	POLICIES AND PROCEDURES
Policy #: 404-1114	Lead Department: UM / Complex Case Management
Title: Continuity of Care	
Original Date: 03/01/2004	Policy Hub Approval Date: 07/02/2020
Approved by: Utilization Management Work Group (UMWG)	


Purpose:

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

Policy:

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

1. Completion of Covered Services by a Terminated or Nonparticipating Provider for specified conditions as required by Health & Safety Code §1373.96;
2. Examples may include an acute condition, serious chronic condition, pregnancy, terminal illness, care of child for up to age 3 years, and procedure authorized as course of treatment. Continued Access to out-of-network providers, for members who transition to Medi-Cal managed care. Examples include new members who transitioned from Medi-Cal fee for service (FFS) to Alliance Medi-Cal, newly enrolled Medi-Cal members; and, newly enrolled Medi-Cal seniors and persons with disabilities (SPDs);
3. MCPs are not required to provide continuity of care for services not covered by Medi-Cal. In addition, provider continuity of care protections do not extend to the following: durable medical equipment, transportation, other ancillary service, and carved-out service providers;
4. If a member changes MCPs, the 12-month continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care 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 continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to providers that the member accessed through their previous MCP;


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

- a. The MCP is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
- b. The provider is willing to accept the higher of the MCP’s contract rates or Medi-Cal FFS rates; and
- c. The provider is a California State Plan approved provider and has no disqualifying quality of care issues;
- d. The provider is willing to provide treatment information as necessary to determine medical necessity for continued care.
- e. Members may change their provider to an in-network provider, at any time, regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MCP must work with the provider to establish a care plan for the member.


4. Continuity of care requirements for new members who did not receive Behavioral Health Treatment (BHT) services from a Regional Center prior to July 1, 2018, are set forth in APL 18-008, *Continuity of Care of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care*.

- a. For Members transitioning from the Regional Center to the Alliance for BHT services effective July 1, 2018, the Alliance will automatically initiate the continuity of care process prior to the transition for BHT services. The Alliance will utilize information provided by the Department Health Care Services (DHCS) for transitioning members to determine if the current BHT provider is currently in network and if a continuity of care arrangement is necessary. The Alliance will make a good faith effort to proactively contact the provider to begin the continuity of care process.
- b. The Alliance will offer members continued access to an out-of-network provider of BHT services (continuity of care) for up to 12 months, in accordance with existing contract requirements and APL 18-008, if all of the following conditions are met:
 - i. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the provider

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at least one time during the six months prior to either the transition of services from the Regional Center to the Alliance or the date of the member’s initial enrollment with the Alliance if enrollment occurred on or after July 1, 2018.

- ii. The provider and the Alliance can agree to a rate, with the minimum rate offered by the Alliance being the established Medi-Cal fee-for-service (FFS) rate for the applicable BHT service.
 - iii. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Alliance’s network.
 - iv. The provider is a California State Plan approved provider.
 - v. The provider supplies the Alliance with all relevant treatment information for the purposes of determining medical necessity, as well as a current treatment plan, subject to federal and state privacy laws and regulations.
- c. If a member has an existing relationship, as defined above, with an in-network BHT service provider, the Alliance shall assign the member to that provider to continue BHT services. BHT services will not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by the Alliance, regardless of whether the services are provided by the Regional Center provider under continuity of care or a new, in-network Alliance provider.
- d. If a continuity of care agreement cannot be reached with the Regional Center provider by the date of transition to the Alliance, the Alliance will transition the member to a new, in-network BHT service provider and ensure that neither a gap nor a change in services occurs until such time as the MCP approves a new assessment and behavioral treatment plan from an in-network BHT service provider.
- e. Covered BHT services must be provided in accordance with treatment plan and continuity of care requirements as outlined in APL 18-008 Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care.
5. MCPs cover outpatient mental health services, as outlined in APL 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual. County Mental Health Plans (MHPs) are required to provide


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specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS.

- 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 non-specialty mental health services from the MCP. In this situation, continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California’s Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as “Psychology”).
 - 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 18-008. Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care. After the continuity of care period ends, the member must choose a mental health provider in the Alliance subcontractor’s network for non-specialty mental health services. 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 continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care 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).
6. Continuity of prescriptions for new Alliance Medi-Cal members as described in procedure 3 below.

