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Division: Care Management	
Department: Member Services	
Title: PHC-CA Continuity of Care – Coordination of Services	
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Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 12/2/2025**
Approving Committee: Utilization Management Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

The purpose of the Continuity of Care (Continuity of Care) Coordination of Services Policy is to describe how PHC California (the Health Plan) allows for enrollees, including newly enrolled Seniors and Persons with Disabilities (SPD) to continue care with their current providers for up to twelve (12) months after being enrolled in the Health Plan.

Policy:

The Health Plan ensures Continuity of Care and integration of services through letters of agreement, memoranda of understanding (MOUs) and/or contractual agreements with providers, community and social service programs generally available through contracting or non-contracting providers.

1. Criteria:

    a. To establish Continuity of Care, enrollees must have an existing relationship with the non-contracted provider (at least one visit) within the prior twelve (12) months before enrollment.

        i. The non-contracted provider is willing to work with the Health Plan, is willing to accept the higher of the Health Plan's contract rates or Medi-Cal Fee-For-Service (FFS) rates (in accordance with H&S Code section 1373.96(d)(2) or (e)(2), and meets the Health Plan's applicable professional standards and has no disqualifying quality of care issues.

        ii. The non-contracted provider is a California State Plan approved provider.

        iii. The non-contracted provider supplies the Health Plan with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

    b. Enrollees may continue seeing an out-of-network provider through the extended Continuity of Care period only if the enrollee who previously (in the past twelve (12) months) was seeing a Medi-Cal Fee-for-Service (FFS) provider and is now required to enroll into a managed care plan. This extended Continuity of Care period does not apply to an enrollee who has been in a managed care plan for twelve months or more or to a beneficiary who has just become eligible for Medi-Cal and must enroll into a managed care plan.

c. Enrollees may also be able to keep seeing their provider when they change managed care plans or if their provider stops participating with the Health Plan's provider network. The Health Plan does not require that enrollees have transitioned from LIHP or FFS in the past twelve (12) months.

d. The Health Plan is not required to provide Continuity of Care for services not covered by Medi-Cal. In addition, provider Continuity of Care protections do not extend to the following:

    i. Durable medical equipment (DME)

    ii. Transportation

    iii. Other ancillary service

    iv. Carved-out service providers.

    v. Continuity of Care protections do not extend to all other ancillary providers such as radiology; laboratory; dialysis centers; Non-Emergency Medical Transportation (NEMT); Non-Medical Transportation (NMT); other ancillary services; and non-enrolled Medi-Cal providers.

    vi. The Health Plan is only required to provide Continuity of Care for covered benefits

2. The following applies when an enrollee changes their Medi-Cal managed care plan:

    a. If an enrollee changes their Medi-Cal managed care plan, the following twelve (12) month Continuity of Care period may start over one time.

    b. If the enrollee changes managed care plans a second time (or more), the Continuity of Care period does not start over as the enrollee does not have the right to a new twelve (12) months of Continuity of Care.

    c. If the enrollee returns to Medi-Cal FFS and later reenrolls into the Health Plan, the Continuity of Care does not start over.

    d. If an enrollee changes managed care plans, the DHCS (Department of Health Care Services) Continuity of Care policy does not extend to providers that the enrollee accesses through his or her previous managed care plan.

3. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity of Care For Approved Provider Types:

    a. The Health Plan is required to cover Non-Specialty Mental Health Services (NSMHS), as outlined in APL 22-005 and APL 22-006, or any subsequent iterations of these APLs. County Mental Health Plans (MHPs) are required to provide Specialty Mental Health Services (SMHS) for enrollees who meet the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic

Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for enrollees under twenty-one (21) years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.

b. The Health Plan must provide Continuity of Care with an Out of Network SMHS provider in instances where an enrollee's mental health condition has stabilized such that the enrollee no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive SMHS from the Health Plan. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide NSMHS (referred to in the State Plan as "Psychology").

