**§ 1300.74.72. Mental Health and Substance Use Disorder Coverage Requirements.**

(a) A health care service plan (health plan) shall provide coverage for mental health and substance use disorder (MH/SUD) medically necessary services (MH/SUD services) pursuant to Health and Safety Code section 1374.72(a) and this Rule.

(b) A health plan shall provide coverage for MH/SUD services delivered by a "health care provider" as that term is defined under Health and Safety Code sections 1374.72(a)(4)(A)–(H).

(c) A health plan shall maintain a provider network sufficient to provide all medically necessary services, including MH/SUD services, within geographic and timely access standards, pursuant to the Knox-Keene Act and its implementing regulations. If such MH/SUD services are not available to an enrollee in accordance with geographic and timely access standards such as those required by Rule 1300.67.2.2 and Rule 1300.67.2.1, the health plan shall provide and arrange coverage for medically necessary MH/SUD services from an out-of-network provider or providers. In such cases:

(1) The health plan shall issue a written notice to the enrollee, the enrollee's authorized representative (if any), and the requesting provider (if any), within five (5) calendar days following the initial request for in-network MH/SUD services, which shall include the following statement in a paragraph separate from other content and in no less than 12-point font on page one or two of the notice:

(Insert health plan name) must arrange and pay for the services requested by (provider's name) from a health care provider outside our network because (plan name) does not have an in-network (Mental Health or Substance Use Disorder (MH/SUD)) provider available within the required timeframe or geographic area. Your provider requested coverage for the following services: (describe services). You will only be responsible for paying your usual in-network cost sharing amount for these services. You may obtain additional information about obtaining out-of-network MH/SUD services from (insert plan name) at (insert plan's toll-free customer service number). If you are having trouble with (insert health plan name) arranging the approved out-of-network services and have been unable to resolve the issue with (insert health plan name), please contact the Department of Managed Health Care's Help Center at 1–888–466–

2219 or go to the Department's website at www.healthhelp.ca.gov to receive additional help.

(2) The health plan shall select and contact an out-of-network provider or providers who are qualified and available to provide the MH/SUD services the enrollee needs. Such provider(s) shall be located consistent with the geographic access standards in Rule 1300.67.2.1, if possible.Within three (3) business days of when the health plan contacts the selected provider, the health plan shall furnish a written authorization to the provider specifying, at a minimum, the following: (a) provider name; (b) service authorization number; (c) services authorized; (d) negotiated reimbursement rate(s); (e) date range for the authorization; (f) the health plan's contact and claims submission information; and (g) the health plan's provider dispute resolution information. The health plan shall document and retain a record of this communication.

(3) The health plan shall schedule the appointment for the enrollee or arrange for the admission of the enrollee if the MH/SUD services will be in an inpatient (including residential) setting, when accepted by the enrollee. The offered appointment or admission shall be scheduled as follows, unless Health and Safety Code section 1367.03 subdivisions (a)(5)(H) or (a)(5)(I) apply:

(A) No more than ten (10) business days after the initial request for non-urgent MH/SUD services; (B)Within 15 business days of a request for specialist physician MH/SUD services;

(C)Within 48 hours of the initial request for urgent MH/SUD services (as defined by Health and Safety Code section 1367.01(h)(2)) when the health plan does not require prior authorization; or

(D)Within 96 hours of the initial request for urgent MH/SUD services (as defined by Health and Safety Code section 1367.01(h)(2)) if the health plan requires prior authorization.

If the enrollee is unable to attend the appointment offered by the health plan, the health plan shall continue to arrange and schedule a new appointment with the same out-of-network provider or a different out-of-network provider to ensure the delivery of medically necessary MH/SUD services.

(4) Within 24 hours of scheduling the appointment or admission, the health plan shall communicate the following information in the most expeditious manner possible to the enrollee, the enrollee's authorized representative, or the enrollee's provider:

(A) that the health plan has scheduled the appointment or admission;

(B) the name of the provider;

(C) the date and time of the appointment or admission; and,

(D) the location and contact information for the provider.

(5) The health plan shall document and retain a record of all communications with the enrollee pursuant to subdivision (c), including a description of the requested MH/SUD services, the name and location of the provider(s) contacted, the date(s) the plan contacted the provider(s), the type of provider(s), the MH/SUD service(s) authorized, and the selected provider(s), location(s), and duration of the MH/SUD service(s) provided.

(6) The limit on the enrollee's financial obligation for out-of-network MH/SUD services pursuant to Health and Safety Code section 1374.72(d) shall be set forth in the written agreement between the health plan and the out-of-network provider(s). The health plan shall contact the enrollee in writing to explain the enrollee's financial obligation to the out-of-network provider(s).