Definitions:

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

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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, member evidences of coverage (EOCs), or member handbook.

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

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


Maternal Mental Health Condition - A 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 year after delivery or diagnosis, whichever occurs later.

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

Non-Participating Provider - A provider who is not contracted with the Alliance to provide services under the member’s plan contract.¹

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).

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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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.

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

1. Is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of the specific member according to a physician’s description and orders.
2. Is made to order or adapted to meet the specific needs of the member.
3. Is uniquely constructed, adapted, or modified to permanently preclude the use of the equipment by another individual, and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.


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 Servicesⁱⁱ
 - 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


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provider and consistent with good professional practice. Completion of Covered Services for a serious chronic condition for both physical and behavioral health will not exceed 12 months from the date of the end of the contract.

- iii. A pregnancy. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
 - iv. A 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.
 - 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.
 - vi. Care of a child from birth to 36 months. Completion of Covered Services will not exceed 12 months from the date of the end of the contract.
 - 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 date of the end of the contract.
- b. Completion of Covered Services by a Terminated Provider to an existing Alliance memberⁱⁱⁱ
- i. The completion of Covered Services shall be provided by a Terminated Provider to a member who, at the time of the contract's termination, was receiving services from that provider for one of the conditions described in 1.a above.

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- ii. Completion of Covered Services is subject to the Terminated Provider’s agreement to continue to abide by the terms of the terminated agreement and to accept Alliance reimbursement rates.
 - iii. The Alliance will not provide for the completion of Covered Services by a provider whose contract was terminated or not renewed for reasons relating to a medical disciplinary cause or reason, fraud, or other criminal activity.^{iv}
 - iv. 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 IPA, medical group, or hospital contract terminations. For additional information regarding Block Transfers, please refer to Alliance Policy 200-3003 – Acute Care Hospital/Provider Group Contract Termination – Block Transfer of Members
- c. Completion of Covered Services by a Non-participating Provider to a newly covered enrollee^v
 - i. The Completion of Covered Services shall be provided by a Non-participating Provider to a newly covered member who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in procedure 1.a above.
 - ii. Completion of Covered Services is subject to the Non-Participating Provider’s agreement to be subject to the same terms and conditions imposed upon currently contracted Alliance providers, including hospital privileging, utilization review, peer review and quality assurance requirements. Completion of Covered Services is also subject to the Non-Participating Provider’s agreement to accept Alliance rates of reimbursement.
 - iii. 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 continuity of care 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.

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- d. Members receiving Completion of Covered Services from Terminated or Non-participating Providers are responsible for required co-payment or cost sharing amounts which are the same as would be paid by the member receiving the same care from a contracted provider. Copayments are not applicable to Medi-Cal unless copayments are approved by the Federal Centers for Medicare and Medicaid Services.
- e. A request is completed when:
 - i. The member has been informed of their continued access right;
 - ii. The Alliance and the provider are unable to agree to a rate;
 - iii. The Alliance has documented a quality of care issue; or,
 - iv. The Alliance has made a good faith effort to contact the provider and the provider is non-responsive for thirty (30) calendar days.
 - v. If the Alliance and the provider are unable to reach an agreement, the Alliance will offer the member an in-network alternative. If the member does not make a choice, the member will be assigned to a provider.

2. Continued Access for Medi-Cal Members

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

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- 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 Durable Medical Equipment, 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 Durable Medical Equipment, the Alliance shall provide continuity of care 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 Primary Care Provider, 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 Primary Care Provider. This process is outlined in Alliance Policy 200-2001 – Primary Care Provider Selection and Auto-Assignment.
 - iii. The member has an existing relationship with a durable medical equipment 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 durable medical equipment.
 - iv. The Provider of Specialized Durable Medical Equipment supplies equipment that meets the definition of “specialized or customized durable medical equipment.”
 - v. The CCS Provider or Provider of Specialized Durable Medical Equipment 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.
 - vi. The Alliance confirms that the CCS Provider or Provider of Specialized Durable Medical Equipment meets applicable CCS standards and has no disqualifying quality of care issues.
 - vii. The CCS Provider makes treatment information available to the Alliance, to the extent authorized by the State and federal patient privacy provisions.
 - viii. The Provider of Specialized Durable Medical Equipment makes information available as requested by the Alliance, to the extent authorized by the State and federal patient privacy provisions.

