	POLICIES AND PROCEDURES
Policy #: 404-1114	**Lead Department:** Utilization Management
Title: Continuity of Care	
Original Date: 03/01/2004	**Policy Hub Approval Date:** 09/28/2016
Approved by: Utilization Management Work Group (UMWG)	

Purpose:

To define Central California Alliance for Health's (the Alliance's) policies and procedures on ensuring Continuity of Care and continued access to care for members meeting specified criteria.

Policy:

The Alliance ensures medical and mental health Continuity of Care and continued access to care for specified newly eligible members, who make a request for continuity of care for up to 12 months with an out-of-network Medi-Cal provider. Eligible members may require continuity of care for services they had been receiving through their prior coverage, either Medi-Cal fee-for – service (FFS) or through another Medi-Cal managed care health plan (MCP). Continuity of Care includes the following concepts:

1. Completion of Covered Services by a Terminated or Nonparticipating Provider for specified conditions as required by Health & Safety Code §1373.96;

2. Examples may include an acute condition, serious chronic condition, pregnancy, terminal illness, care of child for up to age 3 years, and procedure authorized as course of treatment. Continued Access to out-of-network providers, for members who transition to Medi-Cal managed care. Examples include new members who transitioned from Medi-Cal fee for service (FFS) to Alliance Medi-Cal, newly enrolled Medi-Cal members; and, newly enrolled Medi-Cal seniors and persons with disabilities (SPDs),

3. Continuity of Care must be provided with an out-of-network provider when:

    a. The MCP is able to determine that the member has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);

    b. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates; and

    c. The provider is a California State Plan approved provider and has no disqualifying quality of care issues.

    d. The provider is willing to provide treatment information as necessary to determine medical necessity for continued care.

Continuity of prescriptions for new Alliance Medi-Cal members as described in procedure 3 below.

Definitions:

Completion of Covered Services - for the purposes of this policy, Completion of Covered Services refers to Covered Services necessary to complete treatment of specified conditions as defined by Health & Safety Code §1373.96, rendered by a Terminated Provider to a member who was receiving services from the Terminated Provider at the time of the contract termination; or to such Covered Services rendered by a Nonparticipating Provider to a newly enrolled member who was receiving services from the Nonparticipating Provider prior to the member's enrollment in Alliance Medi-Cal.

Continued Access – for the purpose of this policy, Continued Access refers to a newly enrolled or transitioning Alliance Medi-Cal member's ability to continue to receive Covered Services from a provider with whom the member has an ongoing relationship.

Covered Services - medically necessary health care services, supplies, and benefits which members are entitled to receive under their line of business, as defined by applicable regulation, the Alliance's provider contracts, member evidences of coverage (EOCs), or member handbook.

Existing Relationship – New member has seen an out-of-network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of initial enrollment with Alliance for a non-emergency visit.

Existing Relationship, Behavioral Health Treatment (BHT) Provider - Member has seen an out-of-network BHT provider at least once during the six (6) months prior to transition of BHT services from the Regional Center to Alliance.

Terminated Provider – A provider whose contract with the Alliance is terminated.

Non-Participating Provider - A provider who is not contracted with the Alliance to provide services under the member's plan contract.[i]

Procedures:

1. Completion of Covered Services. The Alliance will provide Completion of Covered Services for members in all lines of business as follows:

a. Eligible Conditions and Services[ii]

i. An acute condition. An acute condition is a medical condition that involves an onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. Completion of Covered Services for both physical and behavioral health will be provided for the duration of the acute condition.

ii. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period or requires ongoing treatment to maintain remission or prevent deterioration. Covered Services will be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the member and the non-participating provider and consistent with good professional practice. Completion of Covered Services for a serious chronic condition for both physical and behavioral health will not exceed 12 months from the date of the end of the contract.

iii. A pregnancy. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.

iv. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death in one year or less. Completion of Covered Services will be provided for the duration of the terminal illness.

v. Care of a child from birth to 36 months. Completion of Covered Services will not exceed 12 months from the date of the end of the contract.