c. The Health Plan must allow, at the request of the enrollee, authorized representative, or provider, up to twelve (12) months Continuity of Care with the Out of Network MHP provide. After the Continuity of Care period ends, the enrollee must choose a mental health provider in the Health Plan's Network for NSMHS. If the enrollee later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the Health Plan for NSMHS, the twelve (12) month Continuity of Care period may start over one time. If the enrollee requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the enrollee returns to the Health Plan or changes managed care plans (i.e., the enrollee does not have the right to a new twelve (12) months of Continuity of Care).

d. The Health Plan shall provide Continuity of Care with an out-of-network mental health provider in instances where an enrollee's mental health condition has stabilized such that the enrollee no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from the Health Plan's Behavioral Health Organization, Human Affairs International (HAI).

    i. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health provider types that are permitted through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

4. Covered California to Medi-Cal Transition

a. This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in an enrollee's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning enrollees.

b. To ensure that care coordination requirements are met, the Health Plan must ask these enrollees if there are upcoming health care appointments or treatments scheduled and assist them. If the enrollee requests Continuity of Care, the Plan must help initiate the process at that time. The Health Plan must contact the new enrollee by telephone, letter, or

other preferred method of communication, no later than fifteen (15) calendar days after enrollment. The requirements noted above in this paragraph must be included in this initial enrollee contact process. The Health Plan must make a good faith effort to learn from and obtain information from the enrollee so that it is able to honor active prior treatment authorizations with a network provider and/or establish Continuity of Care.

i. The Health Plan shall ask the member if there are any upcoming scheduled health care appointments or treatments. If the member so chooses, the Health Plan shall assist in initiating the Continuity of Care process at that time according to the provider and service continuity of rights.

ii. The Health Plan shall make a good faith effort to learn from and obtain information from the member so that the Health Plan is able to honor active prior treatment authorizations and/or establish out-of-network Continuity of Care.

c. The Health Plan must honor any active prior treatment authorizations for up ninety (90) days for services that are covered under its Contract. The Health Plan must arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an Out of Network provider. After ninety (90) days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment is completed by the Health Plan, whichever is shorter.

i. A new assessment is considered completed by the Health Plan if the enrollee has been seen in-person and/or via synchronous Telehealth by a Health Plan contracted network provider and this provider has reviewed the enrollee's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
ii. The Prior treatment authorizations must be honored without a request by the member or the enrollee, authorized representative, or provider.

d. The Health Plan must, at enrollee's, authorized representative's, or provider's request, offer up to twelve (12) months of Continuity of Care..

5. Terminating Managed Care Plans

a. If a member is transitioning from a Plan with contracts expiring or terminating to a new Plan on or after January 1, 2023, the enrollee may request Continuity of Care for up to twelve (12) months after the enrolment date with the Plan pre-existing relationship exists with that provider, regardless of the enrollee having a condition listed in HSC section 1373.96. Continuity of Care protections extend to primary care providers, specialists, and select ancillary providers, including physical therapy; occupational therapy; respiratory therapy; BHT; and speech therapy providers. These protections are subject to the Continuity of Care requirements outlined below in this section.

6. Pregnant and Post-Partum Enrollees and Newborns

a. HSC section 1373.96 requires Plan's to, at the request of an enrollee, authorized representative, or provider, provide for the completion of Covered Services relating to pregnancy, during pregnancy, and immediately after the delivery (the post-partum period, which is twelve (12) months), and care of a newborn child between birth and age thirty-six (36) months, by a terminated or nonparticipating health plan provider. These requirements apply for pregnant and post-partum enrollees and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC section 1373.96 for additional information about applicable circumstances and requirements.

b. Pregnant and post-partum enrollees who are assigned a mandatory aid code, who are transitioning from Medi-Cal FFS to a Plan or from Plan's with contracts expiring or terminating to a new Plan on or after January 1, 2023, have the right to request Continuity of Care in accordance with the MCP Contract and the requirements listed in this APL. This requirement is applicable to any existing Medi-Cal provider relationship that is allowed under the general requirements of this APL

7. Terminally Ill Enrollees

a. HSC section 1373.96 requires Plan's to, at the request of an enrollee, authorized representative, or provider, provide for the completion of Covered Services of an enrollee with a terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services must be provided for the duration of a terminal illness, even if it exceeds twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a new enrollee.

