

Contra Costa Health Plan

Utilization Mgmt

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Applies to:

Medi-Cal Medicare Commercial
 All N/A to Indiv. Plans

Regulatory/Accreditation:

DHCS: APL 23.022, 2024 Medi-Cal Managed Care Plan Transition Policy Guide
 CMS: DMHC: AB 1286
 Other Reg. References: HSC 1373.65/95/96 NCQA: N/A
AB 1503

Units:

Administration Advice Nurses All Staff
 Business Services Authorization/CM/UM Health Ed/Cultural Ling.
 Marketing Member Services Planning, Survey, Reg Affairs
 Provider Affairs QM/QI

OPS Council Approval Date & Sign Off

PURPOSE

To provide limited non-participating and non-network provider access to a member, who is currently receiving services, which are eligible for Health Plan coverage until a transition to a plan provider can be arranged. *Services that are not otherwise covered under the terms and conditions of the Health Plan are not eligible for continuity of care.*

POLICY

Terminated Providers* (applicable to all product lines)

****A provider is a person who is a licentiate, as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code. A terminated provider means a provider whose contract to provide services to plan enrollees is terminated or not renewed by the plan or one of the plan's contracting provider groups.***

Contra Costa Health Plan (CCHP) shall allow a member continuity of care with a terminated Health Plan provider who has been providing care to the member for:

- an acute condition, for the duration of the acute condition;
- a serious chronic condition, for a duration enough to complete a course of treatment and arrange for a safe transfer, not to exceed twelve (12) months;
- a pregnancy, for the duration of the pregnancy and the immediate post-partum period (up to 12 months);
- a terminal illness, for the duration of the terminal illness; (even if this exceeds 12 months)
- care for a newborn child whose age is between birth and thirty-six (36) months, for a period not to exceed twelve (12) months;
- performance of surgery or other procedure that has been authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within one hundred eighty (180) days of the contract's termination date. (Note: This authorization is subject to CCHP review to ascertain medical necessity and criteria for safe transfer into network providers.)

Upon request from the member, the plan shall allow a member to continue to see a terminated provider until the services are completed, but in no event for a period exceeding twelve (12) months from the date of the provider contract termination. ***This does not apply to a provider whose contract with the plan has been terminated or not renewed for reasons relating to quality of care concerns documented by the Plan that would result in exclusion/disqualification from Provider network, a medical disciplinary action, fraud, abuse, or other conduct that prohibits the provider from participating in the Medi-Cal program.***

Newly Enrolled Members (Medi-Cal Members transitioning to CCHP due to the 2024 Single Plan Model transition and the 2025 Foster Youth Transition are described in separate sections below)

* Please note that Continuity of Care for newly enrolled Medi-Cal members mandated into managed care due to the Long Term Care Carve-In is described in the CCHP UM Policy 15.071 on Long Term Care)

Medi-Cal Beneficiaries who mandatorily transition from Medi-Cal FFS to enroll as Members in CCHP on or after January 1, 2023 have the right to request Continuity of Care with Providers. This applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal for their Medi-Cal providers. Consistent with federal law, Members must:

- (a) Have access to services consistent with the access they previously had, and
- (b) Be permitted to have continued access to services during a transition from FFS to CCHP, and
- (c) Be permitted to retain their current Provider for a period of time if that Provider is not in CCHP's network when the Member, in the absence of continued services,

would suffer serious detriment to health or be at risk of hospitalization or institutionalization.

Members may request up to 12 months of Continuity of Care with a Provider if a verifiable pre-existing relationship exists with the provider. Additionally, if a member has one of these conditions listed in Knox-Keene Act (Health and Safety Code (HSC) Section 1373.96), CCHP will provide Continuity of Care for the completion of a course of treatment for that specific condition by a terminated Provider or by a nonparticipating Provider at the Member's request.

- An acute condition
- A serious chronic condition
- A pregnancy, including postpartum and maternal mental health condition
- A terminal illness
- The care of a newborn child between birth and 36 months
- Performance of a surgery or another procedure to occur within 180 days from the contract termination date or new coverage's effective date that is authorized by the plan as part of a documented course of treatment

Members also have the right to Continuity of Care for Covered Services and active prior treatment authorizations for Covered Services.

