ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-036
Policy Name	Continuity of Care for Terminated and Non-Participating Providers
Department Name	Health Care Services
Department Owner	Director Utilization Management
Lines of Business	Medi-Cal and Group Care
Effective Date	1/1/2008
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

Overview

The Alliance provides for the completion and continuity of covered services by a terminated or out-of-network/non-participating provider (NPP) of any type at the member's request in accordance with Health and Safety Code Section 1373.96, including medical and mental health service providers.

Policy Statement

A. Current and Newly Enrolled Group Care and Medi-Cal Members

1. Upon their request, current Alliance Members or newly enrolled Members with specified conditions may continue to obtain an Active Course of Treatment and health care services from a terminated or non-contracted provider for a specific condition and time frame as noted below:

   a. **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.

   b. **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 active treatment and to arrange for a safe transfer to another provider, as determined by the Alliance in consultation with the Member and

the terminated provider or non-contracting provider, consistent with good professional practice. Completion of covered services

under this paragraph shall not exceed 12 months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

c. **Pregnancy** is the three trimesters of pregnancy and the immediate postpartum period. Services shall be covered for the duration of the pregnancy and the immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care provider, completion of covered services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

d. **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 is provided for the duration of the 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.

e. **Newborn childcare** is the care of a newborn child between birth and age thirty-six (36) months. Completion of covered services under this paragraph shall not exceed twelve (12) months from the contract termination date or twelve (12) months from the effective date of coverage for a newly covered Member.

f. **Performance of a surgery or other procedure** is a medical procedure that is authorized by the Alliance, if a current Member, or by a previous plan, if a new Member, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the effective date of coverage for a newly enrolled Member, or within 180 days of the termination of the provider for a current Member.

g. **Pediatric Palliative Care** is a patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering for children. Members currently enrolled in the Alliance or transitioning from Medi-Cal FFS, the Alliance will allow, 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 provider. The Alliance will not provide continuity of care for services that were excluded due to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT per DHCS requirements.

2. The terminated or NPP must agree to terms and conditions and rates consistent with those used by the Alliance or provider group in the same or similar geographic area.

    a. If provider refuses rates or terms, The Alliance will make every effort to transition member to an appropriately qualified in-network provider.

    b. If a qualified in-network provider is not available, The Alliance will continue to negotiate rates or locate another qualified provider to care for member.

3. This policy is not applicable for current Members if the provider was terminated for medical disciplinary cause, fraud, abuse of the Medi-Cal program or any patient, convicted

of a felony or other criminal activity, suspended from the federal Medicare or Medicaid programs for any reason, lost or surrendered a license certificate or approval to provide health care or newly covered enrollees with individual coverage.

B. On January 1, 2024, Alameda County transitioned to a Single Plan Model county, and Medi-Cal recipients transitioned from a previous Medi-Cal Managed Care Plan (MCP) to Alameda Alliance for Health (AAH) as their MCP. During the transition, AAH will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition.

    a. The AAH policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.

    b. Particular attention and resources will be focused on members in Special Populations:
        - Adults and children with authorizations to receive Enhanced Care Management (ECM) services
        - Adults and children with authorizations to receive Community Supports (CS).
        - Adults and children receiving Complex Care Management (CCM)
        - Enrolled in 1915(c) waiver programs
        - Receiving in-home supportive services (IHSS)
        - Children and youth enrolled in California Children's Services (CCS)
        - Children and youth receiving foster care, and former foster youth through age 25
        - In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
        - Taking immunosuppressive medications, immunomodulators, and biologics
        - Receiving treatment for end-stage renal disease (ESRD)
        - Living with an intellectual or developmental disability (I/DD) 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 (referred to as "members accessing the transplant benefit" hereafter)
        - Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
        - Receiving specialty mental health services (adults, youth, and children)
        - Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
        - Receiving hospice care
        - Receiving home health
        - Residing in Skilled Nursing Facilities (SNF)
        - Residing in Intermediate Care Facilities for individuals with

Developmental Disabilities (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 (CBAS)

c. See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

C. The Alliance will maintain standards of communication and processes for the appropriate sharing of information (e.g., adequate, timely feedback and consultation) and coordination of care between and among medical and mental health providers, general and specialty practitioners, and institutions, referring and consulting providers.

D. For Group Care Mental Health Services (employer-sponsored group health), The Alliance:

1. Maintains a process for block transfers of enrollees from a terminated provider group to a new provider group or hospital.

