ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE TEMPLATE

Policy Number	UM-058
Policy Name	Continuity of Care for New Enrollees Transitioned to Managed Care After Receiving a~~A~~ Medical Exemption
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	~~Sr.~~ Director Utilization Management~~Director of Health Care Services~~
Line(s) of Business	Medi-Cal
Effective Date	5/3/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD~~5/19/2023~~
Compliance Committee Approval Date	TBD~~6/20/2023~~

POLICY STATEMENT

1. This policy describes The Alliance policy and process to ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care that are included on the Exemption Transition Data report.

2. The Alliance shall maintain an established process for providing required services for Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan.

3. The Alliance is required to consider a request for exemption from MCP enrollment that is denied as a request to complete a course of treatment with an existing FFS or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the MCP's contract with DHCS and all other DHCS Continuity of Care APLs.

4. The Alliance must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers, including behavioral health

providers, for the completion of those services to the extent authorized by law. The beneficiary's existing provider is identified by the National Provider Identifier on the MER.

5. The Alliance must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under APL 11-019, APL ~~15-019~~22-032 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care APLs and DPLs.

6. The Alliance must treat every exemption listed on the Exemption Transition Data report (see Attachment A for data file format details) as an automatic continuity of care request for the identified beneficiary.

7. Once an MCP is notified that a beneficiary is on the Exemption Transition Data report, the Alliance must make every effort to ensure that the beneficiary is allowed to continue to receive ongoing medical/behavioral health care through his or her FFS or nonparticipating health plan provider(s) for the period specified in H&S Code § 1373.96 for a particular illness or condition, including behavioral health conditions. This requirement also applies to instances in which the provider identified on the MER is a specialist who is not included in the network of a subcontracted health plan, independent ~~physicians~~physician's association, medical group, or other entity to which the beneficiary is assigned.

8. The Alliance must attempt to ~~contact the beneficiary via a letter followed by~~ at least two phone calls ~~before ceasing outreach attempts~~. If applicable, on the second failed call attempt a detailed voice message should be left explaining how the beneficiary can contact the MCP. After two phone call attempts, the Alliance sends a letter to the member. If there is still no response, the Alliance waits 5 business days and then makes an additional two phone call outreach attempts.

9. The Alliance must begin processing requests for continuity of care within five working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request. The Alliance must complete their responses to each request within 30 calendar days from the date the MCP receives it, or within 15 calendar days if the beneficiary's medical condition/behavioral health requires more immediate attention, such as upcoming appointments or other pressing care needs. If there is a risk of harm to the beneficiary, the request must be completed in three days. If a beneficiary voluntarily chooses to change MCPs, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

10. The Alliance must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out-of-network) about the requirements.

a. The Alliance must, at a minimum, include information about continuity of care in provider training and new member orientation materials.

11. MCPs must oversee and remain accountable for the requirements in this APL even if they subcontract with another health plan, independent physician's association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this APL. If the beneficiary's FFS or nonparticipating health plan provider is not an in-network provider, the MCP must 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 a continuity of care relationship for the beneficiary.

12. For coordination of care and care transition efforts required under H&S Code § 1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

13. A continuity of care request is considered completed when:

a. The beneficiary is informed of his or her right of continued access or if the MCP and the out-of-network FFS provider are unable to agree to a rate;
b. The MCP has documented quality of care issues; or
c. The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.
~~c.~~d. Rendering provider is a Medi-Cal Provider (Medi-Cal LOB only)

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14. The Alliance may choose to work with a beneficiary's out-of-network doctor past the 12-month continuity of care period, but the Alliance is not required to do so.

15. The Alliance Information Technology Department maintains processes to extract the DHCS Exemption Transition Data Report. The IT Department will ensure distribution to the Alliance UM Department within 2 days for processing.

a. The data file includes beneficiaries who have had a MER denied in the past 45 days. The file contains information for both pending and active beneficiaries. The data file uses the most recent choice/default information on record. For beneficiaries who are pending and not yet active, The Alliance will use the data provided to contact the beneficiary and initiate the continuity of care process. If there is no exemption denial activity for beneficiaries enrolling, an empty exemption file will not be posted to the site.

PROCEDURE

1. DHCS provides a data file to notify MCPs of beneficiaries who received a MER denial in the past 45 days who have or will transition into an MCP. The Exemption Transition Data report is accessible on the Secure Data Exchange Services (SDES)

website for California Health Care Options:
http://healthcareoptions.maximus.com/sdes/.

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a. The Exemption Transition Data report is posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The file posting schedule is available for download from the SDES website by clicking on the SDES web link above. Authorized MCP representatives who have access to the WPF can access the exemption file.

2. The Alliance IT Department will extract the file and upload it to the secure UM folder for processing.

3. The UM Department staff will accept all identified MERs as automatic continuity of care requests and begin outreach to identified members and providers.