If a member is mandatorily transitioning from Medi-Cal FFS to enroll as a Member in CCHP on or after January 1, 2023, the Member may request Continuity of Care for up to 12 months after the enrollment date with CCHP if a pre-existing relationship exists with that Provider, regardless of the Member 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. 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. CCHP is only required to provide Continuity of Care for covered benefits.

CCHP will accept Continuity of Care requests from the Member, Authorized representative, or Provider over the telephone, according to the requester'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. To complete a telephone request, CCHP will take any necessary information from the requester over the telephone.

CCHP must retroactively approve a Continuity of Care request and reimburse providers for services that were already provided if the request meets all Continuity of Care requirements outlined below, including the Provider being willing to accept CCHP's contract rates or Medi-Cal FFS rates, and the services that are the subject of the retroactive request meet the following requirements:

- Occurred after the Member's enrollment into CCHP

- Have dates of service that are within 30 calendar days of the first service for which the Provider requests retroactive reimbursement

The Continuity of Care process begins when CCHP receives the Continuity of Care request. CCHP will first determine if the Member has a pre-existing relationship with the Provider. CCHP will request from an Out-of-Network (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. CCHP will provide Continuity of Care when the following requirements are met:

- CCHP is able to determine that the Member has a pre-existing relationship with the Provider
- The Provider is willing to accept CCHP's contract rates or Medi-Cal FFS rates
- The Provider meets CCHP's applicable professional standards and has no disqualifying quality of care issues; and
- The Provider is a California State Plan approved Provider

CCHP will determine if a relationship exists through the use of data provided by DHCS, such as Medi-Cal FFS utilization data or claims data from an MCP. A Member, authorized representative, or Provider may also provide information to CCHP that demonstrates a pre-existing relationship with the Provider. A Member's self-attestation of a pre-existing relationship is not sufficient proof.

Following identification of a pre-existing relationship, CCHP will determine if the Provider is a Network Provider. If the Provider is a Network Provider, CCHP will allow the member to continue seeing the provider. If the Provider is not a Network Provider, CCHP 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 Continuity of Care for the Member.

CCHP will begin to process non-urgent requests within five working days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request will be completed within the following timelines from the date that CCHP received the request:

- 30 calendar days for non-urgent requests
- 15 calendar days if the member's medical condition requires more immediate attention; or
- As soon as possible, but no longer than three calendar days for urgent requests

CCHP will provide acknowledgement of the Continuity of Care request within the timeframes specified below, advising the Member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. CCHP will notify the member by using the member's known preference 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:

- For non-urgent requests, within seven calendar days of the decision

- For urgent requests, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three calendar days for the decision.

A Continuity of Care request is considered complete when CCHP notifies the Member of their decision. CCHP will attempt to notify the Member of the Continuity of Care decision via the Member's preferred method of communication or by telephone. CCHP will also send a notice by mail to the Member within seven calendar days of the decision.

For Continuity of Care requests that are denied, CCHP will include the following information in the notice:

- A statement of CCHP's decision
- A clear and concise explanation of the reason for denial
- The member's right to file a grievance or appeal

If CCHP and the OON provider are unable to reach an agreement because they cannot agree to a rate, or CCHP has documented quality of care issues with the Provider, CCHP will offer the member a network provider alternative. If the member does not make a choice, the Member must be referred to a Network Provider. If the member disagrees with the Continuity of Care determination, the Member maintains the right to file a grievance.

For Continuity of Care requests that are approved, CCHP will include the following information in the notice:

- A statement of CCHP's decision
- The duration of the Continuity of Care arrangement
- The process that will occur to transition the Member's care at the end of the Continuity of Care period
- The member's right to choose a different Network Provider

If a provider meets all of the necessary requirements, the CCHP will 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 CCHP for a shorter timeframe. In this case, CCHP will allow the Member to have access to that Provider for the shorter period of time.

CCHP will notify the Member 30 calendar days before the end of the Continuity of Care period, using the Member's preferred method of communication, 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.

