	POLICIES AND PROCEDURES
Policy #: 404-1114	Lead Department: Utilization Management
Title: Continuity of Care	
Original Date: 03/01/2004	Date Published: 03/19/2025
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 (C.O.C) and continued access to care for specified newly eligible members, who make a request for C.O.C. for up to 12 months with an out-of-network Medi-Cal provider. Eligible members may require C.O.C for services they had been receiving through their prior coverage, either Medi-Cal fee-for –service (FFS), through another Medi-Cal managed care plan (MCP), through the California Children's Services program or a Covered California Plan. The Alliance also ensures C.O.C. for existing members with a terminating provider.

Continuity of Care includes the following concepts:

1. Completion of Covered Services by a Terminated or Nonparticipating Provider for specified conditions;ⁱ
 - a. At the request of the member, authorized representatives, or provider, the Alliance is responsible for authorizing C.O.C. to Network Providers/Subcontractors whose contracts with the Alliance have been terminated. The Alliance is exempt from authorizing C.O.C. if the provider was terminated for exclusionary reasons related to a medical disciplinary action, fraud, abuse, or other conduct that prohibits the provider from participating in the Medi-Cal program.


Continuity of Care protections extend to Primary Care Providers (PCPs), Specialists, and select ancillary Providers, including physical therapy, occupational therapy, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy providers.

- b. The Alliance covers continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition.
 - c. At the member's request, the Alliance is required to approve completion of covered services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the

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Alliance as a 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 member.

- d. The Alliance allows all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL23-022. Members may directly request continuity of care by calling Member Services at 800-700-3784 or Community Care Coordination at 800-700-3784. For the Hearing or Speech Assistance Line, members may call 800-735-2929 (TTY: Dial 711). After hours continuity of care requests may be directed to the Nurse Advice Line at 844-971-8907.
 - i. Members transitioning to the Alliance may keep authorized and scheduled specialist appointments with Out of Network (OON) (Non-Contracted) providers when C.O.C. has been established and the appointments occur during the 12-month C.O.C. period.
 1. For Medi-Cal members, following a member's mandatory transition from Medi-Cal FFS to the Alliance: Active treatment authorizations for services previously approved remain in effect for 90 days and must be honored without a request by the Member, authorized representative, or Provider. The Alliance arranges for services authorized under the active prior treatment authorization with a contracted provider, or if there is no available contracted provider, with an OON Provider.
 2. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter. A new assessment is considered complete if the member has been seen in-person and/or via synchronous Telehealth by a contracted provider, who has reviewed the member's condition and completed a new treatment plan that includes an assessment of the services previously authorized pre-transition.
 3. In instances where a member would like their OON provider to provide a service and they have a pre-existing relationship with the OON provider, the member may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal FFS to the Alliance, transitioning from another plan with its contract expiring or terminating to the Alliance on or after January 1, 2023, this applies regardless of whether the Member has a condition listed in HSC section 1373.96.. The Alliance will make

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a good faith effort to enter into an agreement with a provider if all Continuity of Care requirements are met.ⁱⁱ

4. The Alliance will ensure Medi-Cal members with authorizations to receive Enhanced Care Management (ECM) do not experience disruptions to the ECM authorization, provider relationships, or services in accordance with the 2024 Medi-Cal MCP Transition Policy Guide. All members enrolled in an existing MCP in counties transitioning to the Single Plan and COHS models will be automatically enrolled into either the Single Plan, COHS, or Kaiser, effective January 1, 2024.
- ii. If a member, authorized representative, or provider requests to keep an authorized and scheduled specialist appointment with an out of network provider that the member has not seen in the previous 12 months and there is no established relationship with the OON provider, the Alliance may arrange for the member to keep the appointment or will review the request for potential redirection in network. If timely redirection is not available (i.e., the Alliance is unable to schedule an appointment with an in-network provider before the member's scheduled appointment with the OON provider), the Alliance will approve the OON request to not delay care and refer the member internally to the Alliance's care coordination services to assist with redirection in network.ⁱⁱⁱ However, since the appointment with the OON provider occurs after the member's transition to the Alliance, it does not establish the requisite pre-existing provider relationship for the member to submit a continuity of care request.
- e. Continuity of Care requests are accepted from the Member, authorized representative, or provider over the telephone, based on the requester's preference. The requester is not required to complete and submit a paper or online form. All necessary information must be provided by the requester over the telephone to complete the request. Following identification of a pre-existing relationship, the Alliance will determine if the provider is a network provider. If the provider is a network provider, then the Alliance will allow the member to continue seeing the provider. If the provider is not a network provider, the Alliance will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish C.O.C for the member.
2. The Alliance is not required to provide C.O.C. for benefits and services that are not covered under the Medi-Cal program, as outlined in the Evidence of Coverage (EOC)

