COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

**Policy & Procedure Number: BHSD #CON-005**

| Primary Category | Impacts |
|---|---|
| BHSD System | ☒ Managed Care ☒ Administration ☐ Service Delivery |
| Funding Stream | ☒ Medi-Cal ☒ Non-Medi-Cal ☒ Managed Care ☒ Fee for Service ☐ MHSA ☐ Block Grant ☒ General Funds |
| Provider Type | ☒ BHSD County Clinics ☒ Contracted Providers ☒ Inpatient Providers |

## BHSD POLICY & PROCEDURE

### I. BHSD P&P INFORMATION

**Assigned Policy Name**: Contracting with Out-of-Plan Providers to Meet Network Adequacy Needs

**Assigned Policy Number:** CON-005

**Policy Owner:** Contracts Division

**Impacted Managed Care Policy Area(s): Mark All That Apply**

| | | | |
|---|---|---|---|
| ☒ | Administration (ADM) | ☒ | Appeals, Grievances, Incidents (AGI) |
| ☒ | Clinical (CLI) | ☒ | Compliance and Confidentiality (COP) |
| ☒ | Contracts (CON) | ☐ | Data Management (DTM) |
| ☐ | Fiscal (FIS) | ☐ | General Operations (GEO) |
| ☒ | Health and Safety (HAS) | ☐ | Health Education (HED) |
| ☐ | Legal (LEG) | ☐ | Medical & Pharmacy (MPS) |
| ☐ | Member Services & Materials (MSM) | ☐ | Personnel (PER) |
| ☒ | Provider Relations (PRR) | ☒ | Quality Management (QAM) |
| ☒ | Reporting (RPT) | ☒ | Service Delivery (SDM) |
| ☒ | Utilization Management (UMR) | | |

### II. BHSD P&P APPROVAL

#### Section A: HHS Compliance and County Counsel

**HHS Compliance**: Date:

**County Counsel**: Date:

#### Section B: BHSD Director

**BHSD Director**: DocuSigned by: Sherri Teras DAB699BA2A1544D... Date: 1/28/2025

| Approved/Issue Date: | Last Review/Revision Date: | Next Review Date: | Inactive Date: |
|---|---|---|---|
| 11/01/24 | | 10/31/27 | |

| III. REPLACES | NEW |
|---|---|

## IV. REFERENCES:

- 42 CFR § 438.66 State Monitoring Requirements
- 42 CFR § 438.68 Network adequacy standards
- 42 CFR § 438.206 Availability of services
- 42 CFR § 438.207(a)-(b)(1) Assurances of adequate capacity and services
- 9 CCR §1810.405 Access Standards for Specialty Mental Health Services
- 28 CCR §1300.67.2.2 Timely Access to Non-Emergency Health Care Services
- WIC § 14197 Medi-Cal Managed Care Plans Time and Distance Requirements
- BHIN No.: 22-033 2022 Federal Network Certification Requirements for County Mental Health Plans (MHPS) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS)
- BHIN No.: 22-032 County Mental Health Plan 274 Provider Network Data Reporting
- BHIN No.: 21-008 Federal Out-of-Network Requirements for Mental Health Plans
- BHIN No.: 20-062 Timely Access Submission Requirements for Mental Health Plans
- BHIN No.: 19-024 Federal Out-of-Network Requirements for Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties
- BHIN No.: 18-059 Federal Continuity of Care Requirements for Mental Health Plans
- BHIN No.: 18-051 Drug Medi-Cal Organized Delivery System Transition of Care Policy
- County of Santa Clara's Board of Supervisor's Policy Manual: Chapter 5 Policies on Soliciting and Contacting.
- BHSD Policy #ADM-007. Access and Availability of Behavioral Health Services
- BHSD Policy #CON-003. Contracting for Psychiatric Inpatient Hospital Service Availability
- BHSD Policy #PRR-010. Network Adequacy Change in Capacity
- BHSD Policy #PRR-015. Provider Network Enrollment, Screening, Selection and Retention
- BHSD Policy #2300 Out of Plan Services
- BHSD Policy #7100 Network Adequacy and Timely Access

## V. PURPOSE:

The purpose of this policy is to outline the procedures the Behavioral Health Services Department (BHSD) will follow to place beneficiaries with out of plan providers when in-network providers are unable to meet the demand for services. This policy outlines the Plan's comprehensive framework for identifying and addressing network adequacy needs.

## VI. POLICY:

BHSD will initiate a Single Case Agreement (SCA) with a qualified provider outside the network under the following circumstances:

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1. The Plan lacks capacity within its network of participating providers.
2. When a specific covered Medi-Cal service is unavailable through participating providers.
3. Medically necessary beneficiary care is required out of county.
4. Continuity of care with an out-of-network provider is requested and approved.

This policy ensures that beneficiaries receive timely and appropriate care when in-network services are not available, with an emphasis on efficiency, effectiveness, and the best interest of the beneficiaries.

The policy will be reviewed every three years, or as necessary, to reflect any changes in regulations, contractual obligations, and service delivery needs.

## VII. DEFINITIONS:

**Beneficiary.** A person seeking or receiving behavioral health services from BHSD that is either a person certified as eligible for Medi-Cal or Medicare services, or someone for whom there is no third-party payor.

**County Contracted Providers (CCPs).** Sub Contracted Providers that agree to provide covered specialty mental health services and/or substance use treatment services to Beneficiaries, or any other organization.