If a member changes MCPs by choice following the initial enrollment in an MCP or if a member loses and then later regains MCP eligibility during the 12-month continuity of Care period, the 12 month Continuity of Care period for a pre-existing Provider may start over one time. If the member changes MCPs or loses and then later regains MCP eligibility a second time (or more), the Continuity of Care period does not start over and the member does not have the right to a new 12 month of Continuity of Care. If the

Member returns to Medi-Cal FFS, if applicable, and later re-enrolls in an MCP, the Continuity of Care period does not start over.

At the member, authorized representative, or Provider's request, CCHP will allow transitioning members to keep authorized and scheduled Specialist appointments with OON providers when Continuity of Care has been established and the appointments occur during the 12 month Continuity of Care period. If a Member, authorized representative, or Provider contact CCHP to request to keep an unauthorized and scheduled Specialist appointment with an OON provider that the member has not seen in the previous 12 months and there is no established relationship with the OON provider, CCHP may arrange for the member to keep the appointment or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the OON provider.

If CCHP is unable to arrange a specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON provider, CCHP will make a good faith effort to allow the Member to keep their appointment with the OON provider.

HSC Section 1373.96 also offers additional protections for Members to continue seeing a terminated or nonparticipating provider, at a Member, authorized representative, or Provider's request, to complete Covered Services for specific conditions for the indicated timeframes:

- 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 (must not exceed 12 months from the contract termination date or 12 months from the effective date of coverage)
- Pregnancy and Postpartum Care – for the duration of the pregnancy and immediate postpartum period of 12 months
 - For individuals diagnosed with a maternal mental health condition, completion of Covered Services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later
- Terminal Illness – for the duration of the terminal illness (may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member)
- Care of a Newborn Child between Birth and 36 Months – must not exceed 12 months from the contract termination date or the effective date of coverage for a newly covered Member
- Performance of a surgery or other procedure that is authorized by the MCP 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 member – within 180 days of the termination date or effective date of coverage

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

Following a member's mandatory transition from Medi-Cal FFS to CCHP on or after January 1, 2023, active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the Member, authorized representative, or Provider. CCHP will 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 OON Provider. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by CCHP, whichever is shorter. If CCHP does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, CCHP may reassess the Member's prior treatment authorization at any time. A new assessment is considered complete by CCHP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

Additionally, in an instance where a service has been rendered with an OON provider, and that Provider satisfied the Continuity of Care requirements, the Member, authorized representative, or Provider may request Continuity of Care to retroactively cover the service.

Durable Medical Equipment Rentals and Medical Supplies:

- CCHP will allow transitioning members 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 90 days following CCHP enrollment and until CCHP is able to reassess, the new equipment or supplies are in possession of the member, and ready for use
 - Continuity of DME and medical supplies must be honored without a request by the Member, authorized representative, or Provider.
- If DME or medical supplies have been arranged for a transitioning Member but the equipment or supplies have not been delivered, CCHP will allow the delivery and for the member to keep the equipment or supplies for a minimum of 90 days following CCHP enrollment and until CCHP is able to reassess.
 - If CCHP does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization
 - After 90 days, CCHP may reassess the Member's authorization at any time and require the member to switch to a Network DME Provider

Non-Emergency Medical Transportation and Non-Medical Transportation

- For NEMT and NMT, CCHP will allow members to keep the modality of transportation under the previous Prior Authorization with a Network provider until CCHP is able to reassess the Member's continued transportation needs

Specific Contexts

- Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity of Care for Approved Provider Types
 - CCHP 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 Members who meet the criteria for SMHS
 - CCHP must provide Continuity of Care with an OON SMHS Provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the MHP and instead become eligible to receive NSMHS from CCHP.
 - 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
 - CCHP must allow, at the request of the Member, authorized representative, or Provider, up to 12 months Continuity of Care with the OON MHP Provider in accordance with the requirements described above
 - After the Continuity of Care period ends, the member must choose a mental health provider in CCHP's network for NSMHS
- Covered California to Medi-Cal Transition
 - If the Member requests Continuity of Care, CCHP will help initiate the process at that time according to the requirements listed previously.
 - CCHP will make a good faith effort to learn from and obtain information from the Member so that it is able to honor prior treatment authorizations with a Network Provider and/or establish Continuity of Care.
 - CCHP will contact the new Member by telephone, letter, or other preferred method of communication, no later than 15 calendar days after enrollment.
 - CCHP will honor any active prior treatment authorizations for 90 days for services that are covered under CCH's Contract.
 - CCHP 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 OON provider.
 - After 90 days, the active authorization remains in effect for the duration of the treatment authorization, or until completion of a new assessment by CCHP, whichever is shorter.
 - A new assessment is considered complete by CCHP if the Member has been seen in-person and/or via a synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes

