ALAMEDA Alliance FOR HEALTH

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POLICY AND PROCEDURE

Policy Number	UM-059
Policy Name	Continuity of Care for Medi-Cal Beneficiaries Who Transition into MediCal Managed Care
Department Name	Utilization Management
Department Officer	Chief Medical Officer
Policy Owner	~~Sr. Director of Health Care Services~~Director Utilization Management
Line(s) of Business	Medi-Cal
Effective Date	5/3/2018
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	~~11/17/2023~~TBD
Compliance Committee Approval Date	~~12/19/2023~~TBD

POLICY STATEMENT

All Alliance members, including Seniors and Persons with Disabilities, who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) or whose contracts are expiring/terminating to AAH as of January 1, 2023, with pre-existing provider relationships (medical or behavioral health,) may make a continuity of care request to the Alliance. For the 1/1/2024 transition of Alameda County to a Single Plan Model, AAH will ensure that continuity of care policies will protect Members access to care in accordance with the DHCS 2024 MCP Transition Policy Guide. Members may request up to 12 months of CoC with a Provider if a verifiable pre-existing relationship exists with that provider for any covered Medi-Cal service, with an out-of-network/nonparticipating Medi-Cal provider, when in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization. Members will have access to services consistent with the access they previously had.

1. Continuity of Care (CoC) protections extend to Primary Care Providers, Specialists and select ancillary providers as follows:

    a. Physical therapy

b. Occupational therapy
c. Speech therapy
d. Respiratory therapy
e. Behavioral health
f. Durable medical equipment (DME)

2. The Alliance will provide continuity of care with an out-of-network (OON) provider when:

   a. The provider is providing a service that is eligible for Continuity of Care (CoC) for Providers.
   b. The Alliance 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).

   c. An existing relationship means the member has seen an out-of-network primary care provider (PCP,) specialist, or behavioral health provider at least once during the 12 months prior to the date of his or her initial enrollment in the Alliance for a non-emergency visit, unless otherwise specified in this policy or by state or federal law.

   d. If the Provider is an OON Provider, the Alliance will contact the Provider and make a good faith attempt to establish COC for the beneficiary.

   e. The Provider accepts the higher of the Alliance contract rates or Medi-Cal FFS rates.

   f. The Provider meets the Alliance's applicable professional standards and has no disqualifying quality of care issues.

      i. For the purpose of the DHCS All Plan Letter, a quality of care issue means The Alliance can document its concerns 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.

   g. The Provider is a California State Plan Approved Provider

   h. The Provider supplies the Alliance with relevant treatment information for the purposes of determining Medical Necessity, as well as a current treatment plan as allowable under applicable federal and state privacy laws and regulations.

3. During the 2024 Managed Care Transition to Single Plan Model, the following policies and procedures apply:

a. For members identified as belonging to Special Populations, AAH will focus attention and resources on transitioning members to minimize the risk of harm from disruptions in their care:

(a) Special Populations include:

- 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)

b) The Previous MCP transitioning Members will transfer supportive information that is important to the incoming Members' care coordination and management.

c) AAH will work with the Previous MCP to transfer and share supportive information important for the Members' care coordination and management.

d) AAH will process CoC for provider requests and notify members according to the requirements of the DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide:
    - If a member's current provider is a network provider in both the Previous MCP and AAH, the member may continue to see their provider when the member transitions to AAH on 1/1/24. No action is required by the member to continue seeing their provider in this case.
    - Some members who transition to AAH on January 1, 2024, will be receiving care from providers who are OON providers for AAH. If members wish to switch their care to an AAH network provider on January 1, 2024, AAH will facilitate that switch. For other members, transitioning to a new provider on January 1, 2024, may disrupt their care. CoC for Providers will enable transitioning members to continue receiving care from their existing providers for 12 months if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with AAH. All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.
        - Eligible Provider Types:
            - Primary Care Providers (PCP)
            - Specialists
            - Enhanced Care Management Providers
            - Community Supports Providers
            - Skilled Nursing Facilities (SNFs)
            - Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
            - Community-Based Adult Services Providers
            - Select ancillary Providers
                - Dialysis centers
                - Physical therapists
                - Occupational therapists
                - Respiratory therapists
                - Mental health Providers