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or member handbook. In addition, provider C.O.C. 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 or carved-out service providers. However, the Alliance must allow members to keep the modality of transportation under a previous authorization until the Alliance is able to assess the members continued transportation needs. The Alliance internally routes CCS requests for C.O.C to the Care Management (CM) team for ongoing support and follow-up per policy 405-1318 Pediatric Complex Case Management. The Alliance will make every effort to ensure continued access to care to providers that have experience and expertise in working with Members with developmental disabilities.

3. If a member changes MCPs, the 12-month C.O.C. period may start over one (1) time. If the member changes MCPs a second time (or more), the C.O.C. period does not start over; the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the C.O.C. period does not start over. If a member changes MCPs, this C.O.C. policy does not extend to providers that the member accessed through their previous MCP.
4. Continuity of Care must be provided with an out-of-network (OON) provider when:
 - a. The Alliance is able to determine that the member has a pre-existing relationship with the provider. To support continuity of care requests and prevent delays in care, the Alliance will accept a Member's self-attestation of a pre-existing relationship with the Provider.
 - b. The provider is willing to accept the higher of the Alliance's contract rates or Medi-Cal FFS rates;
 - c. The provider is a California State Plan approved provider and has no disqualifying quality of care issues; and
 - d. The provider is willing to provide treatment information as necessary to determine medical necessity for continued care. The Alliance will request from an OON 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.^{iv}
 - e. Members may change their provider to an in-network provider, at any time, regardless of whether or not a C.O.C. relationship has been established. When the C.O.C. agreement has been established, the Alliance must work with the provider to establish a care plan for the member.


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5. Utilization and case management support for CCS members includes review of members full claims and authorization activity to support continuity of care for case management, care coordination, service authorization and provider referral services.

6. The Alliance covers outpatient mental health services, as outlined in APL 22-005-No Wrong Door for Mental Health Services Policy and APL 22-006 – Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (NSMHS). County Mental Health Plans (MHPs) are required to provide Specialty Mental Health Services (SMHS) for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder, in accordance with SMHS access criteria.
 - a. The Alliance provides continuity of care with an out-of-network SMHS provider when a member's mental health condition has stabilized, and the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive NSMHS. In this situation, C.O.C. requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide Non-Specialty Mental Health Services (referred to in the State Plan as "Psychology").^v

 - b. The Alliance allows, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements APL 23-022-. Continuity of care for Medi-Cal Beneficiaries who newly enroll 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. After the C.O.C. period ends, the member must choose a mental health provider in the Alliance network for NSMHS. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the Alliance for non-specialty mental health services, the 12-month C.O.C. period may start over one (1) time. If the member requires SMHS from the MHP subsequent to the C.O.C. period, the C.O.C. period does not start over when the member returns to the Alliance or changes MCPs (i.e., the member does not have the right to a new 12 months of continuity of care).

 - c. The Alliance validates all pre-existing relationships of members with providers through the use of data provided by providers, regulators or other health plans with its contract expiring or terminating. For members transitioning from Medi-Cal FFS, the Alliance may validate the pre-existing relationship with the provider

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using Medi-Cal FFS utilization data from DHCS. To determine that a pre-existing relationship exists, a member, authorized representative, or provider may also provide information to the Alliance that demonstrates a pre-existing relationship with the provider.^{vi} To support continuity of care requests and prevent delays in care, the Alliance will accept a Member's self-attestation of a pre-existing relationship with the Provider.

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

Definitions:

California Children's Services (CCS) - CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).