(d) If a health plan fails to arrange coverage for an enrollee as set forth in subdivision (c) of this Rule, all the following shall apply:

(1) The enrollee or enrollee's representative may arrange for the enrollee to obtain care from any appropriately licensed provider(s), regardless of whether

the provider contracts with the health plan, so long as the enrollee's first appointment with the provider or admission to the provider occurs no more than 90 calendar days after the date the enrollee, the enrollee's representative, or the enrollee's provider initially submitted a request for covered MH/SUD services to the health plan. 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.

(2) If the enrollee receives MH/SUD services pursuant to subdivision (d) of this Rule from an out-of-network provider, the health plan shall reimburse all claims from the provider(s) for MH/SUD service(s) delivered to the enrollee by the provider(s), and shall ensure the enrollee pays no more than the same cost sharing that the enrollee would pay for the MH/SUD services if the services had been delivered by an in-network provider, pursuant to Health and Safety Code section 1374.72(d).

(e) If out-of-network coverage is arranged pursuant to subdivisions (c) or (d) of this Rule, the health plan shall reimburse the provider for the entire course of medically necessary services to treat the enrollee's MH/SUD, including follow up MH/SUD services in accordance with Health and Safety Code section 1374.72(d), unless there is an in-network, timely and geographically accessible provider and all of the following criteria are satisfied: the provider can deliver the MH/SUD services to the enrollee, requiring the enrollee to transition to the in-network provider would not harm the enrollee, and transitioning providers is within the standard of care for the enrollee's MH/SUD condition at the time of the transition. The health plan shall be responsible for making the determination in accordance with good professional practice and with the clinical standards set forth in Health and Safety Code sections 1374.721 and 1374.722, that the requirements of subdivision (e) of this Rule are satisfied and shall retain a record of the determination and underlying analysis, rationale, record, and other supporting information.

(1) 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. The notice shall inform the enrollee of the name and contact information of the in-network provider to which the plan intends to transition the enrollee and information about how the enrollee may file a complaint with the plan if the enrollee, the enrollee's representative, or enrollee's provider believes transitioning the enrollee to an in-network provider will harm the enrollee or is not within the standard of care.

(2) If the enrollee or the enrollee's representative expresses dissatisfaction to the transition to an in-network provider, the health plan shall treat that objection as a grievance pursuant to Health and Safety Code section 1368.

(f) A health plan that provides coverage for MH/SUD services through a specialized health plan, mental health plan, or delegate shall have written policies and procedures as set forth in Rule 1300.74.721 describing the health plan's oversight and monitoring process for ensuring the specialized health plan, mental health plan, or delegate complies with the requirements set forth in this Rule. The health plan shall ensure coverage of MH/SUD services for its enrollees regardless of contracting and/or delegation arrangements. The health plan shall ensure that any specialized health plan, mental health plan, or delegate conducting MH/SUD diagnosis of medical necessity and utilization review on its behalf comply with this Rule and Rule 1300.74.721.

(g) A health plan shall set forth its obligation to cover the full range of levels of care pursuant to Health and Safety Code section 1374.72(b)(2) and not limit benefits or coverage for MH/SUD to short term or acute treatment pursuant to Health and Safety Code section 1374.72(a)(6) in its Evidence of Coverage documents. For purposes of this Rule, "Evidence of Coverage documents" means a health plan's Evidence of Coverage, Disclosure Forms, summary of benefits, or any other contract for health care coverage.

(h) A health plan's Evidences of Coverage, Disclosure Forms, and any combined Evidence of Coverage and Disclosure Form shall include the following statement in a separate paragraph in bold and in no less than 12-point font:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If [health plan name] fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1–888–466–2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

(i) A health plan shall preserve the books and records required under this Rule for a period of not less than five (5) years, the last two (2) years of which shall be in an easily accessible location at the headquarters office of the health plan and as required under Rule 1300.85.1.

(j) Enforcement. Failure by a health plan to comply with the requirements of this Rule constitutes a basis for disciplinary action against the health plan. The Director shall have the civil, criminal, and administrative remedies available under the Knox-Keene Act.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1346, 1367.03, 1374.72, 1374.721 and 1386, Health and Safety Code..

**HISTORY:**

1. New section filed 9-23-2003; operative 10-23-2003 (Register 2003, No. 39).
2. Repealer and new section heading, section and NOTE filed 1–12–2024; operative 4–1–2024 (Register 2024, No. 2).