- Behavioral health treatment (BHT) Providers
- Speech therapy Providers
- Doulas
- Community Health Workers

- Ineligible Provider Types:

  - All other ancillary Providers, such as:
    - Radiology
    - Laboratory
    - Non-emergency medical transportation (NEMT)
    - Non-medical transportation (NMT)
    - Other ancillary services
  - Non-enrolled Medi-Cal Providers

e) AAH will ensure that there is no disruption to the relationships between all transitioning members and their PCPs.
   - All transitioning members may request CoC for eligible providers for up to 12 months.
   - AAH will provide more than 12 months of CoC for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including three trimesters of pregnancy, the immediate postpartum period, and 12 months following diagnosis of maternal mental health condition or end of pregnancy, whichever is later). The postpartum period is defined as 12 months
   - ~~e)~~ AAH will retain at least 90% of the transitioning members' PCPs either as network providers or through CoC for provider agreements. If AAH is unable to enter into a contract with a member's PCP, and the member requests to continue with their PCP, AAH will offer a Letter of Agreement (LOA) if all requirements are met. AAH will ensure that the members have the same PCP assignment as they had through their previous MCP, either through the providers' network participation or an LOA. Since the member is already included in the PCP's panel, a closed panel nor a status that the PCP is not accepting new members will affect the assignment of the member to their PCP. If a member wishes to change their PCP, they must notify AAH to assist with obtaining a new PCP.

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f) For coordination of care and care transition efforts, AAH will adhere to the requirements of HCS 1373.96, and will allow non-contracted providers to continue a member's treatment plan for ineligible provider types that are delivering non-contracted services.

g) To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting AAH. The requester may contact AAH prior to the date of service up until December 31, 2024.

g) If the services were rendered prior to the CoC request, the requester must contact AAH within 30 calendar days after the date of service. Upon receiving the request, AAH will confirm that the request meets the CoC requirements listed in section 2 above.

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h) AAH will accept requests made over the telephone, electronically, or in writing, according to the requester's preference. AAH will ensure that transitioning members are able to access assistance from AAH's call center starting November 1, 2023, prior to their enrollment with AAH before January 1, 2024. AAH will confirm that the requirements in the DHCS Managed Care Plan Transition Policy Guide, section on CoC for Providers are met. If requirements are met, AAH will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into an LOA for the member's care and notify the provider and member. AAH will notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of AAH's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email. The timeframe for processing requests and notifying the member and provider will be within the following timeframes appropriate to the member's condition:

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

- These timeframes apply to requests made prospectively. If the prospective request is made in advance of January 1, 2024, then AAH will complete processing the request by January 1, 2024, or according to these timeframes, whichever is later.
- Retroactive requests are not considered urgent or immediate.

4. AAH will ensure that transitioning members who seek assistance before January 1, 2024, while not yet enrolled in AAH are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

5. Provider Agreements

   a. When a CoC for Providers agreement is established, AAH will work with the eligible provider to ensure no disruption in services for the member.
   b. AAH will direct the eligible provider not to refer the member to other OON providers without prior approval from AAH.
   c. After establishing a CoC for Providers agreement with the eligible provider, AAH will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the DHCS Medi-Cal Managed Care Plan Policy Guide, and as agreed upon with the provider.
   d. As the end of the agreed-upon CoC period approaches, AAH will establish a process to transition the member to a network provider.
   e. Sixty calendar days before the end of the CoC for Providers period, AAH will notify the member and the eligible provider about the process for transitioning the member's care.
   f. AAH will identify a network provider, will engage the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of covered services through the transition to the network provider.
   g. If AAH and the eligible provider are unable to reach an LOA, AAH will offer the member an alternative network provider in a timely manner, so the member's service is not disrupted.
   h. If the member does not actively choose an alternative network provider, AAH will refer the member to a network provider
   i. If there is no network provider to provide the Covered Service, AAH will arrange for an OON provider.