California Children's Services (CCS) Provider - Any of the following Providers when used to treat Members for a CCS condition:

1. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.
2. A licensed acute care hospital approved by the CCS program.
3. A special care center approved by the CCS program.

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 existing 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, EOC, or member handbook.

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Existing Relationship –a pre-existing relationship exists when a new member has seen an out-of-network primary care provider (PCP) specialist; or select ancillary Provider including physical therapy, occupational therapy, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy Provider 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.

Maternal Mental Health Condition - is a mental health condition that impacts a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri- or postpartum period, up to one (1) year after delivery or diagnosis, whichever occurs later.

Medical Exemption Requests (MER) – A request for temporary exemption from enrollment into an MCP only until the member’s medical condition stabilized to a level that would enable the member to transfer to a contracted provider of the same specialty without deleterious medical effects.

Non-Participating Provider - A provider who is not contracted with the Alliance to provide services under the member’s plan contract.^{vii}


Out-of-Network Provider - A Provider who is not Contracted and Credentialed with the Alliance for the delivery of covered services.

Specialized or Customized Durable Medical Equipment (DME) - durable medical equipment that meets all of the following criteria:

1. Is uniquely constructed or substantially modified solely for the use of the member
2. Is made to order or adapted to meet the specific needs of the member.
3. Is uniquely constructed, adapted, or modified such that it precludes the use of the equipment by another individual, cannot be grouped with other items meant for the same use for pricing purposes.


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

Whole Child Model (WCM) - The purpose of the WCM program is to incorporate services covered by the CCS Program into Medi-Cal managed care for Medi-Cal-eligible CCS Program members. Managed care plans (MCPs) operating in WCM counties will integrate Medi-Cal managed care and CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.


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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^{viii}
 - 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 contract termination date or 12 months from the effective date of coverage for a newly covered member.
 - iii. Pregnancy and Postpartum Care. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period of 12 months.
 - iv. A maternal mental health condition. The Alliance shall provide completion of covered services by a terminated or nonparticipating provider if the enrollee is undergoing a course of treatment for one of the specified conditions at the time of the contract or policy termination or at the time the coverage became effective. Treatment services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.


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- v. 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. This may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new member.
 - 1. Continuity of Care will be authorized for members who have elected hospice care, including maintaining established patient-Provider relationships, to the greatest extent possible.^{ix}
- vi. Care of a newborn child from birth to 36 months. Completion of Covered Services will not exceed 12 months from the contract termination date or the effective date of coverage for a newly covered member.
- vii. 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 contract termination date or the effective date of coverage for a newly covered member..
- viii. Medical Exemption Requests. MERs apply only to members transitioning from Medi-Cal FFS to the Alliance. An MER should only be used to preserve C.O.C. with a Medi-Cal FFS provider under the following circumstances:
 - 1. The Alliance will consider MERs that have been denied as automatic C.O.C. requests to allow members to complete courses of treatment with OON providers.
 - 2. The Alliance will process C.O.C. requests in accordance will all other applicable requirements, including the validation of a pre-existing relationship with the provider.
 - 3. The Alliance will allow the member C.O.C. for up to 12 months after enrollment.
- b. Completion of Covered Services by a Terminated Provider to an existing Alliance member^x
 - i. The Alliance will coordinate care for impacted members as required by federal and state law, and the contract with DHCS.
 - ii. 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

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receiving services from that provider for one of the conditions described in 1.a above.

- iii. 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.
 - iv. 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.^{xi}
 - v. For Alliance Care In Home Support Services (IHSS) members: The Alliance will submit a block transfer filing to the Department of Managed Health Care (DMHC) when a transfer of 2000 or more members occurs as a result of an independent physician association (IPA), medical group, or hospital contract terminations. For additional information regarding Block Transfers, please refer to Alliance Policy 200-3003 — Block Transfer Hospital and Provider Group Terminations
- c. Completion of Covered Services by a Non-participating Provider to a newly covered enrollee^{xii}
- i. The Completion of Covered Services shall be provided by a Non-participating Provider to a newly covered member who, at the time their 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.
 - iii. The Alliance's processes are communicated to the OON provider through the LOA process, including referral and authorization processes to ensure that the OON provider does not refer the member to another OON provider without authorization from the Alliance. Furthermore, these processes are available to all providers via the Alliance's website and the Provider Manual, as described in Alliance policy 404-1109 – Disclosure of Utilization Management Process to Providers, Members, and the Public. Medically Necessary referrals to other OON providers may be approved if the Alliance does not have an appropriate provider within its network, as


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described in 404-1310 - Authorization Process for Referrals to Out of Service Area and Non-Contracted Specialty Providers.