- assessment of the services specified by the pre-transition active prior treatment authorization
 - Prior treatment authorizations must be honored without a request by the Member, authorized representative, or Provider
 - CCHP must, at the Member, authorized representative, or Provider's request, offer up to 12 months of Continuity of Care.
- Pregnant and Post-Partum Members and Newborns
 - CCHP will, at the request of a Member, 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 12 months), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider.
 - These requirements apply for pregnant and post-partum members who transition from Covered California to Medi-Cal due to eligibility requirements
 - Pregnant and post-partum Members who are assigned a mandatory aid code, who are transitioning from Medi-Cal FFS to CCHP on or after January 1, 2023, have the right to request Continuity of Care
 - This is applicable to any existing Medi-Cal Provider relationship that is allowed under the general Continuity of Care requirements
- Terminally Ill Members
 - CCHP will, at the request of a Member, authorized representative, or Provider, provide for the completion of Covered Services of a Member with a terminal illness
 - Completion of Covered services must be provided for the duration of a terminal illness, even if it exceeds 12 months from the contract termination date of 12 months from the effective date of coverage for a new Member
- Medical Exemption Requests
 - A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to a Network Provider of the same specialty without deleterious effects
 - This only applies to Members transitioning from Medi-Cal FFS to CCHP
 - A MER should only be used to preserve Continuity of Care with a Medi-Cal FFS provider under the circumstances described above
 - CCHP is required to consider MERs that have been denied as automatic Continuity of Care requests to allow members to complete courses of treatment with OON providers in accordance with APL 17-007 or subsequent iterations of this APL

- CCHP must process the Continuity of Care request in accordance to the timelines described above, including validation of a pre-existing relationship with the Provider, and make a good faith effort to come to an agreement with the OON Provider for the duration of the treatment.
- If CCHP reaches an agreement with the Provider, CCHP will allow the Member Continuity of Care for up to 12 months after the enrollment date with CCHP

Medi-Cal Members Transitioning to CCHP due to 2024 Single Plan Model Transition

Anthem-Blue Cross Medi-Cal members who reside in Contra Costa County will transition to CCHP on January 1, 2024, as Anthem Blue-Cross Medi-Cal will be exiting Contra Costa County. Members currently enrolled in CCHP will stay with CCHP. Previously delegated members to Kaiser will transition to Kaiser MCP. Previously delegated members who wish to stay with CCHP will be allowed to stay with CCHP.

This section applies to members who change MCPs on January 1, 2024, protects member access to care after the 2024 MCP Transition and help members maintain trusted relationships with providers and access to needed services as they transition between MCPs, promising positive health outcomes.

- Three key protections for Medi-Cal members
 - Continuity of Care for Providers
 - Member may continue seeing a provider for whom they have a pre-existing relationship even if the provider is OON with CCHP.
 - Continuity of Care for Covered Services
 - Member may continue an active course of treatment as well as receive services previously authorized by the previous MCP.
 - Continuity of Care Coordination and Management Information
 - Previous MCP and CCHP will work together to share supportive information important for members’ care coordination and management.

If a member’s current provider is a network provider in the both the Previous MCP and CCHP, the member may continue to see their provider when the member transitions to CCHP on January 1, 2024. No action is required by member to continue seeing their provider in this case.

Eligible provider types for Continuity of Care:

- PCPs,
- specialists,
- Enhanced Care Management (ECM) providers,
- Community Supports providers,
- SNFs,
- ICF/DDs,
- Community Based Adult Services, and

- Select ancillary providers.

