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To: All IEHP Covered (CCA) Providers
From: IEHP - Provider Relations
Date: August 16, 2024
Subject: **DMHC APL 24-007: SB 855 Regulation Implementation - Mental Health and Substance Use Disorder (MH/SUD) Coverage**

Please be advised that **Department of Managed Health Care All Plan Letter 24-007 (DMHC APL 24-007) – “Implementation of Senate Bill 855 Regulation, Mental Health and Substance Use Disorder (MH/SUD) Coverage,” effective April 1, 2024** applies to the IEHP Covered (CCA) line of business and mandates Plans adhere to Coverage Requirements, a Scope of Required Benefits, and Utilization Review Requirements.

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, that IEHP 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 we are unable to demonstrate we are able to offer an in-network appointment within timely and geographic access standards, we will 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 we do not have an in-network provider available within the required timeframe or geographic area.

Rule 1300.74.72(c)(3) requires we 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 we are 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 we 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.

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.

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.

As a reminder:

IEHP provides a copy of the criteria/guidelines used in these determinations and any related educational materials within 30 calendar days upon request and at no cost. Please reach out to the IEHP Call Center for more information.

Providers should take into consideration when making referrals for MH/SUD services that IEHP is obligated to provide medically necessary MH/SUD services within geographic and timely access standards. If out-of-network MH/SUD services are medically necessary, IEHP will coordinate based on regulatory timeline standards and ensure that Members can see an out-of-network Provider within geographic and timely access standards.

The plan will notify Members if out-of-network services are necessary, and ensure Members only pay their usual in-network cost-sharing amount for these services.

If you have any questions, please contact the IEHP Covered Provider Call Center at call at (909) 291-8691 or (844) 248 - IEHP (4347) or email ProviderServices@iehp.org.

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