6. Enhanced CoC Protections for Special Populations:

   a. Upon receiving data for Special Populations, AAH will proactively begin the Continuity of Care for Providers process

b. AAH will review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024, by January 1, 2024, or within 30 calendar days of receiving data for Special Populations, whichever is sooner.
c. AAH will contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement if requirements in Section V.C of the 2024 MCP Transition Policy Guide are met.
d. AAH will notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:
e. If the member's provider is in Network or is brought in Network as a result of AAH's outreach, then AAH will send notification that the member may continue with his or her provider.
f. If the member's provider is OON and AAH establishes an LOA, then AAH will notify the member that the length of time that they can stay with their provider.
g. If the provider is OON and cannot establish an LOA, AAH will send notification that the member must change to a network provider and assign the member a new network provider.
h. In all cases, the notification will include that the member may choose to change providers and comply with the notification requirements in DHCS 2024 MCP Transition Policy Guide Section V.C. Expectations of the Receiving MCP, and with the required timeline in Figure 6 of the DHCS 2024 MCP Transition Policy Guide
i. During the 6-month CoC for Services period, AAH 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.

7. Enhanced Protections for Members Accessing the Transplant Benefit

    a. If AAH is unable to bring a Transplant Program in Network, AAH will make a good faith effort to:
        1. Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in the DHCS 2024 MCP Transition Policy Guide, section V.C and according to the following terms:
            i. Make explicit the existing statutory requirement that AAH will pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)
            ii. Permit the LOA agreement to continue for the duration of the member's access to the transplant benefit.
        2. If AAH is unable to enter into a CoC for Providers agreement, AAH will:
            i. Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in Figure 6

of the DHCS Medi-Cal Managed Care Plan Transition Policy Guide:

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers
Special Populations	30 calendar days from receipt of Special Populations data	7 calendar days

ii. Explain in writing to DHCS why the provider and AAH could not execute an LOA.

b. AAH will 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)

c. AAH will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

8. Continuity of Care for Covered Services

a. AAH will ensure that all transitioning members continue receiving Covered Services (Services) without seeking a new authorization from AAH during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024.

b. AAH will honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and AAH obtains documentation of the Prior Authorization within the 6-month CoC for Services period. If the request is received before transitioning members are enrolled with AAH on January 1, 2024, AAH will be able to accept and process requests beginning November 1, 2023. Upon receipt of Prior Authorization data, AAH and the member will 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 LOA. If the member needs to continue the service after 6 months, the provider will need to request a new authorization from AAH. AAH will allow members to continue an Active Course of Treatment without Prior Authorization for the 6-month CoC for Services period. AAH and the member will work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a LOA.

i. An Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024, and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

c. During the 6-month CoC for Services period, AAH 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.

9. AAH will 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.
    a. This policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case AAH allows the delivery and permits the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.
10. Transportation Benefits: Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
    a. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then AAH will make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider.
    b. AAH will work with the Previous MCP to support continuation of NEMT/NMT services for transitioning members by the Previous MCP providing authorization data and transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to AAH on November 12, 2023, and refresh weekly starting in December 2023.
11. Continuity of Care and Management of Information during the transition to a Single Plan Model.
    a. The Previous MCP will transfer share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

    b. The Previous MCP will provide to AAH, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members.

    c. AAH will proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.

    d. The Previous MCP will share complete the transfer of supportive data for these members before January 1, 2024, or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

    e. AAH will receive the members known to be receiving inpatient care by December 22, 2023, from the Previous MCP, and will refresh that information daily through January 9, 2024, including holidays and weekends.

        i. Once a member is known to AAH as being in inpatient hospital care, either through the Previous MCP or via other means, AAH will contact the hospital to provide for completion of and coordination of the member's care. AAH will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.