- iv. If a provider meets all of the necessary requirements, including entering into a letter of agreement or contract with the MCP, the MCP must allow the member to have access to that provider for the length of the C.O.C. period (12 months) unless the provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP must allow the member to have access to that provider for the shorter period of time.
- 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 C.O.C. 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. Members Newly Enrolled in the SPD Program – The Alliance will provide Continued Access for a newly enrolled SPD member to an out-of-network provider with whom the member has an existing relationship for up to 12 months 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.^{xiii} Additionally, the Alliance will honor active treatment authorization requests (TARs) for up to ninety (90) 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

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authorization. Treatment authorizations must be honored without a request by the beneficiary or the provider.


- b. CCS-Eligible Members Who Transition to the Alliance Under the Whole Child Model Program – The Alliance will provide Continued Access for a CCS-eligible member who transitions into the Alliance’s Whole Child Model (WCM) program to continue to out-of-network CCS Providers and Providers of Specialized DME, with whom there is an existing relationship for up to 12 months after the transition. For out-of-network CCS Providers and Providers of Specialized DME, the Alliance shall provide C.O.C. under the following conditions:
 - i. The Member has seen the CCS Provider for a non-emergency visit at least once during the 12 months previous to the Alliance’s transition to the Whole Child Model program.
 - ii. If a CCS Specialist or clinic is acting as the CCS-eligible member’s PCP, then the member or the member’s parents, custodial parents, legal guardians, or other authorized representatives may request that the CCS Specialist or clinic continue to serve as the PCP. This process is outlined in Alliance Policy 200-2001 – Primary Care Provider Selection and Auto-Assignment.
 - iii. The Alliance ensures CCS-eligible members receive expert case management, care coordination, service authorization, and provider referral services. At the request of CCS-eligible members, their families, or designated caregivers, the Alliance will allow C.O.C. case management and care coordination from the CCS-eligible member’s existing public health nurse (PHN). The member must elect to continue receiving case management from the PHN within 90 days of transition of CCS services to the Alliance. In the event the county PHN is unavailable, the Alliance will provide the member with an Alliance case manager who has received adequate training on the county CCS program and who has clinical experience with the CCS population or with pediatric patients with complex medical conditions.
 - iv. The member has an existing relationship with a DME provider who has previously provided specialized or customized equipment, such as power wheelchairs, repairs, and replacement parts; prosthetic limbs; customized orthotic devices; and individualized assistive technology. This does not include generally available or non-customized DME.
 - v. The Provider of Specialized DME supplies equipment that meets the definition of “specialized or customized DME.”

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- vi. The CCS Provider or Provider of Specialized DME accepts the Alliance's rate for the service, or the applicable Medi-Cal or CCS FFS rate, whichever is higher, unless the CCS Provider enters into an alternative payment mutually agreed upon by Alliance and the CCS Provider.
 - vii. The Alliance confirms that the CCS Provider or Provider of Specialized DME meets applicable CCS standards and has no disqualifying quality of care issues.
 - viii. The CCS Provider makes treatment information available to the Alliance, to the extent authorized by the State and federal patient privacy provisions.
 - ix. The Provider of Specialized DME makes information available as requested by the Alliance, to the extent authorized by the State and federal patient privacy provisions.
 - x. At its discretion, the Alliance may extend the C.O.C. period beyond 12 months.
 - xi. Additionally, the Alliance will honor active TARs for up to ninety (90) 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. Members Who Transition to the Alliance from FFS Medi-Cal - 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 existing 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 90 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.

