

<u>Requirement</u>	<u>Compliance Comments</u>	<u>Action Required</u>	<u>Responsible Party</u>
<p>1. MCP must approve continuity of care with an out-of-network provider when:</p> <ul style="list-style-type: none"> The MCP has determined that the beneficiary has an ongoing relationship with the provider The provider accepts the higher of the MCP's rates of Medi-Cal FFS rates The provider meets the MCP's credentialing criteria 	<p>The policy does not mention:</p> <ul style="list-style-type: none"> - Looking back 12-months for proof of out-of-network provider relationship; 	<p>Ensure that UM is aware of these requirements and implement in current Work Instructions, consider revising policy to convey these general continuity of care requirements.</p>	<p>UM</p> <p>Added under Definitions</p>
<p>2. Beneficiaries, their authorized representatives, or their provider may request continuity of care. Requests for continuity of care may be accepted over the phone.</p>	<ul style="list-style-type: none"> - The policy already includes language regarding the MCP's acceptance of continuity of care requests by telephone. - The policy does not include language indicating a request for continuity of care can be made by the member's authorized representative or provider. 	<p>Include language stating that requests for continuity of care can be made by a member's authorized representative or a provider.</p>	<p>UM</p> <p>Added under procedure #5</p>
<p>3. MCP must accept retroactive requests for continuity of care. The services corresponding with the request must have occurred after the beneficiary's enrollment into the MCP. Retroactive requests will be approved if they:</p> <ul style="list-style-type: none"> Have dates of services after 12/29/14 (date of APL) Have dates of services within 30 calendar days of the first date of service for which the provider is requesting Are submitted within 30 calendar days of the first service for which the retroactive continuity of care is being requested. 	<ul style="list-style-type: none"> - The policy does not include language regarding the updated retroactive request requirements. 	<p>Include in the policy language regarding retroactive requests for continuity of care.</p>	<p>UM</p> <p>Added under procedure #5.d</p>
<p>4. Continuity of care requests must be completed:</p> <ul style="list-style-type: none"> Thirty calendar days from the date the MCP received the request; Fifteen calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or, Three calendar days if there is risk of harm to the beneficiary. 	<p>The current language in the policy regarding expedited timeframes based on medical need is insufficient as it reads, <i>"The timeframe may be shortened depending on the member's medical condition and/or urgency of request."</i></p>	<p>Update the policy to include the specific timeframe language provided by the APL regarding the expedited completion timeline as necessary. Ensure that relevant staff are aware of the revised request for continuity of care processing times for members whose medical attention requires immediate action.</p>	<p>UM</p> <p>Added under procedure #5.c</p>
<p>5. A request is considered completed when:</p> <ul style="list-style-type: none"> The beneficiary has been informed of their continued access right; The MCP and the provider are 	<p>The policy includes language stating that the member will be promptly notified upon approval or denial. The policy does not include language indicating the Alliance makes an effort to contact the</p>	<p>Consider adding language that the Alliance will make a good faith effort to contact the provider regarding the determination.</p>	<p>UM</p> <p>Added under procedure #1.e</p>

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<p>unable to agree to a rate;</p> <ul style="list-style-type: none"> • The MCP has documented a quality of care issue; or, • The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days. 	provider.		
6. If the MCP and the provider are unable to reach an agreement, the MCP will offer the beneficiary an in-network alternative. If the beneficiary does not make a choice, the beneficiary will be assigned a provider.	This might be sufficiently covered by policy 200-3000 – Primary Care Provider Reselection Process	Verify.	UM Added under procedure 1.e
7. If the provider meets the necessary requirements, the MCP must allow the beneficiary 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 MCP for a shorter timeframe. If this is the case, the MCP will allow the beneficiary to have access to the provider for the shorter timeframe. Beneficiaries can change their providers at any time, to an in-network provider.	The Continued Access language speaks to providing continued access for “up to 12 months”, which covers this requirement.	No action necessary.	UM
8. Upon approval of a continuity of care request, the MCP must notify the beneficiary of the following within 7 calendar days: <ul style="list-style-type: none"> • Approval of their request; • The duration of the continuity of care; • The process that will occur to transition the beneficiary’s care at the end of the continuity of care period; and, • The beneficiary’s right to choose a different provider from the MCP’s provider network. 	The policy mentions timeframes for Medical Director’s review of requests <i>not</i> approved, but does not include these specified timeframes for when requests are approved.	Consider including this language in the policy, or, verify that these requirements are met through Work Instructions to ensure these requirements are communicated to relevant staff & notification to members is occurring as required.	UM Added under procedure #5.e
9. MCP may continue to work with beneficiary’s out-of-network provider past the 12-month continuity of care period.	The policy indicates that 12-months is the cut-off point for continuity of care services.	Determine if the Alliance will continue to work with out of network providers for more than 12 months. If we are willing, consider removing language indicating continuity of care must end at 12-months.	UM Recommend leaving language as is.
10. MCPs will include beneficiaries’ continuity of care protections in beneficiary information and handbooks. The MCP will translate these documents into threshold languages and make them available in alternative formats, upon request. MCP must train their call center staff about beneficiary continuity of care		Ensure this language is included in the Medi-Cal EOC, and ensure relevant Alliance/call center staff are aware of the revised continuity of care requirements.	MS