Initiation of CoC based a Medical Exemption Request for

4. The UM Specialist will review the MERs list. Each member will be assessed for:

a. -Ongoing eligibility with The Alliance

b. Assigned Provider Network and PCP or assigned Direct Provider.

c. Availability of Requested Provider in the Alliance Network

5. Timeframes for MER Requests:

a. Begin processing requests for continuity of care within five working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request.

b. Complete their responses to each request within:

i. 30 calendar days from the date the MCP receives it, or

ii. 15 calendar days if the beneficiary's medical/behavioral health condition requires more immediate attention, such as upcoming appointments or other pressing care needs.

iii. If there is a risk of harm to the beneficiary, the request must be completed in three days.

c. If a beneficiary voluntarily chooses to change MCP (The Alliance) to another MCP, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

6. UM Clinical Specialist contacts the Member or Member's Authorized Representative to review the request and explain the process for CoC based on the denial of the MER.

    a. Outreach attempts:

        i. Two documented outreach calls within two (2) business days of identification.

        ii. If no responses:
            1. Send an outreach communication within five (5) business days of identification by the UM Department.

            2. Followed by two documented telephone calls 5 business days after the mailed communication.

    b. When successful contact is made, staff ~~obtains~~obtain all necessary information to assist in coordination services, i.e., medical records, eligibility segments, claims.

7. UM Clinical Specialist contacts the requested Provider to ensure the Provider agrees to continue providing services to the member.

    a. If the Provider agrees, the UM Clinical Specialist:

        i. Contacts requested provider to ensure they will see member and provides the "statement of reimbursement".

        ii. Reviews the applicable external databases to assess whether the Provider has any disqualifying quality of care issues.

    b. If Provider declines to provide ongoing services, the UM Clinical Specialist will notify the Member and identify an in-network provider to continue the provision of services.

8. Once the Provider is confirmed qualified, the UM Clinical Specialists will:

    a. Create UM authorization requests.

    b. Review the requested services to ensure criteria are met and services are medically necessary.

    c. Criteria (Health and Safety Code 1373.96):

        i. **An acute condition:** An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a

limited duration. Completion of covered services shall 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 of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

iii. **A pregnancy:** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy and immediately after the delivery for up to 12 months.

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iv. **A terminal illness:** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

v. The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

vi. 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 of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

d. The UM Clinical Specialist documents determination in authorization requests.

i. Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:
   1. Notifies Provider Relations (PR) to begin Letter of Agreement process.
   2. Once approved by all parties, UM Clinical Specialist completes authorization request, generates, and sends Approval Notification to Member, Provider, assigned PCP and assigned Provider Group.

ii. For potential denials based on request not meeting service criteria or Provider refusing to see Member or accept rates, the UM Clinical Specialist routes case to the UM Medical Director/ doctoral level Behavioral Health Practitioner with all the information documented in TruCare authorization requests.

e. The UM Medical Director/doctoral level Behavioral Health Practitioner will review all available information and make final determination.

i. If determination is to approve, the UM Medical Director documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete communications. Documentation should include the type of CoC applicable to case and why services are met.

ii. If determination is to deny, the UM Medical Director/ doctoral level Behavioral Health Practitioner documents review in TruCare authorization notes section and routes to UM Clinical Specialist to complete Member communications. Documentation should include:

1. Type of CoC applicable, why services are not met and the applicable denial reason; documents the applicable denial reason in the authorization request.

2. Confirmation that the services can be provided in-network and communication with PCP to obtain the necessary services and authorizations.

f. Development of Plan of Care

i. The Alliance UM Department UM staff will coordinate with OON Provider to obtain a copy of the plan of care during the OON service. The Plan of Care will be shared with the assigned PCP and/or Provider Group to ensure all services necessary to manage the identified treatment plan are in place or arranged.

9. The Member is notified of the ongoing assignment to the Primary Care Provider for all preventive services and non-CoC related services.

10. Transition to In-network

a. For approved CoC, Members will be informed of the approved services, frequency, and duration for services with the OON provider.

b. The Alliance will monitor open existing authorizations with OON providers by the identified UM report.

c. One month prior to the expiration of the OON authorization, the UM Department will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

11. Delegation

a. For services that are the responsibility of the delegate, the UM Clinical Specialist will facilitate and coordinate with the assigned delegate CoC contact. The UM Clinical Specialist documents in the TruCare authorization request the name and phone number of the delegate contact, and the PG outcome. The authorization request determination is documented as a "deny – responsibility of PPG" and case is closed. Delegates are required to process the CoC request as defined by policy or regulation.

DEFINITIONS / ACRONYMS

1. **Medical Exemption Request (MER**) means a request for temporary exemption from enrollment into a managed care plan (MCP) only until the member's medical condition has stabilized to a level that would enable the member to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to members transitioning from Medi-Cal FFS to a managed care plan. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above.

2. **Authorized Representative:** means a person other than the plan member who is authorized to receive confidential information related to the member, and who may speak on the member's behalf.