At the end of the C.O.C. period, the need for continued services will be assessed based on provider and network access, following guidelines laid out in this policy. If criteria to extend the C.O.C period is not met, the Alliance will refer the member to the CM Department to coordinate the members' care, facilitating the transfer of records and other information to the new provider as necessary.

The Alliance allows C.O.C for members through continued access to the LTC facility in which the member is residing at the time of enrollment for up to 12 months. During this time, the Alliance may attempt to place the member at a contracted LTC facility only with approval from the member or the member's authorized representative.


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When the member has an approved authorization in place for services in a SNF/LTC facility, and there is a change in the member's condition under which the facility determines they can no longer meet the member's needs, the member's health has improved sufficiently so that the member no longer needs the services provided by the facility, or the health and safety of individuals in the facility is endangered by the member, the Alliance will arrange and coordinate a discharge of the member and continue to pay the facility the applicable rate until the member is successfully transitioned into an appropriate setting.^{xiv}

The Alliance will allow Members to stay in the same SNF under continuity of care only if all of the following applies:


- The facility is enrolled and licensed by CDPH;
- The facility is enrolled as a provider in Medi-Cal;
- The SNF and the Alliance agree to payment rates that meet state statutory requirements;
- The facility meets the Alliance's applicable professional standards and has no disqualifying quality-of-care issues.

- d. Members who transition to the Alliance mandatorily from Covered California
 - i. For members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage, the Alliance may obtain information from the member, authorized representative, or provider to determine a pre-existing relationship with a provider.
 - ii. For members transitioning from Covered California, the Alliance will make a good faith effort to honor active treatment authorizations that the Alliance is made aware of without a request by the member, authorized representative, or provider, for 90 days for covered services.
 - iii. The Alliance will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider available to provide the service, with an OON provider.
 - iv. After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the Alliance, whichever is shorter.
 - v. Where need for assistance with requesting or coordinating continuity of care services are identified, the Alliance will refer members internally to receive care coordination services.
- e. Members who are receiving covered outpatient behavioral health services - The Alliance will provide Continued Access for a member receiving covered outpatient behavioral health services to a Medi-Cal FFS outpatient behavioral

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health provider with whom the member has an existing 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.


- i. The Alliance contracts with a Managed Behavioral Health Organization (MBHO) for the provision of Non-Specialty Mental Health services, including referrals from County Behavioral Health Department. Medi-Cal members screened with the statewide Screening and Transition tool as requiring Non-specialty Mental Health Services are referred to the 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 through the contract's expiration on June 30, 2025.^{xv} Beginning July 1, 2025, the Alliance will manage non-specialty mental health and behavioral health services internally through its core organizational functions.
- f. Behavioral health services for Medi-Cal members screened according to the Statewide Standard Screening and Transition Tool as having a screening level for mental health and substance use conditions are referred to the County MHP for ongoing care. The Alliance does not cover services for members that have a behavioral health condition that meets medical necessity criteria for SMHS. Exceptions to this must be specifically arranged with the MHP on a case-by-case basis for behavioral health conditions with a strong medical component (i.e. eating disorders). The Alliance will provide Medically Necessary behavioral health services from Alliance's Network Provider.
- g. Members have continued access to out-of-network Providers of BHT services (continuity of care) for up to 12 months, in accordance with the existing contract requirements and for Medi-Cal Members who transition into Medi-Cal manager care. The Alliance must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:
 - i. The Member has an existing relationship with a provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one (1) time during the 6 months prior to the date of their initial enrollment.
 - ii. The Provider agrees to the Alliance rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;
 - iii. The Provider is a qualified Provider under Health & Safety Code Section 1374.73 and the approved State Plan Amendment; and