8. Medical Exemption Request

a. A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the enrollee's medical condition has stabilized to a level that would enable the enrollee to transfer to a network provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from Plan enrollment that only applies to enrollees transitioning from Medi-Cal FFS to a Plan. A MER should only be used to preserve Continuity of Care with a Medi-Cal FFS provider under the circumstances described in this paragraph.

b. Plans are required to consider MERs that have been denied as automatic Continuity of Care requests to allow enrollees to complete courses of treatment with Out of Network providers in accordance with APL 17-007 or subsequent iterations of this APL. The Plan must process the Continuity of Care request in accordance to section I.A of this APL, including the validation of a pre-existing relationship with the provider, and make a good faith effort to come to an agreement with the Out of Network provider for the duration of the treatment. If the Plan reaches an agreement with the provider, the Plan must allow the enrollee Continuity of Care for up to twelve (12) months after the enrollment date with the Plan.

9. Timeline:

a. Once criteria are confirmed as defined above, members will be able to continue receiving any medically necessary services or prescriptions after enrolling in the Plan for up to twelve (12) months.

b. After joining the Plan, enrollees, authorized representatives on file with Medi-Cal, or their provider may make a direct request to the Health Plan for Continuity of Care. Member Services and Care Coordination will begin processing the non-urgent requests within five (5) working days of receipt. Additionally, each Continuity of Care request must be completed within the following guidelines:

    i. Thirty (30) calendar days for non-urgent requests;

    ii. Urgent requests (i.e., there is identified risk of harm to the enrollee) will be completed as soon as possible, but no longer than three (3) calendar days.

    iii. If the member's medical condition requires more immediate attention but is not defined as imminent/serious threat, such as upcoming appointments or other pressing care needs, the process will be completed within fifteen (15) calendar days.

    iv. The start of this Continuity of Care process is defined as when Care Coordination) begins the determination of the criteria to meet an established relationship between member and provider as defined above.

c. The Plan is required to process each request and provide notice to each member no later than thirty (30) calendar days from the date the Plan receives the request, or sooner if the enrollee's medical condition requires more immediate attention. An out-of-network FFS or LIHP provider may not refer the enrollee to another out-of-network provider without prior authorization from the Plan. An out-of-network provider, approved by the Plan, under the extended Continuity of Care period, must work with the Plan and its contracted network of providers.

10. In addition to Continuity of Care with providers, the Plan will identify, assist, link and coordinate services needed by its members through the utilization of community resources available in its service area. By sharing necessary information obtained from the external provider(s) and incorporating into the provision of the member's continued and future care, Continuity of Care is ensured.

11. The Plan must accept requests from a representative, or provider for Continuity of Care over the telephone, according to the requestor's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone.

    a. To complete a telephone request, the Plan may take any necessary information from the requester over the telephone.

12. Retroactive Criteria/Timeline

a. The Health Plan Care Coordination Department will retroactively approve a Continuity of Care (Continuity of Care) request if it meets all the requirements, including the provider being willing to accept the Plan's contract rates or Medi-Cal FFS rates. Claims will reimburse providers for services that were already provided when the request meets all the requirements described in Criteria and the services requested meet the following requirements:

    i. Occurred after the enrollee's enrollment into the Health Plan;

    ii. Have dates of service that are within thirty (30) calendar days of the first service for which the provider requests retroactive reimbursement (i.e., the first date of service is not more than thirty (30) calendar days from the date of the request;

    iii. Retroactive Continuity of Care reimbursement requests must be submitted within thirty (30) calendar days of the first service to which the request applies. *date of first APL addressing retroactive requests;