2. Maintains a process to facilitate the CoC for a new enrollee who has been receiving services from a NPP mental health provider for an acute, serious, or chronic mental health condition when an employer changed health plans. This includes a reasonable transition period to continue the course of treatment with the NPP prior to transferring to a participating provider and includes the provision of mental health services on a timely, appropriate, medically necessary basis from the NPP. The process provides that the length of time of the transition period take into account on a cases-by-case basis, the severity of the enrollee's condition and the amount of time reasonably necessary to effect a safe transfer. The process ensures that reasonable considerations are given to the potential clinical effect of a change of provider on the Member's treatment of the condition. The process describes the process to review a Member's request to continue the course of treatment with the NPP mental health provider.

3. NPP mental health are not required to be contracted with The Alliance or its delegate but will require a written contract as a condition of the right to treatment an Alliance Member defining the same contractual terms and conditions that are imposed upon the participating providers, including location within the service area, reimbursement methodologies and rates of payment. This will include a quality review assessment of the NPP mental health provider.

   a. When The Alliance determines that a member's health care treatment should temporarily continue with an existing provider or NPP mental health provider, the Alliance shall not be liable for actions resulting solely from the negligence, malpractice, or the tortious or wrongful acts arising out of the provisions of service by the existing provider or a NPP mental health provider.

4. Facilitates the completion of covered services pursuant to H&S Section 1373.96.

5. Provides Evidence of Coverage for Member communication describing the policy and informing Members of their rights to the completion of covered services.

6. Maintains processes to ensure that reasonable consideration is given to the potential clinical effects on a Member's treatment caused by a change in provider.

E. In the event a provider is terminated, all assigned Members are notified in writing (Attachment A) of the termination and their right to continue care 60 days prior to the termination effective date and are informed of the procedures for selecting another provider.

F. The Alliance maintains mechanisms to facilitate transition of care (including enrollee notification when:

   1. An individual in a course of treatment enrollees in the Plan and
   2. When a medical group or provider is terminated from the network.

G. The Alliance reserves the right to make final decisions regarding continuity of care.

   1. An Alliance Medical Director makes such decisions with consideration given to the potential effects on the Member's clinical condition and whether they are receiving an active course of treatment for acute or chronic conditions.

H. Communication to Members:

   1. All newly enrolled Members receive a written notice of the continuity of care policy and information regarding the process to request a review under the policy through the plan Evidence of Coverage and Disclosure Forms, and upon request, the Alliance sends a copy of the policy to the Member.

I. Any newly enrolled Member request COC or may obtain a copy of this policy upon written request to Alliance or by calling Member Services.

I. The Alliance is not required to cover services that are not otherwise covered by the Plan.

J. The Alliance notifies members of alternative resources in situations when members are receiving approved and medically necessary services but whose benefit coverage end or has ended.

K. The Alliance will manage the process of care transitions, identify problems that could cause transitions, facilitate safe transitions and, where possible, prevent or minimize unplanned transitions.

L. The Alliance Medical Services, Case and Disease Management Departments and their supporting units as well as the Member Services Department will collaborate in the management of care transition processes. This process includes review to determine whether the member's current treatment/care is transferable to another provider without compromising quality of care.

M. The Alliance utilizes evidenced based criteria, the application of medical necessity and reasonable consideration to the potential clinical effects on the Members' treatment caused by a change in Provider in consideration of a continuation of care.

N. The Alliance may delegate this responsibility to a provider group and ensures that the requirements are met.

O. The Alliance reserves the right to make all final decisions regarding continuity of care for Alliance Members.

PROCEDURE

A. All newly enrolled Members receive the Alliance's notice of the continuity of care policy in the Evidence of Coverage and Disclosure Form that is sent at time of enrollment.

1. Former Covered California members transitioning into Medi-Cal, Seniors and Persons with Disabilities with active Treatment Authorization Requests, and individuals identified on the Exemption Transition Data Report will receive additional outreach regarding continuity of care from the Member Services Department.

B. CoC requests are managed using the same mechanisms and processes for both medical and mental health services.

C. Requests from newly enrolled Members to continue their care with a NPP of any type will typically originate with the Outpatient Utilization Management Department.

1. Any such request is documented by Alliance Utilization Management Department with subsequent referral to an Alliance Medical Director, if necessary.
2. The Alliance UM Department Standards to begin review of request for CoC within:
    a. Routine request within five (5) business days.
    b. Urgent matters are reviewed and responded to within 72 hours.
3. Each continuity of care request must be completed within the following timeline:
    a. Thirty calendar days from the date The Alliance received the request;
    b. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
    c. Three calendar days if there is risk of harm to the member.
    d. Note: timeframes may be extended due NPP contracting phase; contracting should be completed within the standard timeframe but not to exceed 30 calendar days from the date of the receipt of the request.
4. Alliance Medical Services will evaluate the request based on the regulatory requirements outlined in Health and Safety Code Section 1373.96.
5. Alliance Medical Services will notify Alliance Contracts Management via a Health Suite Service Request of all approved authorizations.
6. UM Coordinators are responsible for daily monitoring Health Suite Service Request email distribution inbox.
7. UM Coordinators will review each request for:
    a. Eligibility
    b. Confirmation of Provider network status
    c. Obtaining medical records, if necessary
    d. Assignment to UM Nurse for review

D. UM Nurse Specialist/ Reviewer is responsible for reviewing each Member or NPP request for CoC.

1. Requests are reviewed based on the member conditions as noted in Section 2.1.

E. UM Nurse Specialist or designee will contact the Provider to confirm the request and obtain any additional information as needed.

