Provider Bulletin

Molina Healthcare of California
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Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder Coverage – APL 24-007

This is an advisory notification to Molina Healthcare of California (MHC) network providers applicable to the Marketplace line of business.

This notification is based on All-Plan Letter (APL) 24-007, which can be found in full on the Department of Managed Health Care (DMHC) website at: dmhc.ca.gov/LinkClick.aspx?fileticket=Ggn-0SbhiMc%3d&portalid=0

When this is happening:

On January 12, 2024, the Office of Administrative Law approved the Department of Managed Health Care's (Department) proposed regulation implementing Senate Bill (SB) 855. This regulation takes effect April 1, 2024, and is codified in California Code of Regulations, title 28, sections 1300.74.72, 1300.74.72.01 and 1300.74.721.

What you need to know:

General Overview of the Regulation

1. **Coverage Requirements- Rule 1300.74.72**

   Rule 1300.74.72 repeals and replaces previous Rule 1300.74.72. Rule 1300.74.72 requires, in part, health care service plans maintain a provider network sufficient to provide all medically necessary services, including services to treat mental health and substance use disorders (MH/SUD), within geographic and timely access standards. If the health care service plan is unable to demonstrate that it is able to offer an in-network appointment within timely and geographic access standards, plan shall provide and arrange coverage for medically necessary MH/SUD services from an out-of-network provider or providers.

   Pursuant to Rule 1300.74.72(c), in instances where a plan provides and arranges for out-of-network coverage for medically necessary MH/SUD services due to network inadequacy, within 5 days the plan must provide written notice to the enrollee, the enrollee's authorized representative (if any) and the requesting provider (if any) of the plan's obligation to arrange and pay for out-of-network services because the plan does not have an in-network provider available within the required timeframe or geographic area.

Provider Action

Please take a few moments to participate in our Communication Preference Survey. Your feedback will directly influence Molina's engagement with providers, creating a more seamless and efficient communication experience for our network.

Take the survey at molinahealthcare.surveymonkey.com/r/VS5RGTG!

Coverage Requirements- Rule 1300.74.72 CONT.

Rule 1300.74.72(c)(3) requires plans to schedule the appointment or arrange for the admission with the out-of-network provider for an enrollee within the following timeframes, unless 1367.03(a)(5)(H) or (a)(5)(I) apply:

- No more than 10 business days after the initial request for non-urgent MH/SUD services
- Within 15 business days of a request for a specialist physician MH/SUD services
- Within 48 hours of the initial request for urgent MH/SUD services if no prior authorization is required
- Within 96 hours of the initial request for urgent MH/SUD services if prior authorization is required

Within 24 hours of the scheduling of the out-of-network appointment or admission accepted by the enrollee, the plan must provide the enrollee, the enrollee's authorized representative, or the enrollee's provider with information regarding the appointment or admission.

If the plan is unable to arrange for covered services as set forth above, Rule 1300.74.72(d) permits the enrollee or the enrollee's representative to arrange for care from any appropriately licensed provider, so long as the appointment or admission occurs no more than 90 days after the initial request for services. If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the enrollee may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

Pursuant to Rule 1300.74.72(e), if out-of-network coverage is obtained pursuant to Rule 1300.74.72(c) or (d) as described above, the plan shall reimburse the provider for the entire course of medically necessary services unless there is an in-network timely and geographically accessible provider available to deliver MH/SUD services, transfer to the new provider would not harm the enrollee and transfer is within the standard of care for the enrollee's MH/SUD condition. Before the health plan may transition the enrollee to an in-network provider, the health plan shall provide the enrollee, the enrollee's representative (if any), and the provider(s) treating the enrollee with at least 90 calendar days' notice.

2. Scope of Required Benefits- Rule 1300.74.72.01

Rule 1300.74.72.01 provides a non-exhaustive list of required benefits for MH/SUD care. Plans are required to provide coverage for preventing, diagnosing, and treating MH/SUD as medically necessary for an enrollee in accordance with current generally accepted standards of MH/SUD care.

3. Utilization Review Requirements- Rule 1300.74.721

Rule 1300.74.721 requires plans conducting medical necessity and utilization review use only the nonprofit professional association criteria listed in this rule unless circumstances set forth in section 1374.721(c)(1) and/or (2) apply.

Rule 1300.74.721(l) requires a plan, its contracted entity, or delegate who delays, denies, or modifies MH/SUD services following utilization review to issue written communication to the enrollee or the enrollee's authorized representative and any requesting provider outlining the basis for the delay, denial, or modification. The communication must be sent within five (5) calendar days of the decision for non-urgent care and 72 hours for urgent care.

Rule 1300.74.721(o) requires plans sponsor a formal education program by a nonprofit clinical specialty association to educate all plan staff and contracted third parties that conduct utilization review within six (6) months of adoption of this Rule and at least every three (3) years thereafter.

Lastly, Rule 1300.74.721(q) requires plans, upon request, to provide all utilization review determination criteria and any education program materials to enrollees, the enrollee's authorized representative, and the enrollee's requesting provider at no cost in one or more of the following ways: paper form, electronically by email, or website.

To learn more about the nonprofit professional association criteria used by Molina Healthcare for all mental health and substance use clinical review, a copy of the educational materials can be accessed, at no-cost, directly from each organization provided by clicking directly on the link(s) on our website below,

Members: molinamarketplace.com/marketplace/ca/en-us/Members/Members%20Resources/gna

Providers: molinamarketplace.com/marketplace/ca/en-us/Providers/Communications/Provider-Bulletin

What if you need assistance?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below.

Service County Area	Provider Relations Representative	Contact Number	Email Address
California Hospital Systems (Hospitals, SNFs, CBAS, ICF/DD & ASC Providers)	Teresa Suarez Laura Gonzalez Mimi Howard	562-549-3782 562-549-4887 562-549-3532	Teresa.Suarez2@molinahealthcare.com Laura.Gonzalez3@molinahealthcare.com Smimi.Howard@molinahealthcare.com
Los Angeles County	Clemente Arias Christian Diaz Daniel Amirian LaToya Watts Anita White	562-517-1014 562-549-3550 562-549-4809 562-549-4069 562-980-3947	Clemente.Arias@molinahealthcare.com Christian.Diaz@molinahealthcare.com Daniel.Amirian@molinahealthcare.com Latoya.Watts@molinahealthcare.com Princess.White@molinahealthcare.com
Los Angeles / Orange County	Maria Guimoye	562-549-4390	Maria.Guimoye@molinahealthcare.com
Sacramento County	Johonna Eshalomi Marina Higby	279-895-9354 916-561-8550	Johonna.Eshalomi@molinahealthcare.com Marina.Higby@molinahealthcare.com
San Bernardino County	Luana McIver	909-501-3314	Luana.Mciver@molinahealthcare.com
San Bernardino / Riverside County	Vanessa Lomeli	909-577-4355	Vanessa.Lomeli2@molinahealthcare.com
Riverside County	Patricia Melendez	562-549-3957	Patricia.Melendez@molinahealthcare.com
San Diego / Imperial County	Salvador Perez Dolores Ramos Lincoln Watkins	562-549-3825 562-549-4900 858-300-7722	Salvador.Perez@molinahealthcare.com Dolores.Ramos@molinahealthcare.com Lincoln.Watkins@molinahealthcare.com

If you are not contracted with Molina and wish to opt out of the MHC Provider Bulletin, email mhcproviderbulletin@molinahealthcare.com. Please include the provider's name, NPI, county, and fax number, and you will be removed within 30 days.