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f. AAH will obtain confirmation from the Previous MCP to ensure that they completed all data transfer sharing activities as described below in the Continuity of Care Data Sharing Policy:
   i. The Previous MCP will transmit DHCS required utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to AAH.

12. Acceptance of requests may be from the Member, authorized representative, or Provider. The Alliance will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by phone, electronically or in writing, according to their preference. To complete a telephone, electronic or written request, the Alliance will take any necessary information required to complete the request using the members' preferred method.

4. Retroactive Continuity of Care

   a. Members are able to receive retroactive continuity of care – meaning they can see their prior provider(s) while the Alliance processes a continuity of care request. All continuity of care requirements continue to apply, including a validated pre-existing relationship between the member and provider. The Alliance will retroactively approve and reimburse providers for continuity of care for services that were already rendered if requirements are met.
   b. The member, authorized representative, or provider submitting the continuity of care request must submit the request within 30 calendar days of the first service provided after the member joins the Alliance. The provider can continue to treat the member for those 30 days and will be reimbursed if all continuity of care requirements are met.
   c. Once the Alliance and provider have agreed to terms, the provider must agree to follow the Alliance's utilization management requirements.

5. Validating Pre-existing Relationship

The Alliance will determine if a relationship exists through use of data provided by DHCS to the Alliance, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the Alliance that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the Alliance makes this option available to the member.

6. Acknowledgment of CoC request

The acknowledgement will advise the member that the CoC request has been received, the date of receipt and the estimated timeframe for resolution. Communication will be done using the Member's know preference of communication or by telephone or mail within the following timeframes:

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- 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 of the decision

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7. Request Completion Timeline

Continuity of care begins when the Alliance receives the CoC request. The Alliance will determine if the member has a pre-existing relationship with the provider, the provider is willing to accept the Alliance contract rates or Medi-Cal FFS rates, has no disqualifying quality of care issues and is a CA State Plan approved provider.

a. Each continuity of care request are completed within the following timelines: (all decisions will be communicated to the member by mail)

i. Thirty calendar days from the date AAH received the request for non-urgent requests.

ii. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs: or,

iii. Three calendar days for urgent requests if there is risk of harm to the member.

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

i. The member is informed of his or her right of continued access.

ii. The Alliance and the out-of-network FFS or prior MCP provider are unable to agree to a rate;

iii. The Alliance has documented quality of care issues; or

iv. The Alliance makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

8. Requirements after the Request Process is Completed.

i. If the Alliance and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate, or the Alliance has

documented quality of care issues with the provider, the Alliance will offer the member an in-network alternative.

ii. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

iii. If a provider meets all of the necessary requirements, including entering into a Letter of Agreement or contract with the Alliance, the Alliance 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 Alliance for a shorter timeframe. In this case, the Alliance allows the member to have access to that provider for the shorter period of time.

iv. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the Alliance works with the provider to establish a care plan for the member.

v. Upon approval of a continuity of care request, the Alliance notifies the member by mail of the following within seven calendar days and no more than 3 calendar days for urgent requests:

- The duration of the continuity of care arrangement.
- The process that will occur to transition the member's care at the end of ~~t~~the continuity of care period.
- The member's right to choose a different provider from the Alliance's provider network.

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vi. Upon denial for CoC services the Alliance will notify the member by mail and provider by fax within seven (7) days with:

- A statement of the denial decision.
- A clear and concise explanation for the reasons for denial.
- Rights and responsibilities to file a grievance and/or appeal.

vii. The Alliance notifies the member 60 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 an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the

continuity of care period to ensure continuity of services through the transition to a new provider.