13. Completion of Requests

a. The Continuity of Care process begins when the Plan receives the Continuity of Care request. The Plan must first determine if the enrollee has a preexisting relationship with the provider. The Plan must request from an out-of-network (Out of Network) provider all relevant treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulation. The Plan must provide Continuity of Care when the following requirements are met:

    i. The Health Plan is able to determine that the member has a pre-existing relationship with the provider

        1. The Plan should determine if a relationship exists through use of data provided by DHCS to the Plan or by a Plan with its contract expiring or terminating, such as Medi-Cal FFS utilization data or claims data from a Plan.

        2. A member, an authorized representative, or provider may also provide information to the Plan that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead actual documentation must be provided), unless the Plan makes this option available to the member.

        3. Following identification of a pre-existing relationship, the Plan must determine if the provider is a network provider. If the provider is a network provider, then the Plan must allow the enrollee to continue seeing the provider.

        4. If the provider is not in-network, the Health Plan must contact the provider and make a good faith effort to enter into a contract, letter of agreement (LOA), single-case agreement, or other form of relationship to establish a Continuity of Care relationship for the member.

ii. The provider is willing to accept the Health Plan's contract rates or Medi-Cal FFS rates;

iii. The provider meets the Health Plan's applicable professional standards and has no disqualifying quality of care issues, and

iv. The provider is a California State Plan approved provider.

1. The provider must be enrolled and participating in the Medi-Cal program. A list of suspended or ineligible providers is available here: https://files.medical.ca.gov/pubsdoco/SandILanding.aspx

14. Enrollee Notifications

a. The Plan is required to provide acknowledgement of the Continuity of Care requesting within the timeframes specified below, a advising the enrollee that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. The Plan must notify the enrollee by using the enrollee's known preference of communication or by notifying the enrollee using one of these methods in the following order: telephone call, text message, email, and then notice by mail:

i. For non-urgent requests, within seven (7) calendar days of the decision

ii. For urgent requests, within the shortest applicable timeframe that is appropriate for the enrollee's condition, but no longer than three (3) calendar days of the decision.

b. A Continuity of Care request is considered complete when the Plan notifies the enrollee of the Plan's decision. The plan must attempt to notify the enrollee of the Continuity of Care decision via the enrollee's preferred method of communication or by telephone

c. The Plan must also send a notice by mail to the enrollee within seven (7) calendar days of the Continuity of Care Decision.

i. Enrollee Notification of Denial

1. For Continuity of Care requests that are denied, the Plan must include the following information in the notice:

a. A statement of the Plan's decision.

b. A clear and concise explanation of the reason for denial.

c. The enrollee's right to file a grievance or appeal. For additional information on grievances and appeals, refer to DHCS APL 21-011 or subsequent iterations of the APL.

ii. Enrollee Notification of Approval

1. For Continuity of Care requests that are approved, the Plan must include the following information in the notice:

    a. A statement of the Plan's decision.

        i. The duration of the Continuity of Care arrangement.

        ii. The process that will occur to transition the enrollee's care at the end of the Continuity of Care period.

        iii. The enrollee's right to choose a different network provider.

15. Enrollee and Provider Outreach and Education

    a. The Plan must inform members of their Continuity of Care protections and must include information about these protections in member information packets and handbooks and on the Plan website.

        i. This information must include how the enrollee, Authorized Representative and provider initiate a Continuity of Care request with the Plan.

        ii. In accordance with APL 21-004 or subsequent iteration of the APL, the Plan must translate these documents into threshold languages and make them available in alternative formats, upon request.

    b. The Plan must provide training to the call center and other staff who come into regular contact with members about Continuity of Care protections.