**Network Adequacy Certification Tool (NACT).** A tool required by the state to determine if a Managed Care Plan (MCP) has a sufficient number of provider contracts throughout the plan area to serve the current and estimated future need for County and Certified Contracting Providers.

**Out of County.** Areas outside Santa Clara County's jurisdiction.

**Out of Plan.** Providers that do not currently contract to provide services with BHSD.

**Participating Provider.** A County, Individual Provider or Contracted Certified Provider (CCP) that has agreed to contract with the BHSD Plan to provide eligible services to Beneficiaries covered by its plan.

**Qualified Provider**: A provider who meets the minimum standards and eligibility requirements, this includes having the necessary licenses, certifications, and credentials relevant to their field of practice, meeting BHSD screening and background check criteria, demonstrating adequate treatment capacity and expertise in behavioral health services, and maintaining compliance with state and federal standards, including timely access requirements and clinical guidelines.

**Single Case Agreement (SCA).** A contractual arrangement between a healthcare provider and a payer (such as an insurance company or a governmental health services department) to provide services to a specific beneficiary or group of beneficiaries on a case-by-case basis. This type of agreement is often used when the provider is out-of-network, meaning they do not have a pre-existing contract with the payer.

**The Plan:** Provides oversight to behavioral health Medi-Cal carve out programs. BHSD Medi-Cal managed care plans include the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).

**Utilization Management Program:** The use of utilization management techniques such as prior authorization and concurrent review to ensure health care services are provided at the appropriate level. BHSD's service review process to ensure that the UM Program's service standards, protocols, practice guidelines, authorization and billing procedures, and documentation standards are adhered to by all network service providers.

## VIII. OVERSIGHT AND MONITORING PROCEDURE

| Processes | Requirements |
|---|---|
| **Network Adequacy** Monitoring, Reporting and Contracting | 1. The Plan identifies and acts on network adequacy issues through a review and collection of ongoing reports which include but are not limited to:<br>a. Network Change Request (NCR)<br>b. Network Adequacy Collection Tool (NACT)<br>c. 274 outpatient and residential monthly reports<br>d. Timely access monthly reports<br>e. Utilization Management wait list.<br>f. Beneficiary request for covered services we cannot offer.<br>2. The Plan must report significant loss of network adequacy based on program type and percentage of lost capacity to DHCS, PRR-010 Network Adequacy Change in Capacity.<br>3. When the Plan is unable to meet network adequacy requirements, Leadership authorizes the addition of participating providers to address adequacy deficiencies.<br>4. The Plan will pay for covered service. |
| **Contracting** Single Source Solicitation Process | 1. BHSD Leadership confirms and authorizes the need for services with a new or out of plan provider on a case-by-case basis.<br>2. BHSD/HHS Finance determines funding availability for the new or additional contract for services.<br>3. For emergent network adequacy needs, BHSD Contracts will identify an out of plan provider and establish a single source agreement. BHSD will also explore options to make a permanent |

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|---|---|
| | contract with the new provider to ensure continuity of care.<br>4. Initial approval of an out of plan provider is required. BHSD System of Care, Contracts, Finance, and other relevant parties must collaboratively review and approve the provider, ensuring the provider meets necessary qualifications and treatment capacity.<br>5. BHSD Contracts Administration adheres to Board of Supervisor's Policy Manual: Chapter 5 Policies on Soliciting and Contacting, BHSD Policy #PRR-015. Provider Network Enrollment, Screening, Selection and Retention as well as state and federal contracting regulations.<br>6. Contracts packages, processes, and executes single source agreements with an out of plan provider on a case-by-case basis when needed. |

| **IX. WORKFLOW PROCEDURE** | |
|---|---|
| **Responsible Party** | **Action Required** |
| **BHSD Contracts Administration** | The typical process for establishing Agreements/Single Case Agreements with an out of plan provider includes, but is not limited to the following:<br>1. Receives confirmation from leadership that a new service or County Contracted Provider (CCP) is required to meet network adequacy requirements.<br>a. Works with HHS/BHSD Finance to confirm that funding is available to proceed.<br>2. Works with impacted parties (BHSD Programs/Executives, HHS/BHSD Finance, etc.) to collect information for appropriate single case agreement (SCA).<br>3. Gathers all of the information from Leadership and Finance. Contracts Administration determines the appropriate SCA process and/or obtains the necessary approvals.<br>4. Packages the Agreement with selected CCP(s) and routes for signatures and execution. |

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| **Utilization Management** | 1. Monitors capacity reports while reviewing incoming requests for services or placements. Assess their urgency and appropriateness based on medical necessity and severity of conditions.<br>2. Maintains a comprehensive waitlist database to record all requests, status, and updates. Ensure accurate documentation of beneficiary information and needs. |
| **Provider Relations** | 1. Receives, tracks, reviews, and reports the NCR Temporary and Permanent closure requests and monthly 274 reports to monitor trends that may impact Plan network adequacy.<br>2. Reports network adequacy decreases of 25% or more to DHCS per state requirements.<br>3. Notifies Leadership of reduced and inadequate capacity reports received. |
| **Quality Improvement** | 1. Processes and reports beneficiary requests for Continuity of Care. |
| **X. ATTACHMENTS** | |

**XI. REVISION HISTORY**

| Policy Name | Active Dates Range | Date Approved | Reason for Review | Summary of Changes |
|---|---|---|---|---|
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