From: DMHC Licensing eFiling

Subject: APL 22-030 - Requirement for Plans to “Arrange for” Covered Services

Date: Thursday, December 22, 2022 8:59 AM

Attachments: APL 22-030 - Requirement for Plans to Arrange for Covered Services (12.22.2022).pdf

Dear Health Plan Representative:

The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 22-030 to provide guidance regarding the obligations of health plans to “arrange for” covered services to be delivered by a noncontracted provider when such services are not available from contracted providers within the Knox-Keene Act’s timely and geographic access standards.

Thank you.

Gavin Newsom, Governor
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ALL PLAN LETTER

DATE: December 22, 2022

TO: All Full-Service Health Care Service Plans and Specialized Behavioral Health Plans[1]

FROM: Sarah Ream
Chief Counsel

SUBJECT: APL 22-030 - Requirement for Plans to "Arrange for" Covered Services

This APL provides guidance regarding the obligations of health plans to "arrange for" covered services to be delivered by a noncontracted provider when such services are not available from contracted providers within the Knox-Keene Act's timely and geographic access standards.

I. Background

Senate Bill 855 (Wiener, 2020) requires health plans to provide coverage for medically necessary treatment of mental health and substance use disorders (MHSUD) "under the same terms and conditions applied to other medical conditions…" SB 855 further states that if a plan cannot provide a medically necessary treatment of a MHSUD to a plan enrollee using the plan's contracted providers, within required geographic and timely access standards, the plan must "arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary followup services…"

Subsequently, SB 225 (Wiener, 2022) reiterated that if medically necessary services are not available within a plan's network, the plan "shall arrange for the provision of covered services from providers outside the plan's network…" Additionally, if medically necessary MHSUD services are not available in network within the geographic and timely access standards, the plan "shall arrange coverage outside the plan's network in accordance with" Health and Safety Code (HSC) section 1374.72.

[1] This All Plan Letter applies to full-service commercial health plans, full-service Medi-Cal plans, and specialized behavioral health plans. It also applies to restricted or limited health plans to the extent the plan has been delegated responsibility for providing or arranging for services to treat mental health and/or substance use disorders. This APL does not apply to Medicare Advantage plans or products.

II. Meaning of "Arranging for" Medically Necessary Services

The DMHC is developing regulations to implement SB 855. Those regulations will specify what plans must do to meet the requirement of "arranging for" medically necessary services from noncontracted providers when such services are not available from contracted providers in compliance with the timely and geographic access standards.

In the meantime, the DMHC has received several inquiries about what plans must do to meet SB 855's currently existing and SB 225's forthcoming requirements[2] to arrange for services to be delivered by noncontracting providers when such services are not available in-network. HSC section 1374.72 states:

> …to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards.

A plan *will not* meet the "arranging for" requirement if the plan merely provides an enrollee with the names of noncontracted providers who may be available to provide services. Such actions do not satisfy the requirement to provide services to secure out of network care. Rather, the plan must take additional steps to ensure the enrollee has access to the services. Such steps may include contacting noncontracted providers with the appropriate expertise on behalf of the enrollee to ensure they have appointments available within the timely access standards and advising the enrollee of their available appointment times, or actually scheduling an appointment for the enrollee. Again, simply giving an enrollee a list of providers who might be able to provide services to the enrollee is insufficient to meet SB 855's and SB 225's requirements.

Further, a plan may not delay an enrollee's care beyond the applicable timely access standards due to a lack of a single case agreement or other arrangement with a noncontracting provider. Any cost sharing paid by the enrollee for out-of-network services arranged pursuant to subdivision (d) of HSC section 1374.72 shall accrue to the in-network deductible, if any, and the in-network limit on annual out-of-pocket expenses.

If you have questions regarding this APL, please contact your health plan's assigned reviewer in the DMHC's Office of Plan Licensing.

[2] SB 225 takes effect January 1, 2023.