POLICY AND PROCEDURE

DEPARTMENT: Population Health Clinical Operations (PHCO)	**REFERENCE NUMBER: CA.UM.COM.20 V12**
EFFECTIVE DATE: 11/19/2010	**P&P NAME: COC-Commercial**
REVIEWED/REVISED DATE: 6/24/2026	**RETIRED DATE:**
BUSINESS UNIT: Public Programs	**PRODUCT TYPE: Commercial, HMO, PPO**
REGULATOR MOST RECENT APPROVAL DATE(S):	

SCOPE:
This policy applies to all directors, officers, and employees of Health Net, its affiliates, health plans, contractors and subsidiary companies (collectively, the "Plan") who are responsible for providing Continuity of Care (COC) benefits to the Plan's qualifying members. Health Net does delegate COC responsibility to Participating Provider Groups (PPG) as full risk and shared risk PPGs may be responsible for their own COC reviews.

PURPOSE:
The purpose of this policy and procedure is to identify the regulatory processes to provide COC benefits to eligible Plan members. The objective is to establish procedures to provide continuity-of-care and/or completion-of-care to Plan members who are eligible including when they are affected by the termination of a provider, practice site or change in Member's Plan including new Members who join the Plan from another insurer, or as otherwise set out in this policy.

DEFINITIONS:
Active Course of Treatment: An ongoing treatment for members in which discontinuation could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.
Acute: A serious and sudden condition that lasts a short time and is not chronic. Examples include heart attack, pneumonia, or appendicitis.
Acute Condition: A medical or behavioral health 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.
Affected Enrollee: means enrollees of the plan who are assigned to a Terminated Provider Group or a Terminated Hospital.
Alternate Hospital: means a hospital that will provide services to plan enrollees in place of a Terminated Hospital.
Authorize/Authorization: When the Plan approves treatment for covered health care services.
Benefits: Health care services, supplies, drugs, or equipment that are medically necessary and covered by a Commercial Health Plan.
Block Transfer: means a transfer or redirection of two thousand (2,000) or more enrollees by a plan from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.
Business Day: The term *business day* means Monday through Friday, except the legal public holidays specified in *5 U.S.C. § 6103*, any day declared to be a holiday by federal statute or executive order, or any day with respect to which the U.S. Office of Personnel Management has announced that Federal agencies in the Washington, DC, area are closed.
Care Manager: A Plan professional who is employed to manage and coordinate medical cases to ensure quality and efficient use of health care resources.

Chronic: A condition that is long-term and ongoing and is not acute. Examples include diabetes, asthma, allergies, and hypertension.

Continuity of Care (COC): Is the process by which the Member and the Provider are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.

Continuity of Care Request Form: The form used by Members or their authorized representative to request consideration and assistance during the Continuity of Care process.

Customary Participating Provider Rate: Payment rate used by the Plan for currently contracted Providers who provide similar services in the same or similar geographic area as the terminated or Non-Participating Provider.

Delegated Partner: A contracted entity given authority to perform certain functions on behalf of the Plan. Those functions include but are not limited to claims processing, customer service, utilization management, complex care management, disease management, appeals and grievances.

Delegated Partner Closure: The closure of a medical group due to bankruptcy, acquisition, or contract termination by the Plan or the Preferred Provider Group (PPG).

Delegation: The formal process by which the Plan determines whether a contracting partner is delegated the responsibility for performing specified activities in any of the following programs: Utilization Management, Claims Processing, Customer Service and Member Connections, Disease Management, Complex Case Management, Pharmacy Management, Behavioral Health Management, Credentialing and re-credentialing, Appeals and Grievances.

Disability: A physical or mental condition that substantially limits a person's ability in at least one major life activity.

Enroll/Enrollment: The process by which a member joins the Plan's available health coverage.

Enrollee Transfer Notice: means a written notice that is sent to enrollees who are assigned to a Terminated Provider group or terminated hospital.

Exclusions: Any medical, surgical, hospital or other treatments for which the Plan's Program offers no coverage.

Existing Member Eligible for Continuity of Care: A member whose commercial group changes to or adds any Health Net HMO product that includes a reduced network from the group's current Health Net HMO product, Health Net will offer the same scope of continuity of care for completion of services as addressed in this policy, regardless of whether the group enrollee had the opportunity to retain his/her current provider by selecting either:

1. a Health Net product with an out-of-network benefit;
2. a different Health Net HMO network product that includes the enrollee's current provider; or
3. another carrier's product.

Existing Relationship/Ongoing Relationship (specific to this policy): a Member who, at the time of the contract's termination, was receiving services from that provider.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care: Standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to *Section 1374.73*. Valid, evidence-based sources establishing generally accepted

standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Maternal Mental Health Condition: A mental health condition that can impact a member during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. (*California (CA) Health and Safety (H&S) Code § 1373.96 (n) (2)*).