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viii. ~~h.~~ if the member does not continue services from their pre-existing provider the Alliance will arrange for CoC covered services without delay with an in-network provider or if there is no network provider with an OON provider.

9. The Alliance's Extended Continuity of Care Option: The Alliance may choose to work with the member's out-of-network provider past the 12-month continuity of care period, but the Alliance is not required to do so to fulfill its obligations under state contractual requirements. Extended CoC will be provided to following Special Populations:

Special Population	Duration
Receiving Hospice Care	For the 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

10. Member and Provider Outreach and Education

a. The Alliance will inform members of their continuity of care protections and includes information about these protections in member information packets and handbooks and on the Alliance website. This information includes how the member and provider initiate a continuity of care request with the Alliance. The Alliance will translate these documents into threshold languages and make them available in alternative formats, upon request. The Alliance provides training to call center and other staff who come into regular contact with members about continuity of care protections.

b. Provider Referral Outside of the Alliance's Network

i. An approved out-of-network provider must work with the Alliance and its contracted network and must not refer the member to another out-of-network provider without authorization from the Alliance. In such cases, the Alliance will make the referral, if medically necessary, and if the Alliance does not have an appropriate provider within its network.

ii. The Alliance will work with the approved OON provider and communicate its requirements on letters of agreement, referral, and authorization processes.

11. Medi-Cal FFS to Managed Care Transition:

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a. The Alliance will use treatment authorization requests (TAR)data or prior authorization (PA) data to identify PA authorizations, including authorized procedures, surgeries, DME, medical supplies, OP rehab, respiratory therapy, or behavioral health
b. Active prior treatment authorizations for services remain in effect for 90 days and will be honored by the Alliance without a request by the member, authorized representative, or provider;
c. The Alliance 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;
d. 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 an Alliance network provider, whichever is shorter;
e. If the Alliance does not complete a new assessment, the active treatment authorization remains in effect and after 90 days
f. the Alliance may reassess the member's prior treatment authorization at any time
g. A new assessment is considered complete if the Member has been seen in person and/or via synchronous telehealth by a network provider and the 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
h. Where a service has been rendered with an OON provider and that provider satisfies the CoC requirements, the Member, authorized representative, or provider may request CoC retroactively to cover the service. (see #4)
i. If reassessing Enhanced Care Management (ECM) authorizations after 90 days, the Alliance will reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria. The Alliance will provide continuity of care with an out-of-network provider for FFS members who voluntarily transition to the Alliance to receive Enhanced Care Management (ECM) services.

12. Mental Health Plan Transition into Medi-Cal Managed Care:

a. The Alliance covers required outpatient mental health services for beneficiaries 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 specialty mental health services (SMHS) for beneficiaries who meet the medical necessity criteria for SMHS.

b. A member can request continuity of care with an out-of-network SMHS provider in instances where the member's mental health condition has stabilized such that the member no longer qualifies for SMHS and the responsibility for the member's mental health services transitions from the MHP to Alameda Alliance for Non-Specialty Mental Health Services (NSMHS). CoC only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medi-Cal State Plan, to provide NSMHS. 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 MHP provider in accordance with the requirements mandated by the state.

After 12 months the member must choose a mental health provider in the Alliance network for NSMHS. If the member later requires additional specialty mental services, the 12-month CoC 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 AAH or changes MCPs (i.e., the Member does not have the right to a new 12 months of Continuity of Care).

13. ~~13.~~Behavioral Health Treatment for Members Under the Age of 21 Upon Transition:

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a. The Alliance is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.

b. In accordance with existing contract requirements for Behavioral Health Treatment Coverage for Members Under the Age of 21, the Alliance will offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this policy are met.

c. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to AAH or the date of the member's initial enrollment AAH if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the Alliance will assign the member to that provider to continue BHT services.

d. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into the Alliance, or the date of the member's enrollment into the Alliance, if the enrollment date occurred after the transition.

e. The Alliance will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

~~c.~~14. ~~14.~~Transition of BHT Services from Regional Centers (RCs) to Alameda Alliance

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~~i.~~a. At least 45 days prior to the transition date, DHCS will provide the plan with a list of members for whom the responsibility for BHT services will transition from RCs to the Alliance, as well as member-specific utilization data.