16. Provider Referral Outside of the Plan's Network

    a. The Plan must work with the approved Out of Network provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the Out of Network provider does not refer the enrollee to another Out of Network provider without authorization from the Plan. In such cases, the Plan will make the referral, if medically necessary, if the Plan does not have an appropriate provider within its network.

    b. An approved out-of-network provider must work with the Health Plan and its contracted network and must not refer the member to another out-of-network provider without the Health Plan's authorization.

        i. In such cases, the Health Plan will make the referral, if medically necessary, if the Health Plan does not have an appropriate provider within its network.

17. Twelve (12) Month Continuity of Care Period Restart

a. If an enrollee changes Health Plan's by choice following the initial enrollment in a Health Plan or if an enrollee loses and then later regains Health Plan eligibility during the twelve (12) month Continuity of Care period, the twelve (12) month Continuity of Care period for a pre-existing provider may start over one time. For example, if an enrollee enrolls in a plan on January 1, 2023, but then later changes plans by choice on April 1, 2023, then the twelve (12) month Continuity of Care may start over one time and the enrollee may see the provider until April of the following year. If the enrollee changes plans or loses and then later regains plan eligibility a second time (or more), the Continuity of Care period does not start over and the enrollee does not have the right to a new twelve (12) months of Continuity of Care. If the enrollee returns to Medi-Cal FFS, if applicable, and later re-enrolls in a plan, the Continuity of Care period does not start over.

18. Scheduled Specialist Appointments

a. At the enrollee, authorized representative, or provider's request, the Health Plan must allow transitioning enrollees to keep authorized and scheduled Specialist appointments with Out of Network providers when Continuity of Care has been established and the appointments occur during the twelve (12) month Continuity of Care period.

b. If an enrollee, authorized representative, or provider contacts the Health Plan to request to keep an authorized and scheduled Specialist appointment with an Out of Network provider that the enrollee has not seen in the previous twelve (12) months and there is no established relationship with the Out of Network provider, the Health Plan may arrange for the enrollee to keep the appointment or schedule an appointment with a network provider on or before the enrollee's scheduled appointment with the Out of Network provider.

c. If the Health Plan is unable to arrange a Specialist appointment with a network provider on or before the enrollee's scheduled appointment with the Out of Network provider, the Health Plan is encouraged to make a good faith effort to allow the enrollee to keep their appointment with the Out of Network provider. However, since the appointment with the Out of Network provider occurs after the enrollee's transition to the Health Plan, it does not establish the requisite pre-existing provider relationship for the enrollee to submit a Continuity of Care request.

19. Continuity of Care Protections in HSC section 1373.96

a. HSC section 1373.96 offers additional protections for enrollees to continue seeing a terminated or nonparticipating provider, at an enrollee, authorized representative, or provider's request, to complete Covered Services for specific conditions outlined in the table below. HSC section 1373.96 specifies timeframes for each condition, some of which differ from the policy in this APL. The following table describes the protections in HSC section 1373.96, some of which overlap and some of which are in addition to protections provided by the policy in this APL.

Condition	Timeframe in which the PLAN must provide for the completion of Covered Services

Acute	For the duration of the condition.
Serious Chronic	For the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider. The completion of Covered Services must not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered enrollee.
Pregnancy and Postpartum Care	For the duration of the pregnancy and immediate postpartum period of twelve (12) months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of Covered Services for the maternal mental health condition must not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later.
Terminal Illness	For the duration of the terminal illness. This may exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a new enrollee.
Care of a Newborn Child between Birth and Age 36 Months	Must not exceed twelve (12) months from the contract termination date or the effective date of coverage for a newly covered enrollee.
Performance of a surgery or other procedure that is authorized by the PLAN as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.	Within one-hundred and eighty (180) days of the termination date or effective date of coverage.