vi. Surgery or other procedure. 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 from the date of the end of the contract.

b. Completion of Covered Services by a Terminated Provider to an existing Alliance member[iii]

i. The completion of Covered Services shall be provided by a Terminated Provider to a member who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in 1.a above.

ii. Completion of Covered Services is subject to the Terminated Provider's agreement to continue to abide by the terms of the terminated agreement and to accept Alliance reimbursement rates.

iii. The Alliance will not provide for the completion of Covered Services by a provider whose contract was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity.[iv]

c. Completion of Covered Services by a Non-participating Provider to a newly covered enrollee[v]

i. The Completion of Covered Services shall be provided by a Non-participating Provider to a newly covered member who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in procedure 1.a above.

ii. Completion of Covered Services is subject to the Non-Participating Provider's agreement to be subject to the same terms and conditions imposed upon currently contracted Alliance providers, including hospital privileging, utilization review, peer review and quality assurance requirements. Completion of Covered Services is also subject to the Non-Participating Provider's agreement to accept Alliance rates of reimbursement.

d. **Members receiving Completion of Covered Services from Terminated or Non-participating Providers** are responsible for required co-payment or cost sharing amounts which are the same as would be paid by the member receiving the same care from a contracted provider. Copayments are not applicable to Medi-Cal unless copayments are approved by the Federal Centers for Medicare and Medicaid Services.

e. A request is completed when:

i. The member has been informed of their continued access right;

ii. The Alliance and the provider are unable to agree to a rate;

iii. The Alliance has documented a quality of care issue; or,

iv. The Alliance has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.

v. If the Alliance and the provider are unable to reach an agreement, the Alliance will offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to a provider.

2. Continued Access for Medi-Cal members

a. The Alliance will provide Continued Access for a newly enrolled SPD member to an out-of-network provider with whom the member has an ongoing relationship if the member requests Continued Access, there are no quality of care issues, and the provider will accept Alliance rates or Medi-Cal FFS rates, whichever is higher.[vi] Additionally, the Alliance will honor active treatment authorization requests (TARs) for up to sixty (60) days or until a new assessment is completed by the Alliance. New assessments are considered completed if the beneficiary has been seen by a contracted provider and the new provider has completed an assessment of the services specified by the pre-transition active treatment authorization. Treatment authorizations must be honored without a request by the beneficiary or the provider.

b. The Alliance will provide Continued Access for a member who transitions to the Alliance from FFS Medi-Cal, to an out-of-network provider with whom the member has an ongoing relationship if the member requests Continued Access, there are no documented quality of care issues, and the provider will accept Alliance rates or Medi-Cal FFS rates, whichever is higher. Additionally, the Alliance will honor active treatment authorization for up to 60 days or until a new assessment is completed by the Alliance. New assessments are considered complete in accordance with the same standard outlined above in section 2.a.

c. The Alliance will provide Continued Access for a member receiving covered outpatient behavioral health services to a Medi-Cal FFS outpatient behavioral health provider with whom the member has an ongoing relationship if the member requests Continued Access, there are no quality of care issues, and the provider will accept Alliance rates or Medi-Cal FFS rates, whichever is higher.[vii]

i. The Alliance contracts with a Managed Behavioral Health Organization (MBHO) for the provision of mild to moderate outpatient mental health services. Medi-Cal members with mild to moderate mental health disorders and autism spectrum disorder, are referred to MBHO for outpatient care, or Behavioral Health Treatment. The MBHO will provide for Continued Access as described above. The Alliance will ensure that its delegate complies with all requirements related to Continued Access.[viii]

ii. Behavioral health services for Medi-Cal members with severe mental health disorders are referred to the County Behavioral Health for ongoing care. The Alliance does not cover services for members that have a behavioral health condition that meets medical necessity criteria for County, or Specialty behavioral health services. Exceptions to this must be specifically arranged with County Behavioral Health on a case by case basis for behavioral health conditions with a strong medical component (i.e. eating disorders).