~~ii.~~b. The Alliance considers every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide the Alliance with member utilization and assessment data from the RC prior to the service transition date. AAH uses the DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member's parent or guardian files a request for continuity of care.

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~~iii.~~c. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the Alliance will attempt to contact the member's parent or guardian to determine their preference. If the Alliance does not have access to member data that identifies an existing BHT provider, the Alliance will contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the Alliance in offering continuity of care.

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~~iv.~~d. If the RC is unwilling to release specific provider rate information, then the Alliance may negotiate rates with the continuity of care provider without being bound by the usual requirement that the Alliance offer at least a minimum FFS-equivalent rate. If the Alliance is unable to complete a continuity of care agreement, the Alliance ensures that all ongoing services continue at the same level with an Alliance in-network provider until the Alliance has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.

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~~v.~~e. AAH uses the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

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15. Existing Continuity of Care Provisions Under California State Law:

a.

In addition to the protections set forth above, the Alliance members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), the Alliance will allow members to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) 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 Alliance-contracting provider.

Additional requirements pertaining to continuity of care are set forth in Health and Safety Code (HSC) §1373.96 and require the Alliance to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are

required to complete services for the following conditions: 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 up to 12 months), pregnancy (all trimesters, delivery and 12 months post- partum), terminal illness (for the duration of the terminal illness which may exceed 12 months), the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the health plan as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

To maintain compliance with the law, the Alliance allows for completion of covered services as required by HSC §1373.96, to the extent that doing so allows member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this policy. The Alliance allows for the completion of these services for certain timeframes which are specific to each condition and defined under HSC §1373.96.

16. Pregnant and Post-Partum Beneficiaries:

As required by law (reference: HSC §1373.96) the Alliance will, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and 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. This process will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

The Alliance allows Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into the Alliance the right to request out-of-network provider continuity of care for up to 12 months in accordance with the Alliance's contract and the general requirements. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this policy (continuity of care for members transitioning from FFS to managed care).

17. Medical Exemption requests (MER):

a. A Medical Exemption Request is a request for temporary exemption from enrollment into a MediCal 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 AAH provider of the same specialty without deleterious medical effects.
b. A MER only applies to Members transitioning from Medi-Cal FFS to AAH.
c. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under these circumstances.
d. AAH is only required to consider MERs that have been denied as an automatic continuity of care request to allow to the Member to complete a course of treatment with a Medi-Cal FFS provider
e. The Alliance considers MERs that have been denied as an automatic continuity of care request to allow the member to complete a course of treatment with a Medi-Cal FFS provider.

18. Covered California Medi-Cal Transitioning members:

a. This section specifies provisions for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year.

b. To ensure that continuity of care and coordination of care requirements are met, the Alliance asks these members if there are upcoming health care appointments or treatments scheduled and assist them. If the member requests CoC, the Alliance will help in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights.

c. When a new member enrolls in the Alliance, the Alliance contacts the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this section are included in this initial member contact process.

d. The Alliance will make a good faith effort to learn from and obtain information from the M~~m~~ember so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

e. The Alliance will honor any active prior treatment authorizations for up to 90 days 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 AAH, whichever is shorter. FFA new assessment is considered completed by the Alliance if the member has been seen by an Alliance contracted provider, (in person and/or via

synchronous Telehealth,) and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations are honored without a request by the member or the provider

f. The Alliance will, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this policy.

19. When the Alliance and the OON treating provider are unable to reach an agreement with the terminated or OON provider because they cannot agree to a rate or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, the Alliance is not required to continue the provider's services. If the Alliance has documented quality of care issues with the provider, the Alliance will offer an in-network alternative.