The member, Authorized representative, or provider (Requester) must request CoC for providers by contacting CCHP. Requester may contact CCHP prior to the date of service up until December 31, 2024. CCHP must process CoC for Providers' requests and notify members according to certain timelines.

Timeframes for CoC Provider process:

Request	Description	Timeframe for Processing Request	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the member	As soon as possible, but no longer than 3 calendar days	within the shortest applicable timeframe that is appropriate for the member's condition but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar Days	7 calendar days

- Transplant
 - DHCS requires mandatory overlap of the previous MCP's and CCHP's Center of Excellence Transplant programs to the maximum extent possible to permit any member accessing the transplant benefit to continue with the same transplant programs.
- Extended duration of CoC
 - The duration of CoC for providers period extends beyond 12 months for certain Special Populations
 - Receiving hospice care – for duration of the terminal illness
 - Pregnancy or Postpartum – within 12 months of pregnancy completion or maternal mental health diagnosis
 - Receiving hospital inpatient care – for the duration of the acute condition

Special Populations:

- Transitioning members who will have enhanced protections leading up to and throughout the 2024 MCP Transition
 - Generally, individuals living with complex or chronic conditions.

- 2024 MCP CoC policy requires that both the Previous MCP and CCHP focus attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care.
- Transitioning members in Special Populations will be identified by DHCS or Previous MCP Data
- Special populations include:
 - Adults and children with authorizations to receive ECM.
 - Adults and children with authorizations to receive Community Supports
 - Adults and Children receiving complex case management.
 - Enrolled in 1915© waiver programs.
 - Receiving in-home supportive services
 - Children and Youth enrolled in CCS/CCS whole Child model.
 - Children and youth receiving foster care, and former foster youth through age 25.
 - In active treatment for the following chronic communicable diseases: HIV/AIDS, TB, Hepatitis B, Hepatitis C
 - Taking immunosuppressive medications, immunomodulators, and biologics
 - Receiving treatment for end-stage renal disease
 - Living with an intellectual or developmental disability (I/D) diagnosis
 - Living with a dementia diagnosis
 - In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months.
 - Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
 - Receiving specialty mental health services
 - Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
 - Receiving hospice care
 - Receiving home health
 - Residing in SNF
 - Residing in ICF-DD
 - Receiving hospital inpatient care
 - Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
 - Newly prescribed DME (within 30 days of January 1, 2024)
 - Members receiving community-based adult services.

Continuity of Care for Covered Services:

- Enables all transitioning members to continue receiving covered services without seeking a new authorization from CCHP during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024
- Requires CCHP to honor active Prior authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and CCHP obtains documentation of the Prior Authorization within the 6-month CoC for Services period.

- CCHP must be able to accept and process requests in those instances beginning November 1, 2023
- Upon receipt of prior authorization data, CCHP and the member must work together to continue the member’s authorized service with a network provider if the member’s provider is OON and does not enter a CoC for Providers agreement.
- If the member needs to continue the service after 6 months, the provider should request a new authorization from CCHP

Enhanced CoC for Service Protections for Special Populations:

- To minimize disruptions in care for Special Populations at the end of the 6-month CoC for Services period, CCHP must continue to honor Prior Authorizations and Active Courses of Treatment for the full 6-month CoC for Services period (until July 1, 2024) and until CCHP assesses clinical necessity for ongoing services.
 - During the 6-month CoC for services period, CCHP must examine utilization data of Special Populations to identify any Active Course of Treatment that requires prior authorization and must contact those providers to establish any necessary prior authorizations.
- Transplant
 - CCHP must start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024)

Timeframes for Processing CoC for Providers for Special Populations:

<u>Timeframes for Processing CoC for Providers</u>	<u>Timeframe for Notifying Member After Processing CoC for Providers</u>
<u>30 calendar days from receipt of Special Populations Data</u>	<u>7 calendar Days</u>

Continuity of Care Coordination and Management Information:

- Transitioning members in Special Populations who are receiving care management services from their Previous MCP will change to a new Care Manager on January 1, 2024, upon transitioning to CCHP
- Transitioning members receiving CCM services are expected to continue receiving these services from CCHP
- All MCPs serving Medi-Cal members in 2024 and beyond are expected to contract with all ECM providers.
 - Disruptions in care by ECM providers are not expected.
 - In rare cases where a member is receiving care management services from an ECM provider who is not a CCHP network provider, CCHP will follow the CoC for Providers requirements.