If the Health Plan is not able to come to an agreement with the terminated provider or nonparticipating provider, or if the enrollee, authorized representative, or provider does not submit a request for the completion of Covered Services by said provider, the Health Plan is not required to continue the provider's services

20. Continuity of Medi-Cal Covered Services and Prior Treatment Authorizations

a. All enrollees have the right to continue receiving Medi-Cal services covered under the Health Plan's Contract when transitioning to a plan even in circumstances in which the enrollee does not continue receiving services from their pre-existing provider.

i. The Health Plan must arrange for Continuity of Care for Covered Services without delay to the enrollee with a network provider, or if there is no network provider to provide the Covered Service, with an Out of Network provider.

ii. In an instance where an enrollee would like their Out of Network provider to provide a service and they have a pre-existing relationship with the Out of Network provider, they may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal FFS to a plan, transitioning from a plan with its contracts expiring or terminating to a new plan on or after January 1, 2023, or if the conditions in HSC section 1373.96 are met. The Health Plan must make a good faith effort to enter an agreement if all Continuity of Care requirements are met.

b. Following an enrollee's mandatory transition from Medi-Cal FFS to a plan or from plan's with contracts expiring or terminating to a new plan on or after January 1, 2023, active prior treatment authorizations for services remain in effect for ninety (90) days and must be honored without a request by the enrollee, authorized representative, or provider.

i. The Health Plan must arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an Out of Network provider.

ii. After ninety (90) days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the Health Plan, whichever is shorter.

iii. If the Health Plan does not complete a new assessment, the active treatment authorization remains in effect and after ninety (90) days, the Health Plan may reassess the enrollee's prior treatment authorization at any time. A new assessment is considered complete by the Health Plan if the enrollee has been seen in person and/or via synchronous Telehealth by a network provider and this provider has reviewed the enrollee's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

iv. If a Health Plan is reassessing Enhanced Care Management (ECM) authorizations after ninety (90) days, the Health Plan must reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria.

v. <u>PHC California is a voluntary enrollment plan.</u>

c. Additionally, in an instance where a service has been rendered with an Out of Network provider, and that provider satisfies the Continuity of Care requirements, the enrollee, authorized representative, or provider may request Continuity of Care to retroactively cover the service. See additional information and requirements for retroactive requests under section I.A.2 of APL 22-032.

i. Durable Medical Equipment Rentals and Medical Supplies

1. The Health Plan must allow transitioning enrollees to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing provider, under the previous Prior Authorization for a minimum of ninety (90) days following plan enrollment and until the new plan is able to reassess, the new equipment or supplies are in possession of the enrollee, and ready for use. Continuity of DME and medical supplies must be honored without a request by the enrollee, authorized representative, or provider. Additionally, if DME or medical supplies have been arranged for a transitioning enrollee but the equipment or supplies have not been delivered, the Health Plan must allow the delivery and for the enrollee to keep the equipment or supplies for a minimum of ninety (90) days following plan enrollment and until the new plan is able to reassess. If the Health Plan does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization. After ninety (90) days, the Health Plan may reassess the enrollee's authorization at any time and require the enrollee to switch to a Network DME provider.

ii. Non-Emergency Medical Transportation and Non-Medical Transportation

1. For NEMT and NMT, plans must allow enrollees to keep the modality of transportation under the previous Prior Authorization with a network provider until the new plan is able to reassess the enrollee's continued transportation needs.

iii. Plans must use Treatment Authorization Request (TAR) data or Prior Authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. Plans must pay claims for Prior Authorizations or existing authorizations when data is incomplete.

21. <u>Reporting</u>

a. Plans must continue to report on existing metrics related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents. DHCS may request additional reporting on Continuity of Care at any time and in a manner determined by DHCS.