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a. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.
b. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

20. DME equipment rentals and medical supplies will be honored without a request by a member or provider. If the DME or medical supplies have been arranged, but the equipment or supplies shave not been delivered, the Alliance will allow for the delivery of the equipment and supplies for a minimum of 90 days following enrollment until the Alliance can complete a new assessment. The original authorization will remain in effect for the duration of the treatment authorization. After 90 days, the Alliance may reassess at any time and move the member to a network DME provider.

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21. For Non-emergency medical (NEMT) and non-medical (NMT) transportation services the member will be allowed to keep the modality of transportation under their previous prior authorization with a network provider until a new assessment can be made.

22. For Enhanced Care Management (ECM) authorizations after 90 days are reassessed using the ECM discontinuation criteria and not the ECM population of focus eligibility criteria.

23. 12-Month continuity of Care Period Restart

a. if a member changes MCPs by choice following the initial enrollment or if a member loses and then later eligibility during the 12-month CoC period, the 12-month CoC for a pre-existing provider may start over one time. For example, if a member enrolls in on 1/1/23, but then changes to a different MCP by choice on 5/1/23, the CoC may start over one time and the member may see that provider until May of the following year.

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b. If a beneficiary changes their Medi-Cal MCP a second time or more, the COC period does not start over. The beneficiary does not have the right to a new COC 12-month period. If the beneficiary returns to Medi-Cal FFS and later reenrolls in a

Medi-Cal MCP, the COC period does not start over. If the member changes their Medi-Cal MCP, this COC policy does not extend to Providers they utilized under their other managed care plan.

24. Scheduled Specialty Appointments
    a. the Alliance will allow transitioning members to keep authorized and scheduled specialist appointments with OON providers when CoC has been established and the appointments occur during the 12-month CoC period.
    b. if a member or provider requests to keep scheduled specialist appointments with an OON provider and the member has not seen the provider in the previous 12 months and there is no established relationship with the OON provider, the Alliance make a good faith effort to arrange for the member to keep the appointment with a network provider on or before the appointment with the OON provider. If the Alliance is unable to do so, since the appointment is after transitioning to the Alliance and there is no pre-existing relationship, CoC would not apply.

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25. Delegates are required to comply with all applicable state and federal laws and regulations, contract requirements and other DHCS guidance, including All Plan Letters.

PROCEDURE

1. Initiation of non-MER request:

    a. Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to the Alliance for continuity of care.

    b. When this occurs, the Alliance begins to process the request within five working days following the receipt of the request, however, the request is completed in three calendar days if there is a risk of harm to the member. For the purposes of this policy, "risk of harm" is defined as an imminent and serious threat to the health of the member.

    c. The continuity of care process begins when the Alliance starts the process to determine if the member has a pre-existing relationship with the provider.

    d. The UM Coordinator receives request for CoC through the HealthSuite Service Request, facsimile, or telephone call from provider.

        1 The Alliance accepts requests for continuity of care over the telephone, according to the requester's preference, and does not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a

telephone request, the Alliance may take any necessary information from the requester over the telephone.

e. The UM Coordinator verifies eligibility and product line, creates a shell authorization request in the Clinical Information System (TruCare), selects indicator for non-MER CoC and routes request to appropriate UM Clinical Specialist.

f. The UM Clinical Specialist reviews the request, contacts the Member or Provider for any additional information to determine the type of CoC service required and document existence of an existing relationship.

1 Existing relationships can be validated through data provided by DHCS to The Alliance, such as Medi-Cal FFS utilization data.

2 A Member or his or her provider may also provide information demonstrating a pre-existing relationship with a provider.

3 A Member may not attest to a pre-existing relationship; actual documentation must be provided.

g. The UM Clinical Specialist obtains all necessary information to assist in making the initial determination, i.e., medical records, eligibility segments, claims.