F. The UM Nurse Specialist/ Reviewer is responsible for ensuring communication among the providers between all levels of care (e.g. acute inpatient care, sub-acute admissions, outpatient care/treatment) will contact the appropriate The Alliance delegate's UM Staff or to facilitate the timely exchange for co-management. UM Nurse Specialist/ Reviewer or designee will contact the requested NPP to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information is obtained, the request is forwarded to The Alliance Medical Director to confirm CoC exists and meets criteria.

    a. If criteria met, the UM Coordinator will notify the Alliance Contracts Management team via Health Suite SR process with all applicable information to begin rate negotiations.

    b. The UM coordinator will generate an approval level for Continuity of Care as outlined by regulation to all applicable parties.

    c. If criteria is not met, the Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.

        - The UM Coordinator will create communication to the member and provider(s) as scribed by the Medical Director.UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

G. For Mental Health Services

1. The Behavioral Health (BH) department staff are responsible for ensuring the review of request for CoC with a NPP mental health provider.

2. For services that require co-management, the BH staff are responsible for ensuring communication among the providers between all levels of care (e.g., inpatient care, partial hospitalization, outpatient care, day, and residential treatment) and will facilitate the timely exchange of information for co-management.

3. When needed, the BH staff will ensure communication between and among BH and medical providers to ensure appropriate evaluation, screening, diagnosis, and treatment of serious mental health illness, serious emotional disturbances, and autism conditions.

H. Rates of Payment and Agreement of Terms

1. Through a Letter of Agreement, Alliance Contracts Management will offer the non-contracting providers who may continue services:

    a. The rates and methods of payment similar to those used by the Alliance or the provider group for currently contracted providers providing similar services or the Medi-Cal fee for service rate, whichever is higher.

    b. The rates offered will be for providers who are not capitated and who are practicing in the same similar geographic areas as the non-contracting provider.

    c. The NPP will be subject to the same contractual terms and conditions as contracting providers.

2. If the NPP agrees to the rate, terms and conditions, Contract Management notifies Medical Services and Medical Services sends to the member and the provider a notice authorizing the continued services.

3. If the NPP does not agree to the rates, or terms and conditions or fails to respond to the Alliance within 30 calendar days of the request for continuity of care, the following will occur:
    a. Contract Management will notify Alliance Medical Services to reverse the authorization.
    b. Alliance Medical Services will send the member and the provider a notice that continuity of care services have been denied because the Alliance and the non-contracted provider were unable to reach agreement.
    c. Medical Services will coordinate with Member Services to identify an alternative provider for the member to continue receiving care with a contracted provider.

I. UM Nurse Specialist or designee will contact the requested Provider to confirm agreement to of existing active treatment plan or criteria met and NPP agreement to continue services to Member.

1. Once information obtained,
    a. When rates approved, the UM Coordinator will notify the Member and NPP in writing as well as the assigned PCP and assigned Provider Group to ensure necessary documentation as well as verification of primary care continuing as the responsibility of the Provider Group.
    b. If rates not agreed upon,
        1). The Alliance Medical Director will document the reason for the denial of the determination in the UM Clinical Information System.
        2). UM Coordinator is responsible for management of UM referral determination documentation and written communication to the Member and NPP under the direction of the UM Medical Director.
            i). UM Coordinator will contact the assigned PCP and Provider Group to ensure communication of the denial and coordination of necessary medical treatment.

J. In situations when members are receiving approved and medically necessary services but whose benefit coverage ends, the Alliance notifies members of the existence of alternative resources. (Attachment B).

K. Managing Transitions/Members in hospital or sub-acute setting at the time of the termination

1. Identification of planned transitions from members' usual setting of care to the hospital and transitions from the hospital to the next setting.
    a. Planned/Unplanned Transitions. All elective inpatient admissions require prior authorization by the Alliance or a delegated Provider Group.
        1) For terminating providers/ Contracted Facilities, The Alliance/Provider Groups will obtain a list of all maintain paper and electronic files on all authorization requests to identify Members who may be impacted by the termination.

b. For newly enrolled Members who are hospitalized at the time of the assignment to The Alliance and who meet the criteria noted in Section 2.1, the UM Nurse Specialist will review each case with the UM Medical Director and follow the stated procedures in this section.