3. **California State Plan**: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130(c), the Department of Health Care Services (DHCS) issued interim guidance on September 15, 2014 in APL 14-011 to include BHT services as a covered Medi-Cal benefit for beneficiaries under 21 years of age when medically necessary, based upon recommendation of a licensed physician and surgeon or a licensed psychologist after a diagnosis of ASD to the extent required by the federal government.2 BHT services, such as Applied Behavior Analysis (ABA) and other evidence-based interventions, professional services, and treatment programs, prevent or minimize the adverse effects of ASD, and promote, to the maximum extent practicable, the functioning of a beneficiary with ASD.

4. **Continuity of Care (COC):** means a process for ensuring that care is delivered seamlessly across a multitude of delivery sites and transition in care throughout the course of the disease.

5. **Department of Health Care Services (DHCS):** means the State agency responsible for administration of the federal Medicaid (referred to Medi-Cal in California) Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health related programs.

Fee-for-Service (FFS): means a method of payment based upon per unit or per procedure billing for services rendered to an eligible beneficiary.

6.

6. **Managed Care Provider (MCP):** means a participating provider or a contracted provider in a Medi-Cal Managed Care Health Plan.

7.

7. **Medically Necessary or Medical Necessity:** Those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical practitioner, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain, that are: c

8. Consistent with nationally accepted standards of medical practice:
    a. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.
    b. For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.
    c. For purposes of covered services for Medi-Cal members, the term "medically necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and
    d. When determining the medical necessity of Covered Services for a Medi-Cal member under the age of 21, "medical necessity" is expanded to include the requirements applicable to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT Supplemental Services as defined in Title 22, 51340 and 51340.1.

9. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), Alliance will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards as follows:
    a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body enrollee, or otherwise medically necessary under 42 CFR §1395y;
    b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under Title 22 California Code of Regulations (CCR) Section 51303.

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10. **Members:** Any eligible beneficiary who is enrolled in any of Alliance's product lines of business.

11. **Out of Network (OON):** means a non-participating provider or a non-contracted provider in a Medi-Cal Managed Care Health Plan.

12. **Primary Care Provider (PCP):** means a primary care physician or clinic responsible for coordinating, supervising, and providing primary health care services to a member, including but not limited to initiating specialty care referrals and maintaining continuity of care.

13. **Provider:** means primary care physicians, specialists, ancillary providers, clinics, and hospitals.

14. **Quality of Care Issue (DHCS definition)** means The Alliance can document its concerns with the with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other Alliance members.

15. **Risk of Harm** is defined as an imminent and serious threat to the health of the member.

16. **Seniors and People with Disabilities (SPD):** means person(s) 65 years or older and/or individual(s) meeting one of the following criteria: he or she has a physical or mental impairment that substantially limits one or more of his/her major life activities; he or she has a record of such an impairment; he or she is regarded as having such an impairment.

17. **Treatment Authorization Request (TAR):** means a referral or request for services. Services may be initial or ongoing.

AFFECTED DEPARTMENTS/PARTIES

Utilization Management
Case Management
Member Services
Provider Relations
Compliance

RELATED POLICIES AND PROCEDURES

- UM-036, "Cont. Covered Services for Members with Terminated Providers"
- BH-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/16/2019, 3/18/2021, 3/22/2022, 6/20/2023

REFERENCES

1. All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data (Supersedes APL 14-012 and 14-013)
2. All Plan Letter 22-032~~18-008~~ (Supersedes All Plan Letters 18-008, 15-019, 14-021, ~~and~~ 13-023) Continuity of Care for Medi-Cal Beneficiaries Who Transition Into Medi-Cal Managed Care
3. All Plan Letter 17-007 (Supersedes APL 15-001 and 13-013 revised) Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption
4. Welfare and Institutions Code §14185 (b)
5. All Plan Letter 18-006~~15-025~~ (Supersedes APL 15-025 and 14-011 Interim Policy) Responsibilities for Behavioral Health Treatment Coverage for Children Diagnosed with Autism Spectrum Disorder Health and Safety (H&S) Code §1373.96
6. All Plan Letter 11-019 Extended Continuity of Care for Seniors and Persons with Disability
7. ~~All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data~~

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MONITORING

1. Delegated Medical Groups
   a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
   b. The Alliance reviews reports from delegated groups for continuity of care.
   ~~b.~~
2. Internal Monitoring
   a. The Utilization Management Department, on a routine basis, reviews:
      i. Logs/Reports of the various continuity of care requests. Audits are performed on selected files to ensure compliance with the regulatory requirements.
      ii. Complaints and grievances for continuity of care are reviewed to identify problems and trends that will direct the development of corrective actions plans to improve performance.
   b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. If opportunities to improve are identified, continuous improvement plans are implemented.

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3. Monthly Reports
   a. Department of Health Care Services (DHCS)

The Alliance submits monthly reports for Continuity of Care following the submission process and format outlined in the DHCS All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data.