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

1 Approvals – UM Clinical Specialist contacts Member to inform them of the approval determination and next step. The UM Clinical Specialist:

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

2. Reviews applicable websites to verify Provider does not have any quality of care restrictions.

3. Notifies Provider Relations (PR) to begin Letter of Agreement process, initiates PR communications.

4. 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.

2 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 Behavioral Health Practitioner with all of the information documented in TruCare authorization requests.

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

1 If determination is to approve, the UM Medical Director/doctoral Behavioral Health Practitioner 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.

2 If determination is to deny, the UM Medical Director/doctoral 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.

j. Development of Plan of Care

1 The Alliance UM Department UM staff or Behavioral Health staff as appropriate 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.

k. Transition to In-Network Services

1 The Member may change their provider to an in-network provider at any time regardless of whether or not the CoC relationship has been established.

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

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

2. One month prior to the expiration of the OON authorization, the UM and CM/BH Departments will coordinate with the Provider and the Member to begin transitioning back services to the in-network provider.

3 When the Alliance and the OON treating provider are unable to reach an agreement because they cannot agree to a rate or the Alliance has documented quality of care issues with the provider, the Alliance will coordinate with the PCP or assigned Provider Group to identify an in-network alternative.

1. If the Member does not make a choice, the Member will be referred or assigned to an in-network provider.

2. If the Member disagrees with the result of the CoC process, the Member maintains the right to pursue a grievance and/or appeal.

l. The Alliance submits reports related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.

m. Delegation

1 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

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.

Applied Behavioral Treatment (ABA): means services provided under a behavioral treatment plan that has measurable goals over a specific timeline for the specific beneficiary being treated and developed by a qualified autism service provider.

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.

Autism Spectrum Disorder (ASD): means a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS) and Asperger syndrome. These conditions are now all called ASD.

Behavioral Health Treatment (BHT): means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

California State Plan: In response to the CMS guidance and in accordance with Title 42 Code of Federal Regulations Section 440.130©, 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.

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.

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.

Durable Medical Equipment (DME): means any medical equipment necessary to use in the home to aid a better quality of living.

Early, Periodic Screening, Diagnosis, and Treatment Services (EPSDT): means the federal program requiring states to provide screening, preventive, and medically necessary diagnostic and treatment services, to members of Medicaid Managed Care 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.

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

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:

1. 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 2, "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.
    ~~d.~~

2. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the 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.

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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.

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

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

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.

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

Quality of Care Issue (DHCS definition) means The Alliance can document its concerns 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.

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

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.

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"
- UM-058, "COC for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption".

➢ UM-002 Behavioral Health Services

REVISION HISTORY

5/3/2018, 4/19/2019, 5/21/2020, 3/18/2021, 3/22/2022, 06/20/2023, 12/19/2023, 04/25/2024

REFERENCES

- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- APL 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
- APL 20-017 Requirements for Reporting Managed Care Program Data (Supersedes APLs 14-013 (Revised) and 14-012)
- ~~All Plan Letter (~~APL ~~)~~ 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (Supersedes APL 19-014)
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- ~~2024 Medi-Cal Managed Care 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. (Supersedes All Plan Letters 22-032, 18-008, 15-019, 14-021 and 13-023)
- 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

- ~~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~~
- ~~All Plan Letter 20-017 Requirements for Reporting Managed Care Program Data~~
- Duals Plan Letter 15-003 Continuity of Care
- ~~All Plan Letter 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21~~
- Health and Safety (H&S) Code §1373.96, 1371.8, 1373.65, 1373.95
- Welfare and Institutions Code §14185

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.
2. Internal Monitoring
   a. The Utilization Management Department, on a routine basis, reviews:

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i. Logs/Reports of the various continuity of care requests. Quarterly audits are performed on selected files to ensure compliance with the regulatory requirements.

b. 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.

c. 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.

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.