from the request received if the beneficiary's condition requires more immediate attention such as upcoming appointments or other pressing care needs or three (3) calendar days from the request received if there is a risk or harm to the beneficiary.

Retroactive approvals shall be granted by TCBHS if the provider meets the continuity of care requirements, services were provided after a referral was made to TCBHS and the beneficiary is determined to meet medical necessity criteria for SMHS. TCBHS shall review all retroactive reimbursements to determine if approval is warranted.

Upon receiving a request for Continuity of Care, the DDCS will verify that the beneficiary has an established pre-existing relationship with the provider, is an established residence in Trinity County, has been referred for SMHS by another MHP or MCP, and/or has been determined to meet medical necessity criteria.

Once the beneficiary meets the above criteria, the DDCS will verify and document the out-of-network or terminated provider has not been terminated due to quality of care issues, has a provider type that is consistent with the State plan and meets the applicable professional standards under the State law, agrees in writing to the same contractual terms and conditions current contracted providers are subject to and is willing to comply with the state requirements for SMHS including documentation requirements, supplies the DDCS with all relevant treatment information, including documentation of current assessment and treatment plan, and is willing to accept the higher of TCBHS contract rates or Medi-Cal FFS rates.

Upon the beneficiary and the provider meeting all of the necessary requirements, TCBHS contracting unit will contact the provider in an effort to enter into a contract or single-case agreement. When the formal agreement is entered in to, the DDCS will inform the beneficiary and/or their authorized representative in writing of the approved request. The notification will include the duration of the continuity of care arrangement, the process 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 TCBHS’s provider network.

The DDCS may deny a request for continuity of care if the provider does not agree to comply with TCBHS and Department of Health Care Services (DHCS) requirements, the provider and TCBHS are unable to agree on a rate, if the beneficiary changes their county of residence more than two times, TCBHS has a documented quality of care issue with the provider, or the provider has been non-responsive for 30 or more calendar days. The DDCS will inform the beneficiary and/or their authorized representative of the denial in writing which will include a clear explanation of the reasons for the denial, the availability of in-network providers, how and where to access

services from TCBHS, the right to file an appeal, and TCBHS beneficiary handbook and provider directory.

TCBHS will submit the continuity of care report to DHCS with the network adequacy submissions which will include the date of all requests, the beneficiary name(s), the name(s) of the beneficiary's pre-existing provider, the address of the providers office, whether the provider has agreed to terms and conditions of a contract with TCBHS, and the status of the request including the deadline for making a decision regarding the beneficiary's request.