Medically Necessary/Medical Necessity (DMHC For Products/Plans enrolled through Large Employer Groups): means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medical Necessity: Except where state or federal law or regulation requires a different definition, Health Net defines "Medically Necessary" or comparable term in each agreement with Physicians, Physician Groups, and Physician Organizations and will not include in any such agreement a definition of Medical Necessity that is different from this definition.

"Medically Necessary" or "Medical Necessity" shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" mean standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

All medical necessity determinations by the health care service plan concerning service intensity, level of care placement, continued stay, and transfer or discharge of enrollees diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of *Section 1374.721.*

Pursuant to Insurance Code, Section 10144.52 Health Net bases any medical necessity determination or the utilization review criteria that the Plan, and any entity acting on the Plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental

health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Member: means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health and Substance Use Disorders: means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

New Member: A newly enrolled member with the Plan.

Non-Participating Provider: A licensed health care professional or facility which does not have a service contract with the Plan or respectively, with an affiliated Delegated Partner or contracted facility, and is responsible for providing health care services for the Member who has requested completion of services with that professional or facility at the in-network benefit level.

Participating Provider: A physician, ancillary service Provider, hospital or health center that is contracted with the Plan or a subcontractor of the Plan, who provides covered services to Plan members.

Participating Physician Group (PPG): A group of physicians contracted with the Plan to furnish medical services to Plan Members.

Practice Site: An office or facility where one or more providers provide care or services.

Pregnancy: (Policy related definition) The three trimesters of pregnancy and the immediate postpartum period.

Prior Authorization: The formal process requiring a health care provider to obtain advanced approval to provide specific services or procedures. Prior authorization is required for most services or care; however, for emergency or out-of-area urgent care services, prior authorization is not required or needed.

Provider: The term includes Providers contracted with the Plan sponsor, non-contracted Providers, and sub-contractors, including, but not limited to, pharmacists, pharmacies, physicians, hospitals and long-term care facilities.

Provider Group: means a medical group, independent practice association, or any other similar organization.

Quality of Care Issue: Any alleged act or behavior by a network Provider or provider that may be detrimental to the quality or safety of member care or care is not compliant with evidence-based standard practices of care.

Sensitive Services: All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner

violence, and includes services described in *Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929 6930 of the Family Code, and Sections 121020 and 124260 of the CA H&S Code*, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition: A member's medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: Persists without full cure or worsens over an extended period or requires ongoing treatment to maintain remission or prevent deterioration.

Special Populations: Individuals living with complex or chronic conditions. This designation is designed to focus attention and resources on transitioning members, to minimize the risk of harm from disruptions in their care.

Specialist: A physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified or recognized by a board of physicians or like peer group, or an organization offering qualifying examinations (board certified) as having special expertise in that clinical area of practice.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing a member's death within one year or less. (*CA H&S Code Section 1373.96*).

Terminated Provider: A Provider whose contract to provide covered services to members is terminated or not renewed by the Plan or one of The Plan's Delegated Partners.

Utilization Review: Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.

Utilization Review Criteria: Any criteria, standards, protocols, or guidelines used by the Plan to conduct utilization review.

With Cause: Provider's termination is due to, including, but not limited to, credentialing term, hospital privileging, utilization review, peer review, and quality issues.

Without Cause: An elective termination, leaving the network, moving out of area.

POLICY:

The Plan provides eligible members Continuity of Care (COC) assistance when the Member is affected by termination of a provider, practice site, or change in the Member's Plan. Other individuals who do not have appropriate legal authorization may not request assistance for the enrollee. The enrollee will be contacted directly by the Plan associate if this instance occurs to confirm the Member request.

PROCEDURE:

I. Eligibility

A. Continuity of Care may apply in the following instances:
   1. Delegated Partner change – because of a Delegated Partner closure.
   2. Primary Care Provider (PCP) or physician specialist change –because the PCP or specialist changes his/her affiliation with a Delegated Partner or termination of the contract with Health Net.

3. A Health Net provider contract with a hospital is terminated or a new group member is receiving services eligible for COC from a Non-Participating hospital.
4. Members that are involuntarily transferred to another Delegated Partner.
5. New group Member joining Health Net from another insurer or for members of existing Health Net commercial groups changing to any Health Net HMO product that includes a reduced network from the group's current Health Net HMO product.
6. Specific employer benefit change (e.g., change from an employer selected provider to Health Net provider).
7. Continuity of Care with a non-contracted mental health provider for a new group member when the member's employer has changed to Health Net coverage.
8. Psychologist or other providers deliver behavioral health treatment whose contract with Behavioral Health Administrator is terminated.
9. New IFP members who are new to the Plan who were affected by the withdrawal of previous coverage from any portion of a market.