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protections.			
11. Approved out-of-network providers must work with the MCP and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from the MCP. The MCP will make the referral if medically necessary and if the MCP does not have adequate providers in network.		Although it might be implied in the policy's current language, consider adding prior authorization language to 1(c)(2) in the policy.	UM Covered under 404-1310 Authorization Process for Referrals to Out of Service Area and Non-contracted Speciality Providers
12. MCP beneficiaries with mild to moderate impairment resulting from a mental health diagnosis can request continued access from an out-of-network FFS provider for up to 12 months, beginning 1/1/14.	The policy clearly states our contract with a Managed Behavioral Health Organization that handles continuity of care issues for mild to moderate impairments	No action necessary.	
13. Former LIHP beneficiaries can request continued access from an out-of-network FFS provider for up to 12 months, with the 12-month timeframe beginning 1/1/14, regardless of when the request was made in 2014. MCPs must assign transition beneficiaries to their LIHP PCP according to the data provided by DHCS.	The policy clearly covers this requirement in 2(b).	Since it is now 2015 and the 12 month period since 1/1/14 is over, suggest removing this language during 2015 annual review.	UM Deleted
14. MCP will ask beneficiaries if they have any upcoming healthcare appointments or treatments scheduled and assist beneficiaries to initiate the continuity of care process if the beneficiary chooses to do so. When a new beneficiary enrolls in Medi-Cal, the MCP shall contact the beneficiary by telephone, letter or other method no later than 15 days after enrollment. The MCP will make a good faith effort to learn from and obtain information from the beneficiary that will assist the MPC to honor prior treatment authorizations and/or establish out-of-network provider continuity of care.	Confirmed by Jan Wolf that this is occurring through new member orientations done by Care Call and through the new member packets.	No action necessary.	
15. The MCP will honor active treatment authorization for up to 60 days or until a new assessment is completed by the MCP. New assessments are considered completed if the beneficiary has been seen by an MCP-contracted provider and the new provider has completed an assessment of the services specified by the pre-transition active treatment	This information is not currently stated in the policy.	Information regarding the Alliance honoring active authorizations to newly transitioned Covered California Members needs to be incorporated in the policy.	UM Added under procedure #2 a.

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authorization. Treatment authorizations must be honored without a request by the beneficiary or the provider.			
16. For newly enrolled SPD beneficiaries, the MCP will honor active treatment authorization for up to 60 days or until a new assessment is completed by the MCP. New assessments are considered completed if the beneficiary has been seen by an MCP-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.	As with Covered California transitioned members, the Alliance must honor any active TAR for newly enrolled SPD members until a new assessment is completed.	Expand section 2(c) of the policy to include this language reinforcing that as with Covered California transitioned members, the Alliance must honor any active TAR for newly enrolled SPD members until a new assessment is completed.	UM Added under procedure #2 b.
17. MCPs will provide continued access to out-of-network BHT providers for up to 12 months beginning 9/15/14. Beneficiaries must have an existing relationship with the BHT provider (has seen the provider at least twice during the 12 months prior to 9/15/14). Retroactive requests for BHT services are limited to services provided after 9/15/14 or the date of the beneficiary's MCP enrollment if enrolled after 9/15/14. MCPs must continue ongoing BHT services until a comprehensive diagnostic evaluation and assessment and established treatment plan is completed.	BHT information is currently included in the policy, but information regarding retroactive services must be added.	Expand section 2(f) of the policy to include language regarding retroactive services for BHT service. Consider adding to the policy the requirement instructing the Alliance to continue BHT services with the non-participating provider until the Alliance conducts a comprehensive diagnostic evaluation and assessment, and establish a treatment plan, or, ensure this is covered in a Work Instruction if more appropriate.	UM Included procedure #5, c, d.
18. MCPs may be required to report on metrics related to any continuity of care provisions at any time, and in a manner determined by DHCS.	Already indicated in the policy.	No action necessary.	