Procedure:

1. The Health Plan care coordination staff will utilize the chronic care model as the framework for all care coordination efforts with its members. For services needed that are available as part of the provider network, the Health Plan care coordination staff will:

a. Identify member needs as requested by the members and/or provider.

b. Assist member in locating a provider within the plan network if requested.

c. Assist provider with needed agreements to provide Continuity of Care.

d. Assist member in scheduling appointment if needed.

e. Follow-up with member to ensure that services were received and met the members' needs.

f. Document coordination of care activities

2. The Health Plan shall complete the Continuity of Care request review process within the following timelines:

    a. The Health Plan shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

    b. Thirty (30) calendar days from the date of the request

    c. If the member's medical condition requires more immediate attention but is not defined as imminent/serious threat, the process will be completed within fifteen (15) calendar days.

    d. If there is risk of harm to the member (defined as imminent/serious threat to health), the process shall be completed within three (3) calendar days.

3. Notification Requirements: The Health Plan shall notify the member in writing, and as required and in accordance with All Plan Letter (APL) 22-032 Continuity of Care for Medi-Cal Member Who Transition into Medi-Cal Managed Care (Revised) within seven (7) calendar days of the completion of a Continuity of Care Request.

    a. The outcome of the request (approval or denial) sent to the enrollee by U.S. Mail.

    b. The process that will occur to transition the enrollee at the end of the Continuity of Care period, if approved; and

    c. The enrollee's right to choose a different provider from the Health Plan's provider network.

    d. If the Health Plan and the out-of-network provider are unable to reach an agreement on the rate, or the Health Plan has documented quality of care issues with the provider, the Health Plan shall offer the enrollee a network provider alternative. If the enrollee does not make a choice, the enrollee will be assigned to a Network provider.

    e. If the enrollee does not agree with the result of the Continuity of Care determination, the enrollee retains the right to pursue a grievance, in accordance with the Health Plan's Grievance Policies and Procedures.

4. <u>A Continuity of Care request is considered completed when</u>:

a. The Health Plan notifies the member, in the manner outlined above, of the outcome of the request.

b. The Health Plan and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;

c. The Health Plan has documented quality of care issues with the Medi-Cal FFS provider; or

d. The Health Plan makes a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

5. Requirements after the Request Process is Completed:

    a. If the Health Plan and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate, or the Health Plan has documented quality of care issues with the provider, the Health Plan will offer the member an in-network alternative.

        i. If the member does not make a choice, the member will be referred or assigned to an in-network provider.

        ii. If the member disagrees with the result of the Continuity of Care process, the member maintains the right to file a grievance.

    b. If a provider meets all the necessary requirements, including entering into a letter of agreement (LOA) or contract with the Health Plan, the plan must allow the member to have access to that provider for the length of the Continuity of Care period unless the provider is only willing to work with the plan for a shorter timeframe.

        i. In this case, the Health Plan must allow the member to have access to that provider for a shorter period.

    c. At any time, enrollees may change their provider to a network provider regardless of whether or not a Continuity of Care relationship has been established.

        When the Continuity of Care agreement has been established, the Health Plan must work with the provider to establish a care plan for the member.

6. The Health Plan must notify the member thirty (30) calendar days before the end of the Continuity of Care period, using the enrollee's preferred method of communication, about the process that will occur to transition the member's care to an in-network provider at the end of the Continuity of Care period.

a. This process includes engaging with the member and provider before the end of the Continuity of Care period to ensure continuity services through the transition to a new provider.

7. Types of services that may be included, but not limited to, are:

    a. Primary care providers

    b. Specialty providers

    c. Home health

    d. Mental health and substance abuse

    e. Vision care

    f. Dental care

    g. Various therapeutic modalities (speech, occupational, physical)

8. For services needed that are not available within the Health Plan provider network, the Health Plan's care coordination staff will:

    a. Maintain contact with local social service agencies specializing in the needs of HIV/AIDS members.

    b. Maintain listings of such agencies as well as contacts at local health departments, charitable organizations, shelters, and pharmaceutical assistance programs.

    c. Provide the member with contact information of agencies appropriate for the members' needs

    d. Assist member in scheduling appointments if needed.

    e. Follow-up with members to ensure that services were received and met the members' needs.

    f. Document coordination of care activities on the care plan and progress note.