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- h. Alliance shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period as described in APL 23-010.
 - i. An Alliance Network Provider may update the BHT treatment plan upon completion of an assessment and discontinue BHT services if the evaluation determines that BHT services are not medically necessary.
3. Continued Access to DME Rentals and Medical Supplies
- a. Transitioning members may keep their existing DME rentals and medical supplies from their existing provider under the previous Prior Authorization for a minimum of 90 days following enrollment into the Alliance and until the new the Alliance is able to reassess, the new equipment or supplies are in possession of the Member, and ready for use.
 - b. Continuity of DME and medical supplies are honored without a request by the Member, authorized representative, or Provider. Additionally, if DME or medical supplies have been arranged for a transitioning member but the equipment or supplies have not been delivered, the member may keep the equipment or supplies for a minimum of 90 days following enrollment and until the Alliance is able to reassess.
 - c. If a new assessment is not completed, the authorization remains in effect for the duration of the treatment authorization. After 90 days, the Alliance may reassess the member's authorization at any time and require the member to switch to a contracted DME Provider.
4. Non-Emergency Medical Transportation and Non-Medical Transportation
Transitioning members may keep the modality of transportation under the previous authorization with a contracted provider until the Alliance is able to reassess the member's continued transportation needs.

The Alliance must use authorizations data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies.

5. The Alliance will authorize continuity of care to Members through continued access to a Community Based Adult Services (CBAS) Provider with whom there is an existing relationship for up to 12 months after Member Enrollment. This includes access to Out-of-Network Providers if there are no quality-of-care issues and the Provider will accept the Alliance's rate or the Medi-Cal Fee-For-Service (FFS) rate, whichever is

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higher, as set forth in Exhibit A, Attachment III, Subsection 5.2.12 (Continuity of Care for Seniors and Persons with Disabilities).^{xvi}

6. Continued Access to Prescriptions

New Alliance Medi-Cal Members - The Alliance will approve the continued use of a physician-administered drug (PAD) that is part of a prescribed therapy in effect for the member immediately prior to the date of enrollment, regardless of whether the drug is covered by the Alliance. This will continue until the prescribing physician no longer prescribes the PAD in accordance with Alliance Policy 403-1114 – Continuing Pharmacy Care for New Members.^{xvii}


- a. CCS-Eligible Members Who Transition to the Alliance Under the Whole Child Model Program - The Alliance shall permit a CCS-eligible member who transitions into the Alliance’s Whole Child Model program to continue use of any currently prescribed PAD drug that is part of a prescribed therapy for the enrollee’s CCS-eligible condition or conditions immediately prior to the date of enrollment, whether or not the PAD is covered by the Alliance, until the Alliance and the member’s prescribing CCS provider has completed an assessment of the member, created a treatment plan, and agrees with the Alliance that the particular prescription drug is no longer medically necessary, or the prescription drug is no longer prescribed by the enrollee’s CCS provider.

7. Process for review of a member’s request for the completion of Covered Services.


Members will be notified of their right to obtain Continuity of Care and their continuity of care protections under the circumstance specified above via the EOC or member handbook included in the packet of information sent to new enrollees. The EOC is also available on the Alliance’s website. This information includes how a member, authorized representative, and providers may initiate a continuity of care request with the Alliance. A copy of this C.O.C. 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 C.O.C. for continued access to care or service by calling the Alliance’s Member Services Department at 1-800-700-3874.

- a. C.O.C. requests for continued access to care or service will be referred to the Utilization Management (UM) Department.

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- i. Once the completed request is received, the Alliance will provide acknowledgment of the request within seven (7) calendar days for non-urgent requests and within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three calendar days for urgent requests.
 - ii. The letter of acknowledgment includes confirmation that the C.O.C. request has been received, the date of receipt, and estimated timeframe for resolution, via the member's known preferred method of communication, or by notifying the member using one of these methods in the following order: telephone call, text message, email and then notice by mail.
- b. For CCS-eligible members who receive Continued Access during the transition into the Alliance's Whole Child Model program, the Alliance shall notify the CCS member, in writing, 60 days prior to the end of their authorized continuity of care period. The notice shall explain the right to petition the Alliance for an extension of the C.O.C. period, the criteria the Alliance will use to evaluate the petition, and the appeals process if the Alliance denies the petition.
- c. The Alliance will begin to process non-urgent requests within five (5) working days following the receipt of the C.O.C request. Additionally, the Alliance's UM Department will complete requests for Continued Access to care or service within the following timelines:
 - i. Within 30 calendar days from the date of receipt for non-urgent requests;
 - ii. Within 15 calendar days if members medical condition requires more immediate attention, such as upcoming appointments or other pressing healthcare needs; or,
 - iii. As soon as possible, but no later than three calendar days for urgent requests (i.e., if there is identified risk of harm to the member).^{xviii}
- d. The Alliance will approve retroactive requests for C.O.C. and reimburse providers for previously delivered services if the request meets all Continuity of Care requirements. These requirements including the provider's agreement to accept the Alliance's contract rates or Medi-Cal FFS rates. The services requested must meet the following requirements:
 - i. The services must have occurred after the member became eligible for coverage with the Alliance; and,
 - ii. Post service C.O.C dates of service should be within 30 calendar days of the first date of service for which the provider is requesting retrospective reimbursement.^{xix}