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- ix. At its discretion, the Alliance may extend the continuity of care period beyond 12 months.
 - x. Additionally, the Alliance will honor active treatment authorization requests (TARs) for up to sixty (60) days or until a new assessment is completed by the Alliance. New assessments are considered 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 60 days or until a new assessment is completed by the Alliance. New assessments are considered complete in accordance with the same standard outlined above in section 2.a.

Upon approval of a continuity of care request, the Alliance must notify the member of the following within seven calendar days:

- i. The request approval and duration
- ii. The process that will occur at completion of the continuity of care period
- iii. The member's right to choose an Alliance in-network provider.

At the end of the continuity of care period, the need for continued services will be assessed based on provider and network access, following guidelines laid out in this policy.

- d. 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 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.^{vii}
- i. The Alliance contracts with a Managed Behavioral Health Organization (MBHO) for the provision of mild to moderate outpatient mental health services, including referrals from County Behavioral Health Department. Medi-Cal members with mild to moderate mental health disorders, autism

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spectrum disorder, and those needed BHT 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.^{viii}

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


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

3. Continued Access to Prescriptions

New Alliance Medi-Cal Members - The Alliance will continue use of a single-source drug which is part of a prescribed therapy in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by the Alliance, until the prescribed therapy is no longer prescribed by the contracting physician, as described in Alliance Policy 403-1114 – Continuing Pharmacy Care for New Members.^{ix}

- 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 prescription 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 prescription drug 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.

- 4. The Alliance is not responsible for covering services or providing benefits that are not

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covered benefits under the program as outlined in the Evidence of Coverage (EOC) or member handbook.

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

- a. Members will be notified of their right to obtain Continuity of Care under the circumstance specified above via the EOC or member handbook included in the packet of information sent to new enrollees. A copy of this Continuity of Care policy and information regarding the process for a member to request completion of Covered Services is also available upon request by a member.

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

- b. Continuity of Care requests for continued access to care or service will be referred to the Utilization Management (UM) Department.
- c. 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 his or her authorized continuity of care period. The notice shall explain the right to petition the Alliance for an extension of the Continuity of Care period, the criteria the Alliance will use to evaluate the petition, and the appeals process if the Alliance denies the petition.
- d. The Alliance’s UM Department will process requests for Continued Access to care or service within 30 calendar days from the date of receipt; 15 calendar days if members medical condition requires more immediate attention, such as upcoming appointments or other pressing healthcare needs; or, three calendar days if there is risk of harm to the beneficiary.
- e. The Alliance will process retroactive requests for Continuity of Care. The services requested must have occurred after the member became eligible for coverage with the Alliance. Retroactive or post-service requests will be approved if they:
 - i. Dates of service are within 30 calendar days of the first date of service for which the provider is requesting


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- ii. Are submitted within 30 calendar days of the first service for which the retroactive continuity of care is being requires.
- f. A Medical Director will review requests for Continuity of Care that do not meet criteria for approval.
 - i. A Medical Director’s review of the request will include a review of all records relevant to the member’s medical condition, including a telephonic discussion with the member’s physician or other specialists as required. If all pertinent medical records are available, the Medical Director will make a decision within 5 working days from the receipt of the information needed to make a decision, but in no case longer than 30 days from the receipt of required information. The timeframe may be shortened to three days depending on the on the member’s medical condition and/or urgency of request.
 - ii. If the Medical Director determines the request meets criteria, the member and provider will be notified in writing that the request has been approved within 2 working days of the decision. The timeframe may be shortened depending on the member’s medical condition and/or urgency of request.
 - iii. If the Medical Director determines that the request does not meet criteria, the member and provider will be notified in writing that the request has been denied within 2 working days of the decision. The notice to the member will include notification of their right to file a complaint at this time.
 - iv. In reviewing requests for completion of Covered Services, the Medical Director will ensure that consideration is given to the potential clinical effect on the member’s treatment caused by a change of provider.
- 6. The Alliance submits continuity of care reports to DHCS as contractually required.