d. Members aged 0 through 20 who are receiving Behavioral Health Treatment (BHT) for the treatment of a confirmed diagnosis of Autism Spectrum Disorder (ASD)[ix]

i. The Alliance contracts with an MBHO for the provision of BHT for ASD. For members receiving BHT services paid for by a Regional Center, or from a Non-participating Provider, the Alliance's MBHO will provide Continued Access to an out-of-network provider for up to 12 months if the member requests Continued Access if the following conditions are met:
   1. The member has an existing relationship with a qualified Autism provider An existing relationship means a beneficiary has seen an out-of-network provider at least one time during the six months prior to responsibility of BHT services being transitioned from the Regional Center to the MCP, or the date of the beneficiary's initial enrollment in the MCP if enrollment occurred on, or after, September 15, 2014;
   2. There are no documented quality of care issues, and the provider will accept MBHO rates or Medi-Cal FFS rates, whichever is higher.
   3. The provider is a California State Plan CMS approved provider; and

4. The provider supplies the MCP 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.

ii. MBHO BHT services will be continued at the same level of care until a new assessment has been conducted and a new treatment plan has been established and approved by the MCP regardless of whether the services are provided by the Regional Center provider under continuity of care or a new in-network MCP provider. MCPs must ensure continuity of care even if a comprehensive diagnostic evaluation has not yet been completed for a transitioning beneficiary. If a continuity of care agreement cannot be reached, the MCP must appropriately transition the beneficiary to a new in-network BHT provider and ensure that neither a gap nor a change in services occurs until such time that the MCP approves a new assessment and behavioral treatment plan from an in-network BHT provider.

iii. Members receiving BHT services through the Regional Center at the time of the implementation of the Medi-Cal managed care Autism Spectrum Disorder benefit will automatically continue receiving BHT services through contracted network provider for continuity of care from the Regional Centers until they are transitioned to plan network providers.

e. Continued Access does not apply to providers of durable medical equipment, transportation, ancillary services, or carved-out services.

3. Continued Access to prescriptions for new Alliance Medi-Cal members

   a. The Alliance will continue use of a single-source drug which is part of a prescribed therapy in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the Alliance, until the prescribed therapy is no longer prescribed by the contracting physician.[x]

4. The Alliance is not responsible for covering services or providing benefits that are not covered benefits under the program as outlined in the Evidence of Coverage (EOC) or member handbook.

5. Process for review of a member's request for the completion of Covered Services.

   a. Members will be notified of their right to obtain Continuity of Care under the circumstance specified above via the EOC or member handbook included in the

packet of information sent to new enrollees. A copy of this Continuity of Care policy and information regarding the process for a member to request completion of Covered Services is also available upon request by a member.

An eligible member, their authorized representative, or their provider may request Continuity of Care for continued access to care or service by calling the Alliance's Member Services Department at 1-800-700-3874.

b. Continuity of Care requests for continued access to care or service will be referred to the Utilization Management (UM) Department.

c. The Alliance's UM Department will process requests for continued access to care or service within 30 calendar days from the date of receipt; 15 calendar days if members medical condition requires more immediate attention, such as upcoming appointments or other pressing healthcare needs; or , three calendar days if there is risk of harm to the beneficiary.

d. The Alliance will process retroactive requests for Continuity of Care. The services requested must have occurred after the member became eligible for coverage with the Alliance. Retroactive or post-service requests will be approved if they:

    i. Have dates of after 12/29/2014 (date of APL)

    ii. Dates of service are within 30 calendar days of the first date of service for which the provider is requesting

    iii. Are submitted within 30 calendar days of the first service for which the retroactive continuity of care is being requires.

e. A Medical Director will review requests for Continuity of Care that do not meet criteria for approval.

    i. A Medical Director's review of the request will include a review of all records relevant to the member's medical condition, including a telephonic discussion with the member's physician or other specialists as required. If all pertinent medical records are available, the Medical Director will make a decision within 5 working days from the receipt of the information needed to make a decision, but in no case longer than 30 days from the receipt of required information. The timeframe may be shortened to three

days depending on the on the member's medical condition and/or urgency of request.

ii. If the Medical Director determines the request meets criteria, the member and provider will be notified in writing that the request has been approved within 2 working days of the decision. The timeframe may be shortened depending on the member's medical condition and/or urgency of request.

iii. If the Medical Director determines that the request does not meet criteria, the member and provider will be notified in writing that the request has been denied within 2 working days of the decision. The notice to the member will include notification of their right to file a complaint at this time.

iv. In reviewing requests for completion of Covered Services, the Medical Director will ensure that consideration is given to the potential clinical effect on the member's treatment caused by a change of provider.