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Post service C.O.C. requests should be submitted within 30 calendar days of the first service for which the retroactive continuity of care is being requested.

- e. A Medical Director will review requests for C.O.C. 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 five (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 (3) 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 two (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 two (2) working days of the decision.
 - 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.
- 8. The C.O.C. request is considered complete when the Alliance notifies the member of the decision. The Alliance must provide notification to the member by mail, and to the Alliance's CCS Case Manager, within 7 calendar days of making the decision.^{xx} Furthermore, the Alliance must attempt to notify the member of the decision via the member's preferred method of communication or by telephone.
 - a. Member Notification of Denial: For requests that are denied, the following language will be included in the notice:
 - i. A statement of the Alliance's decision

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- ii. A clear and concise explanation of the reason of the denial, and offer the Member an alternative Network Provider
 - iii. The member's right to file a grievance or appeal, in alignment with Alliance policy 200-9002 – Member Grievance and Appeal System.
- b. Member Notification of Approval: For requests that are approved, the following language will be included in the notice:
 - i. A statement of the Alliance's decision
 - ii. Notification that the provider is in-network or brought in-network and that they may continue with their provider or the duration of the C.O.C. arrangement,
 - iii. The process that will occur to transition the member's care at the end of the C.O.C. period.
 - iv. The member's right to choose a different Network Provider.


When a C.O.C period has been established, the Alliance must work with the Provider to establish a plan of care for the Member.

9. The Alliance notifies the member 30 calendar days before the end of the continuity of care period, using the member's preferred method of communication. The notification shall include information about the process that will occur to transition the member's care to a network provider at the end of the continuity of care period, which includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.
10. The Alliance submits C.O.C. reports to DHCS as contractually required. The Alliance will report on existing metrics related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.^{xxi}

References:

Alliance Policies:

- 200-3003 – Block Transfer Hospital and Provider Group Terminations
- 200-2001 – Primary Care Provider Selection and Auto-Assignment
- 200-9002 - Member Grievance and Appeal System
- 403-1114 – Continuing Pharmacy Care for New Members
- 404-1109 – Disclosure of Utilization Management Process to Providers, Members, and the Public
- 404-1743 – Intermediate Care Facility/Developmental Disabled Homes
- 404-1310 – Authorization Process for Referrals to Out of Service Area and Non-Contracted Specialty Providers
- 405-1318 - Pediatric Complex Case Management

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408-1305 – Behavioral Health Services

Impacted Departments:

- Behavioral Health
- Care Management
- Compliance
- Member Service
- Pharmacy
- Provider Services

Regulatory:

- 42 Code of Federal Regulations § 438.62
- Health & Safety Code, § 1373.96
- Welfare & Institutions Code, § 14185(b)

Legislative:

- State Bill (SB) 586 Whole Child Model for California Children’s Services
- Assembly Bill (AB) 577: Maternal Mental Health Continuity of Care

Contractual (Previous Contract):


- DHCS Medi-Cal Contract Exhibit A, Attachment 9, Provision 16. B.
- DHCS Medi-Cal Contract Exhibit A, Attachment 18, Provision 9. J, K and L
- DHCS Medi-Cal Contract Exhibit A, Attachment 20, Provisions 1 and 2.
- DHCS Medi-Cal Contract Exhibit A, Attachment 22, Provision 1.A.
- DHCS Medi-Cal Contract Exhibit A, Attachment 23, Provision 1.F
- DHCS Medi-Cal Contract Exhibit A, Attachment 23, Provision 5. A and C

Contractual (2024 Contract):

- Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.5.2
- Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.2.7.D
- Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.5.3.A
- Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.2.12.A
- Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.2.12

DHCS All Plan Letters:

- APL 21-003 – Medi-Cal Network Provider and Subcontractor Terminations
- APL 22-005 – No Wrong Door for Mental Health Services Policy
- APL 22-006 – Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
- APL 22-012– Governor’s Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX
- APL 22-018–Ensuring Access to Transgender Services
- APL 24-009- Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 - Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21

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APL 24-011 - ICF/DD - LTC Benefit Standardization and Transition of Members to Managed Care
 APL 23-022 – Continuity of Care for Medi-Cal Beneficiaries who Newly Enroll 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
 APL 24-015 - CALIFORNIA CHILDREN’S SERVICES WHOLE CHILD MODEL PROGRAM
 DMHC All Plan Letters:
 DMHC APL 19-013 –Block Transfer Enrollee Transfer Notices
 DMHC APL 20-001 – (OPL) Newly Enacted Statutes Impacting Health Plans
 NCQA (Effective 3/27/24):
 NCQA NET-4B
 Supersedes:
 Policy 401-1507 – Continuity of Care
 DHCS APL’s 13-023, 14-021, 15-019 18-008, 22-032 are all superseded by 23-022
 DHCS APL 14-011, 15-025, 18-006 and 19-014 are all superseded by 23-010
 DHCS APL 20-020 are all superseded by 22-012
 DHCS APL’s 22-018 and 23-004 are all superseded by 24-009
 DHCS APL 23-027 was superseded by 24-010
 APL 23-034- CCS WCM Program was superseded by 24-015

Other References:
 Attachment:

Lines of Business This Policy Applies To


- ☐ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 – present)
 (01/01/1996 – present)
 (07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
04/12/2023	04/12/2023	Paige Harris, Regulatory Reporting Supervisor	UMWG
08/01/2023	08/01/2023	Danah Hernandez, Regulatory Reporting Supervisor	UMWG
01/31/2024	01/31/2024	Carissa Grepo, RN UM Manager – Prior Auth	UMWG
12/6/2024	12/6/2024	Kelly Tlemcani, Business Analyst II	UMWG

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02/14/2025	02/14/2025	Kelly Tlemcani, Business Analyst II	UMWG

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- ⁱ Health & Safety Code §1373.96
 - ⁱⁱ DHCS APL 23-022, Page 2, Policy, I. Continuity of Care Requirements.
 - ⁱⁱⁱ DHCS APL 23-022 Page 7-8, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, B. Scheduled Specialist Appointments
 - ^{iv} DHCS APL 22-032, Page 4, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, 3. Completion of Requests
 - ^v DHCS APL 23-022, Page 12, Policy, VI. Specific Contexts, A. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity of Care for Approved Provider Types
 - ^{vi} DHCS APL 23-022, Page 4, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, 4. Validating Pre-Existing Relationship
 - ^{vii} Health & Safety Code, §1373.96(m)(2)
 - ^{viii} Health & Safety Code, §1373.96(c)
 - ^{ix} DHCS 2024 Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7.B
 - ^x Health & Safety Code §1373.96(b)(1)
 - ^{xi} Health & Safety Code §1373.96(h)
 - ^{xii} Health & Safety Code §1373.96(b)(2)
 - ^{xiii} DHCS 2024 Medi-Cal Contract, Exhibit A, Attachment III, Provision 5.2.12. AE
 - ^{xiv} Health & Safety Code § 1373.96
 - ^{xv} DHCS All Plan Letter 23-, page 9
 - ^{xvi} DHCS 2024 Medi-Cal contract, Exhibit A, Attachment III, Provision 5.2.12
 - ^{xvii} Welfare & Institutions Code §14185(b)
 - ^{xviii} DHCS APL 23-022, Page 5, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, 5. Timeline
 - ^{xix} DHCS APL 23-022, Page 3, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, 2. Retroactive Requests
 - ^{xx} DHCS APL 23-022, Page 5, Policy, I. Continuity of Care Requirements, A. Processing Continuity of Care Requests, 6. Member Notifications
 - ^{xxi} DHCS APL 22-032, Page 12, Policy, V. Reporting