Members in Inpatient Hospital Care:

- For members in inpatient hospital care on January 1, 2024, CCHP is responsible for initiating contact with hospitals and coordinating transitional care services.
 - Previous MCP must inform CCHP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends.
 - Once a member is known to CCHP as being in inpatient hospital care, either through the previous MCP or other means, CCHP must contact the hospital to provide for completion of a coordination of the member's care.
- Previous MCPs are responsible for paying for all covered services prior to January 1, 2024, and CCHP is responsible on or after January 1, 2024

Additional Continuity of Care Protections:

- Durable Medical Equipment Rentals and Medical Supplies
 - CCHP must allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member, and ready for use.
 - After 6 months, CCHP may reassess the member's authorization at any time and may require the member to switch to a network provider of DME.
 - If CCHP does not complete a new assessment, the authorization remains in effect for the duration of the original treatment authorization.
 - Policy applies to DME or medical supplies that have been arranged for but not yet delivered.
- NEMT and NMT
 - CCHP will ensure no disruptions to transitioning members' access to NEMT and NMT benefit.
 - Review data provided by Previous MCP to identify members with scheduled NEMT/NMT services.
 - Confirm a network provider to deliver the scheduled NEMT/NMT services or allow transitioning member to keep scheduled transportation service with the OON NEMT/NMT provider.
 - Accept and process member requests for NEMT/NMT before January 1, 2024
 - Honor all prior authorizations for NEMT/NMT approved by the previous MCP for 6 months and until CCHP is able to reassess the member's continued transportation needs.
- Scheduled Specialist Appointments
 - CCHP will arrange for member to either keep appointment with OON specialist (no pre-existing relationship; does not qualify for CoC for Providers) or schedule an appointment with a network provider on or before the member's scheduled appointment with the OON provider.

Medi-Cal Members Transitioning to CCHP due to 2025 Foster Youth Transition

Foster Youth and Former Foster Youth Medi-Cal members who reside in Contra Costa County will transition to CCHP on January 1, 2025.

This section applies to members who transition to CCHP on January 1, 2025, protects member access to care after the 2025 Foster Youth Transition in order to help members maintain trusted relationships with providers and access to needed services as they transition. This section specifically delineates enhanced Continuity of Care guidelines and protections that apply to the transitioning Foster Youth population.

Three key protections for transitioning members:

- Continuity of Care for Providers
 - Member may continue seeing a provider for whom they have a pre-existing relationship even if the provider is OON with CCHP
- Continuity of Care for Covered Services
 - Member may continue an active course of treatment as well as receive services previously authorized
- Continuity of Care Coordination and Management Information

If a member's current provider is a network provider in CCHP, the member may continue to see their provider when the member transitions to CCHP on January 1, 2025. No action is required by the member to continue seeing their provider in this care.

Upon receipt of Medi-Cal member level detailed transition data from the Department of Health Care Services (DHCS) for the Transitioning Population, or at least 30 calendar days prior to the Transition Date, CCHP will conduct outreach to out-of-Network eligible Providers with whom Medi-Cal members have pre-existing relationships to initiate a Network Provider Agreement or continuity of care for Providers agreement. CCHP will review all available data within 30 calendar days of receiving data for the Medi-Cal member, including but not limited to the Medi-Cal member level detailed transition data from DHCS, to identify the eligible Providers who provided services to Medi-Cal members prior the Transition Date. CCHP will complete outreach to eligible out-of-Network Providers within 60 calendar days of the Transition Date. Outreach is defined as at least three separate attempts made to the eligible out-of-Network Provider to achieve positive contact. These outreach attempts must include at least two different modes of communication, such as, phone calls, emails, mailers, etc. After achieving positive contact with the out-of-Network Provider(s), CCHP will engage in good faith negotiations to achieve agreement.