L. Honoring Existing and Active Prior Treatment Authorizations (PAs) and Treatment Authorization Requests (TARs)

1. For terminated providers, the UM Department will collaborate with Provider Relations to ensure any associated Provider Groups are notified of these specific members with an existing and active PA or TAR that the Alliance or the delegate will honor the PA or TAR for ninety (90) days or until an appropriate assessment is completed by a contracted provider.

M. Block Transfers – Please refer to the Alliance's Block Transfer P&P for the Alliance's process for handling the termination of a Provider contract that could involve the block (entire) transfer of Members.

N. Delegated Providers

1. The Alliance will ensure compliance with the regulatory requirements for continuity of care by delegated groups and oversee the compliance through the delegation oversight process; i.e., quarterly reporting, annual on-site review, investigation of complaints, and review of denials.

2. Any written, printed, or electronic notification to the Member regarding a contract termination or block transfer (transfer of all of a provider's Members) must include the following language: "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 The Alliance's Member Service Department, 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.ca.gov".

O. Continuity of Care Reporting Requirements:

1. The Analytics, IT and Medical Services Departments will work together in order to ensure the Alliance submits all required quarterly continuity of care reports.

2. On a monthly basis, the UM Manager or designee will review CoC data and reporting requirements to ensure data is available for internal and regulatory reporting.

3. On a quarterly basis, the UM Manager and Director of Health Services will review the CoC data and provide a summary report with identification of opportunities to improve the UM experience to the UM Committee.

4. On a monthly basis, the IT department will provide data to the Compliance Department for regulatory reporting.

DEFINITIONS

1. **Active Treatment** - An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol.
2. **Individual Provider** – A person who is licentiate, as defined in Section 805 of Business and Professional Code or a person licensed under Chapter 2 of Division 2 of the Business and Professions Code.
3. **Nonparticipating Mental Health Provider –** A psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed social worker, or licensed professional clinical counselor who does not contract with the specialized health care service plan that offers professional mental health services on an employer-sponsored group basis.
4. **Nonparticipating Provider** - A provider who is not contracted with the enrollee's health care service plan to provide services under the enrollee's plan contract.
5. **Non-Contracted Provider** – Any provider that is not contracted with the Alliance.
6. **Planned Transitions** include elective surgery or a decision to enter a long-term care facility.
7. **Post-Partum Period** – Commonly defined as the six weeks after childbirth.
8. **Provider** – any professional person, organization, health facility, or other person or institution licensed by the State to deliver or furnish health services.
9. **Provider Group –** A Medical Group, Independent Practice Association, or any other similar organization.
10. **Unplanned Transitions** include any non-elective admission to an acute or long-term care inpatient facility, or any emergency room visit.
11. **Terminating Provider** – any Provider whose contract with the Alliance is in the process of termination, regardless of which entity initiated the termination process.
12. **Transition -** Movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery**.**

AFFECTED DEPARTMENTS/PARTIES

Member Services
Provider Relations
Contract Management
Health Analytics
Medical Services

Behavioral Health

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. PRV-002 Block Transfers
2. BH-002 Behavioral Health Services
3. UM-001 UM Program
4. UM-058 CoC for New Enrollees with MER
5. UM-059 CoC for Enrollees Transitioning into Medi-Cal Managed Care

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REVISION HISTORY

10/28/2009, 4/1/2011, 1/25/2012, 9/7/2012, 12/5/2012, 1/9/2013, 1/30/2013, 12/26/2013, 4/25/2014, 7/14/2014, 2/11/2015, 01/10/2016, 04/12/2018, 3/21/2019, 3/19/2020, 5/21/2020, 3/18/2021, 5/20/2021, 6/28/2022, 02/21/2023, 6/20/2023, 12/19/2023, 04/25/2024

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 21-003 Medi-Cal Network Provider and Subcontractor Terminations
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- Continuity of Care Workflow for Member Services Department
- Continuity of Care Authorization Workflow for Medical Services Department
- Health & Safety Code Sections 1371.8, 1373.65, 1373.95 & 1373.96
- Letter of Agreement Process in Policy and Procedure NTM-CON-002
- Medi-Cal and Group Care Evidence of Coverage
- NCQA Standards

MONITORING

The Compliance and Utilization Department are responsible for initial and annual delegation oversight of the provision of continuity of care services.

At least annually, the UM Department will review this policy annually for compliance with regulatory and contractual requirements.

At least annually, the UM Department will review a statistically significant file review selection to evidence compliance with the CoC processes.

Outcomes of the annual delegation oversight and file review are presented to the Quality Improvement Health Equity Committee annually.