II. Continuity of Care is not applicable in the following instances:

A. Members who are not in an Active Course of Treatment for one of the designated conditions as identified in *CA H&S Code 1373.96(c)* or whose request for continued treatment for an acute condition does not meet medical necessity.

B. Continued care provided by a physician that has been terminated due to disciplinary action relating to a medical disciplinary cause or reason, as defined in *paragraph (6) of subdivision (a)* of *Section 805* of the *Business and Professions Code*, or fraud or other criminal activity.

C. Member or his/her authorized representative failed to submit a "Health Net Member Continuity-of-Care Request Form" within timeframes and conditions outlined in their respective Evidence of Coverage (EOC).

D. The Terminated Provider does not agree to provide care to the member through the completion of care period under terms and conditions of the terminated Participating Provider Agreement. Health Net may require a non-participating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Non-Participating Provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the non-participating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

E. If a member change plans by choice following the initial enrollment, who had the option to continue with their previous health plan or provider and instead voluntarily chose to change health plans. (See *H&S Code 1373.96 (j)*).

Active Prior Treatment Authorizations: The Plan will honor any active prior treatment authorizations for 90 days for covered services. The Plan will arrange for services authorized under the active prior treatment authorization with Network Provider, or if there is no Network Provider, with a Non-Participating Provider. After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the Plan, whichever is shorter. Prior treatment authorizations will be honored without a request by the Member, Authorized representative or Provider. The Plan will, at the request of the Member, authorized representative, or Provider's request, offer up to 12 months *(See H&S Code 1373.96)*. In the instance of a block transfer, the Plan will transfer the Member to an in-network provider if applicable. If the Member has an active prior treatment authorization the Member will continue to receive their treatment as authorized (*H&S Code 1373.65*).

A. The Plan allows eligible Members to continue seeing a terminated or non-participating Provider at the member's, authorized representative's, or Provider's request to complete covered services for specific conditions *(CA H&S Code Section 1373.96)*.
B. The Plan also allows for completion of covered services to the extent that doing so would allow a member a longer period of treatment by an out-of-network Provider than would otherwise be required *(H&S Code Section 1373.96).*

III. Non-Participating Provider Eligibility to Provide COC Benefits:

A. In an instance where a Member would like their Non-Participating Provider to provide a service and they have a pre-existing relationship with the Non-Participating Provider, they may make a COC request if they are transitioning from their current plan to a Health Net Commercial Plan.
B. The Plan must make a good faith effort to negotiate and enter into a Network Provider Agreement or a Letter of Understanding (LOU) for Providers agreement if all COC requirements are met, as follows:
    1. The provider is providing a service that is eligible for COC (see Members EOC for covered services)
    2. When the provider meets the Plans applicable professional standards and has no disqualifying quality of care issues; and
    3. When the provider is a licensed CA provider or otherwise legally authorized to furnish the requested covered service in the jurisdiction where the service is rendered.
C. Coverage is subject to provider network participation and plan-specific guidelines. Refer to specific plan documents (e.g. Summary of Benefits and Coverage, Provider Manual, and Evidence of Coverage) for full details of what is covered and excluded within the Plan COC benefits. When COC is approved, services by an eligible terminated or Non-Participating Provider will be administered using the applicable COC terms, including in-network cost-sharing treatment where required by law.

IV. The Plan receives the COC Request/Referral

A. The source for COC referrals can be, but is not limited to**:**

1. Member-submitted COC request form
2. Member Services
3. Provider Network
4. Open Authorization list from a terminated Delegated Partner received from Provider Network
5. Provider Services
6. Sales/Marketing
7. Worksite Wellness
8. Health Net Medical Directors
9. Health Net contracted Delegated Partners
10. Health Net members
11. Behavioral Health Administrator

For a Current Member Requiring a Delegated Partner Change due to a Delegated Partner Closure:

A. Provider Network Administrator (PNA) request from Delegated Provider a report to identify affected members. PNA Coordinates production of letters with Provider Transitions Unit and letters will be mailed out, by the Provider Transitions Unit, with required language instructing members how to get assistance with Continuity of Care if applicable. The Plan does not require that the member complete a form, but will accept a request for continuity of care via telephone from a requestor.

B. Provider Network Management will send out a broadcast informing the proper departments of the large termination with the member count that is affected.

C. For a Member requiring COC in the case of involuntary termination of a benefit plan or specialist(s) for a reason other than cause the Member Services Department will provide or assist the member in filling out the Health Net Continuity-of-Care Request Form and e-mail or fax it to the Continuity of Care Team.