Continuity of Care for Covered Services

- Enables all transitioning members to continue receiving covered services without seeking a new authorization from CCHP during the 6-month Continuity of Care for services period from January 1, 2025 to July 1, 2025
- During the 6 month Continuity of Care for Services period, CCHP will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization and will contact those providers to establish any necessary Prior Authorizations

- Requires CCHP to honor active prior authorizations when transitioning data is received and/or when requested by the member, Authorized Representative, or provider. CCHP will also obtain documentation of the Prior Authorization before or within the 6- month Continuity of Care for Services period.

If a member needs to continue the service after the 6 month Continuity of Care for Services period, the provider should request a new authorization from CCHP.

Continuity of Care for Providers

- CCHP will proactively begin the Continuity of Care for Providers process prior to the transition and contact all eligible providers with whom Members have Pre-Existing Relationships to initiate a Network Provider Agreement or a Continuity of Care Providers agreement. CCHP will review all available data to identify eligible providers that provided services to these members during the 12 month preceding
 - CCHP will notify the member and the Member's Care Manager, when applicable, if the member's provider is in Network as a result of CCHP's outreach. CCHP will send notification that the member may continue with their provider
 - If the member's provider is out of network and CCHP is able to establish a CoC for Provider Agreement, CCHP will notify the member of the length of time that they can stay with their provider.
 - If the provider is out of network and cannot establish a CoC for Providers agreement, CCHP will send notification that the member must change to a network provider and assign the member a new network provider.

All other members

If another situation arises where a member is requesting care from a provider that is out of network for that member, CCHP shall allow an enrollee a reasonable transition period (up to a month) to continue his or her course of treatment with a non-participating (including a mental health provider) prior to transferring to a participating provider (including a mental health provider) to ensure a safe transfer of care. CCHP shall work as quickly as possible to safely transfer this care back to an in-network provider for the member.

NON-CONTRACTING PROVIDER'S AGREEMENT

Provision of continuity of care services from a non-contracting provider (either a terminated provider or a new member) is also contingent upon the provider's agreement in writing to accept the same contractual terms and conditions that are imposed upon contracting providers. This also includes compensation that is similar to those used for currently contracting providers providing similar services who are not capitated and who are practicing in the same or similar geographic area as the non-contracting provider. If the non-contracting provider does not agree to the terms, conditions, and rates, CCHP is not obligated to continue to provide such services.

If care is not continued due to a contractual disagreement, Case Management (CM) will facilitate an immediate safe transfer of care to a CCHP provider. If the Plan subsequently

reaches agreement with a terminated provider after a notice has been sent out to enrollees, the Plan must offer the member the option to return to the provider or remain with their current reassigned provider. (SEE TEMPLATE NOTICE TO MEMBERS ASSIGNED TO A TERMINATED PROVIDER).

*CONTINUITY OF CARE FOR MENTAL HEALTH SERVICES APPLY TO EMPLOYER BASED PLANS AND UNDER CIRCUMSTANCES WHEN THE EMPLOYER CHANGES HEALTH PLANS. CCHP IS NOT REQUIRED TO INCLUDE THE NONPARTICIPATING PROVIDER INTO OUR NETWORK, BUT MAY REQUIRE THE NONPARTICIPATING PROVIDER TO ENTER INTO CCHP'S STANDARD MENTAL HEALTH PROVIDER CONTRACT.

CONTINUITY OF CARE LIABILITY

If a member's health care service should temporarily continue with the member's existing provider to make a safe transfer, the Health Plan is not liable for actions resulting solely from the negligence, malpractice, or other tortious or wrongful acts arising out of the provision of services by the existing provider.

PROCEDURE

Upon the member's request, any CCHP department can accept a continuity of care request. All departments are responsible for forwarding the request to Utilization Management (UM).

If Member is Unable to Request

If a member is unable to make a request for continuity of care because of their current medical condition, CCHP will ensure that the member's care is continued with the current provider until a safe transfer to a plan provider can be made.