6. The Alliance submits continuity of care reports to DHCS as contractually required.

References:

Alliance Policies:

Impacted Departments:

Behavioral Health
Care Management
Compliance
Member Service
Provider Services

Regulatory:

Health & Safety Code, §1373.96
Welfare & Institutions Code, §14185(b)

Legislative:

Contractual:

DHCS Medi-Cal Contract Exhibit A, Attachment 9, Provision 16, B.
DHCS Medi-Cal Contract Exhibit A, Attachment 18, Provision 9.j and k
DHCS Medi-Cal Contract Exhibit A, Attachment 20, Provisions 1 and 2.
DHCS Medi-Cal Contract Exhibit A, Attachment 22, Provision 1.A.

MMCD Policy Letter:

MMCD All Plan Letter 13-023
MMCD All Plan Letter 14-011

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MMCD All Plan Letter 14-021
MMCD All Plan Letter 15-019
MMCD All Plan Letter 15-025

NCQA:

Supersedes:

Policy 401-1507 Continuity of Care

Other References:

Attachment:

Lines of Business This Policy Applies To	**LOB Effective Dates**
☒ Medi-Cal	(1/01/1996 – present)
☐ Healthy Kids Santa Cruz	(7/01/2004 – present)
☒ Alliance Care IHSS	(7/01/2005 – present)
☒ Medi-Cal Access Program (MCAP)	(2/01/2009 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
08/01/2005	08/01/2005	Barbara Flynn, RN, HS Director	Barbara Flynn, RN, HS Director
03/01/2010	03/01/2010	Kaite McGrew, HS Admin. Assistant	Richard Helmer, MD, CMO
08/01/2010	08/01/2010	Richard Helmer, MD, CMO	Richard Helmer, MD, CMO
11/01/2011	11/01/2011	Barbara Flynn, RN, QI Director	David Altman, MD, AMD
09/14/2012	09/14/2012	Andres Aguirre, QI Mgr.	Barbara Flynn, RN, QI Dir.
10/11/2012	10/11/2012	CQIW	Andres Aguirre, QI Mgr.
10/25/2012	10/25/2012	Andres Aguirre, QI Mgr.	Andres Aguirre, QI Mgr.
02/01/2013	02/01/2013	Kaite McGrew, Jenifer Kugler	UMWG
04/04/2013	04/04/2013	Jenifer Kugler, Compliance Manager	UMWG
05/21/2013	05/21/2013	Adrian Garcia, Compliance Specialist	UMWG
12/12/2014	12/12/2014	Jacqueline Van Voerkens, HS Admin Assistant	UMWG
05/01/2015	05/01/2015	Kathy Dean, RN, UM Manager – Prior Auth	UMWG

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Reviewed Date	Revised Date	Changes Made By	Approved By
10/07/2015	10/07/2015	Kathy Dean, RN, UM Manager – Prior Auth	UMWG
4/5/16	08/30/2016	Kathy Dean, RN, UM Manager – Prior Auth	UMWG

[i] Health & Safety Code, §1373.96(m)(2)
[ii] Health & Safety Code, §1373.96(c)
[iii] Health & Safety Code, §1373.96(b)(1)
[iv] Health & Safety Code, §1373.96(h)
[v] Health & Safety Code, §1373.96(b)(2)
[vi] Medi-Cal Contract, A.9.16.B
[vii] MMCD All Plan Letter 13-023, page 4
[viii] MMCD All Plan Letter 14-011, page 4
[ix] MMCD All Plan Letter 14-011
[x] Welfare & Institutions Code §14185(b)