9. For care coordination efforts needed at discharge from an institution, the Health Plan will:

    a. Receive notification of inpatient admission;

    b. Follow Inpatient Utilization processes;

    c. Complete Transition of Care Assessment, Care Plan, Medication Reconciliation and Discharge Planning;

d. Whenever possible, meet with member inpatient;

e. Discuss Discharge plan with Discharge Planner, Utilization Review RN, member and if appropriate, member support system (i.e., family, friends) to assure all needed services are ordered and available;

f. Collaborate with primacy care provider (PCP) on hospitalization and provide discharge plan (uploaded/delivered to EMR (Electronic Medical Record));

g. Implement the plan of care by assisting the discharge planner with referrals to community-based organizations. This may include, but not be limited to, home health care, Hospice, mental health, substance abuse, or a specialty hospital;

h. Communicate interventions to the Primary Care Physician;

i. Document coordination of care activities.

10. Bock Transfers: see PHC California Policy and Procedure PR 20, DMHC Block Transfer Policy.

Definitions:

1. Authorized Representative: A person who has the authority under applicable law to make health care decisions on behalf of adults.

2. Continuity of Care (Continuity of Care): Services provided to a member rendered by an out-of-network provider with whom the enrollee has pre-existing provider relationship

3. Existing Relationship: The Health Plan member has seen an out-of-network PCP or specialist at least once during the twelve (12) months prior to the date of his, her or their initial enrollment in the Health Plan for a non-emergency visit, unless otherwise specified in APL 18-008. Self-attestation is not sufficient to provide proof of a relationship with a provider unless the Health Plan makes this option available to the member.

4. Quality of Care issues: For the purposes of this Policy and Procedure and pursuant to DHCS APL 18-008, this means that the Health Plan can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other Health Plan members.

5. Risk of harm: For the purposes of this Policy and Procedure and pursuant to DHCS All Plan Letter (APL) 18-008, this is defined as an imminent and serious threat to the health of the member.

Monitoring:

Member Services and Care Coordination team will receive, document, and monitor requests for Continuty of Care for new members. Associate Director of Care Coordination will review for meeting criteria. Registered Nurse Care Team Mannager (RNCTM) will monitor and document process on the Continuity of Care (Continuity of Care) Log.

The Health Plan may be required to report on metrics related to any Continuity of Care provisions outlined in APL 22-032 and any superseding APL, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

Reporting of Continuity of Care Requests and outcomes will be submitted to the Utilization Management Committee and the Managed Care Compliance Committee at the quarterly scheduled meetings. Utilization Management Committee members will review data and provide oversight and feedback to facilitate improved quality operations to access, continuity and coordination trending and utilization efforts.

The Utilization Management Committee reviews, updates, if necessary, and approves this Policy and Procedure at least annually.

Reference(s):

1. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-032: Continuity of Care for Medi-Cal Beneficiaries in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who Transition into a new Medi-Cal Managed Care Health Plan on or After January 1, 2023, dated December 27, 2022.

2. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-008: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised), dated December 7, 2018.

3. California Health and Safety Code, §1373.96

4. Title 28 of the California Code of Regulations (CCR) section 1300.67.1.

5. HSC sections 1363(a) (15) and 1373.96

6. 42 CFR section 438.62

7. MCP Contract, Exhibit A, Attachment 9, Section 16A

8. PHC California Policy and Procedure PR 20, DMHC Block Transfer Policy

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
7/3/2023	16.3	Dept. of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0196	Approved
9/20/2023	16.3	DHCS	2024 O/R R.0172	Approved
11/30/2023	16.3	DHCS	2024 O/R R.0117	Approved
	16.4	DMHC	Filing 20254473	Pending