If Member is Able to Request Continuity of Care

When a member requests continued services with a nonparticipating or non-network provider because s/he believes continuity of care is needed, the Utilization Management Unit will document the request and acknowledge the request by letter at the time the request is made. If the request for continuity of care is granted, arrangements for the services will be made within ten (10) working days or sooner if medically appropriate. If the Health Plan denies the request, the Plan will inform the enrollee the denial reason(s) as described previously

To effect a safe transfer, the enrollee shall be allowed a reasonable transition period to continue his or her course of treatment with a non-participating (including a mental health provider) prior to transferring to a participating provider (including a mental health provider). CCHP will process the continuity of care request (including mental health services) in a timely manner. The decision to grant or deny a request for continuity of care shall be based on continuity of care provisions, medical necessity and accessibility to similar services. In conjunction with the Chief Medical Officer or designee, the UM nurse will review the length of time necessary for continued services with the existing provider based on medical necessity. Reasonable consideration is given to the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer

is on a case-by-case basis. If continued care with the existing provider is appropriate, the member's care will be coordinated until a safe transfer to a plan provider can be made. A safe transfer will be determined by the existing provider, CCHP Chief Medical Officer or designee, and receiving physician.

Notice Filing Requirements to Members Assigned to a Terminated Provider

CCHP will provide affected members with an approved notice 60 days prior to a contractual termination. (A *terminated provider means a provider whose contract to provide services to plan enrollees is terminated or not renewed by the Plan or one of the Plan's contracting provider groups.*)

Notice Filing Requirements to DMHC (For Members Assigned to a Terminated Provider)

CCHP will File the proposed enrollee notice with DMHC at least 75 days prior to a contract termination; the notice shall include language regarding an enrollee's right to continue seeing a health care provider. DMHC has 7 calendar days to approve or specify changes, or it is deemed approved.

Hospitals as Terminated Providers

If the terminated provider is a hospital and the Plan assigns enrollees to a provider group with exclusive admitting privileges to the hospital, the Plan shall send the notice to each enrollee who is a member of the provider group and who resides within a 15 mile radius of the hospital; if it is an individual provider terminating a contract with a provider group, the Plan may require the group to provide the notice.

NOTICE TO MEMBER OF TERMINATED PROVIDER

If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact Contra Costa Health Plan's Member Services Department at 1-877-661-6230 (Press 2) and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.hmohelp.com.

Contra Costa Health Plan (CCHP) is sending you this notice to inform you that your provider's contract with CCHP may soon be ending. CCHP allows you to receive continuity of care with a terminated Health Plan provider who has been providing care to you for:

- an acute condition, for the duration of the acute condition.
- a serious chronic condition, for a duration enough to complete a course of treatment and arrange for a safe transfer, not to exceed twelve (12) months;
- a pregnancy, for the duration of the pregnancy and the immediate Post-Partum Coverage Period; a terminal illness, for the duration of the terminal illness;

- care for a newborn child whose age is between birth and thirty six (36) months, for a period not to exceed twelve (12) months;
- and performance of surgery or other procedure that has been authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within one hundred eighty (180) days of the contract's termination date. This authorization is subject to CCHP review to ascertain medical necessity and criteria for safe transfer into network providers.

If you have any of these conditions, upon request, you may continue to see a terminated provider until the services are completed, but in no event for a period exceeding twelve (12) months from the date of provider contract termination (or such longer time period, as determined by the Health Plan, as being medically necessary to provide care to the member consistent with professional practice). *This does not apply to a provider whose contract with the plan has been terminated or not renewed for reasons relating to fraud, criminal activity, medical disciplinary cause, or quality of care concerns documented by the Plan that would result in exclusion/disqualification from Provider network.* .

In the event your current provider does not continue to contract with CCHP, Case Management will help facilitate a selection of a new Primary Care Provider (PCP). The CCHP Provider Directory that accompanied your Evidence of Coverage lists the PCPs, physicians, clinics, hospitals and other health care professionals and facilities available to you.

CCHP is not obligated to offer continuity of care if the terminated provider does not accept previous terms and agreements. If care is not continued due to a contractual disagreement, Case Management will facilitate immediate safe transfer of care to a CCHP provider. If, however, the provider does continue to contract with CCHP after you have already been reassigned, you will have a right to either stay with your reassigned provider or return to your original provider. Please remember, however, that CCHP wants you to develop a close physician-patient relationship with the PCP you select, so you should not change physicians unnecessarily or during the course of ongoing treatment as this could adversely affect your health care.