References:

Alliance Policies:

- 200-3003 – Acute Care Hospital/Provider Group Contract Termination - Block Transfer of Members
- 200-2001 – Primary Care Provider Selection and Auto-Assignment
- 403-1114 – Continuing Pharmacy Care for New Members

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Impacted Departments:

- Compliance
- Member Service
- Pharmacy
- Provider Services

Regulatory:

- 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:

- 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

MMCD Policy Letter:

- MMCD All Plan Letter 13-023
- MMCD All Plan Letter 14-011
- MMCD All Plan Letter 14-021
- MMCD All Plan Letter 15-019
- MMCD All Plan Letter 15-025
- MMCD All Plan Letter 17-018
- MMCD All Plan Letter 18-008
- DMHC All Plan Letter 19-013
- DMHC All Plan Letter 20-001

NCQA:

Supersedes:

- Policy 401-1507 – Continuity of Care

Other References:

Attachment:

Lines of Business This Policy Applies To	LOB Effective Dates
<input checked="" type="checkbox"/> Medi-Cal	(1/01/1996 – present)
<input checked="" type="checkbox"/> Alliance Care IHSS	(7/01/2005 – present)


Revision History:



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Reviewed Date	Revised Date	Changes Made By	Approved By
08/01/2005	08/01/2005	Barbara Flynn, RN, HS Director	Barbara Flynn, RN, HS Director
03/01/2010	03/01/2010	Kaite McGrew, HS Admin. Assistant	Richard Helmer, MD, CMO
08/01/2010	08/01/2010	Richard Helmer, MD, CMO	Richard Helmer, MD, CMO
11/01/2011	11/01/2011	Barbara Flynn, RN, QI Director	David Altman, MD, AMD
09/14/2012	09/14/2012	Andres Aguirre, QI Mgr.	Barbara Flynn, RN, QI Dir.
10/11/2012	10/11/2012	CQIW	Andres Aguirre, QI Mgr.
10/25/2012	10/25/2012	Andres Aguirre, QI Mgr.	Andres Aguirre, QI Mgr.
02/01/2013	02/01/2013	Kaite McGrew, Jenifer Kugler	UMWG
04/04/2013	04/04/2013	Jenifer Kugler, Compliance Manager	UMWG
05/21/2013	05/21/2013	Adrian Garcia, Compliance Specialist	UMWG
12/12/2014	12/12/2014	Jacqueline Van Voerkens, HS Admin Assistant	UMWG
05/01/2015	05/01/2015	Kathy Dean, RN, UM Manager – Prior Auth	UMWG
10/07/2015	10/07/2015	Kathy Dean, RN, UM Manager – Prior Auth	UMWG
04/05/2016	08/30/2016	Kathy Dean, RN, UM Manager – Prior Auth	UMWG
09/18/2017	10/03/2017	Kathy Dean, RN UM Manager – Prior Auth	UMWG
05/04/2018	05/04/2018	Kathy Dean, RN UM Manager – Prior Auth	UMWG
09/18/2018	09/18/2018	Kathy Dean, RN UM Manager – Prior Auth	UMWG
07/16/2019	07/16/2019	Mary Peddy UM Admin Assistant	UMWG
06/16/2020	06/16/2020	Tammy Brass, RN UM/CCM Manager	UMWG

	POLICIES AND PROCEDURES
Policy #: 404-1114	Lead Department: UM / Complex Case Management
Title: Continuity of Care	
Original Date: 03/01/2004	Policy Hub Approval Date: 07/02/2020
Approved by: Utilization Management Work Group (UMWG)	

ⁱ Health & Safety Code, §1373.96(m)(2)

ⁱⁱ Health & Safety Code, §1373.96(c)

ⁱⁱⁱ Health & Safety Code, §1373.96(b)(1)

^{iv} Health & Safety Code, §1373.96(h)

^v Health & Safety Code, §1373.96(b)(2)

^{vi} Medi-Cal Contract, A.9.16.B

^{vii} MMCD All Plan Letter 13-023, page 4

^{viii} MMCD All Plan Letter 14-011, page 4

^{ix} Welfare & Institutions Code §14185(b)