D. Upon notification of a potential transitional care issue the Care Manager will contact current providers for treatment plan and coordination of care to the incumbent providers if appropriate. Continuation of Specialist will comply with Health Net's Continuity of Care criteria.

V. For a Current Member with involuntary Delegated Partner or PCP change:

A. The Customer Service department receives a phone call from a Member requesting assistance with Delegated Partner transfer or PCP change.

B. If the Customer Service staff identifies that the Member needs medical or behavioral health care coordination, he/she will complete a "Health Net Member Continuity-of-Care Request Form" for the Member and forward the form to his/her Supervisor for review.

C. The Customer Service Supervisor, after reviewing the Continuity of Care Form for its appropriateness and completeness, will forward it to Continuity-of-Care Team via fax, or email.

VI. For a New Member:

A. When the New Member or his/her authorized representative contacts Customer Service directly:

B. The New Member may contact Customer Services requesting Continuity-of-Care as he/she transfers from his/her previous health insurer to the Plan.

C. The Customer Service representative will contact the New Member to assist him/her with administrative issues/requests e.g., PCP and/or Delegated Partner selections and benefit explanations.
D. If the New Member requires medical or behavioral health care coordination, the Customer Service representative will obtain the necessary information and complete the "Health Net Continuity-of-Care Assistance Request Form," or in the case of behavioral health care, if more appropriate, the call will be transferred directly to the Behavioral Health Administrator.
E. The Customer Service Supervisor, after reviewing the transition form for its appropriateness and completeness, will forward it to Continuity of Care Team via fax, or email.
F. When the Sales/Marketing staff identifies a New Member in need of transitional care assistance:
   1. The Sales/Marketing staff, upon identifying a New Member requesting/requiring Continuity-of-Care, will provide the member with a "Health Net Member Continuity-of-Care Assistance Request Form" to fill out.
   2. The Member is instructed to send the completed form directly to the Continuity of Care Team.

VII. Provision for the completion of covered services for the following conditions:

A. The health care service plan shall provide for the completion of covered services for the following conditions:

(1) An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

(2) (A) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or Non-Participating provider and consistent with good professional practice.

(B) Completion of covered services under subparagraph (A) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

(3) (A) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

(B) 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 shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

(4) A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided

for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
(5) The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
(6) Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.

VIII. Continuity of Care Review Process:

A. The Continuity of Care Review Process is completed in alignment with the Utilization Management turnaround times as outlined in *CA H&S Code 1367.01*.
B. Based on Medical Necessity, benefit coverage, individual Member needs and Health Net UM policies and procedures, the Plan associate reviews each Member's COC request for COC eligibility and criteria under the direction of the Plan's Medical Director.
C. The Plan associate gathers available pertinent medical information/records from the Member, Delegated Partner staff and providers to assess the Member's care needs as indicated.
D. If transition to an in-network provider is indicated, the Member will be referred to Care Management for care coordination and support.
E. If the Member requests COC for his/her previous provider that is Non-Participating with Health Net/affiliated Delegated Partner and the member's condition/situation meets Continuity of Care criteria, the Non-Participating Provider is contacted to determine willingness to continue to care for this member under a standard Health Net agreement.
F. If the member requests COC for his/her Non-Participating/Terminated Provider, the Plan associate will evaluate the enrollee's application and medical records to determine if COC criteria are met in accordance with benefit coverage criteria.
   The Plan associate presents the member's case information to the Health Net Medical Director for review when the member's situation does not meet Continuity of Care criteria and when the time frame for course of therapy needs to be determined and within the applicable regulatory timelines (routine/urgent).
G. The Health Net Medical Director will evaluate the member's case and determine if an immediate change from the Non-Participating Provider to Health Net/affiliated Delegated contracted provider will have an adverse impact on the member's health outcome.

IX. Approvals:

A. Upon approval of the COC request, the Medical Director will specify the extent and duration of services to be provided to the member.
B. The Plan associate may refer to the Fee Negotiation Unit or other Provider Services contracting person to establish a contract with and send a LOU to the Non-Participating Provider. The Care/Case Manager

COC Registered Nurse will enter an authorization for the contracted service in the medical management system.

For approved COC services, the amount of and requirement for copayments, deductibles, or other cost-sharing components will be the same as would be paid by the Member if receiving care from a provider currently contracting with or employed by the Plan, unless a more protective product-specific or federal rule applies.

Unless otherwise agreed, services rendered by a terminated or Non-Participating Provider under this policy will be compensated at rates and methods of payment similar to those used by the Plan or Provider Group for currently contracting providers providing similar services who are not capitated and who practice in the same or a similar geographic area.

C. Communication of determinations to members and Providers will be made in accordance with applicable state and federal guidelines for notification.
   1. The Plan complies with Assembly Bill 1184 in regard to communication of Sensitive Services and will not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual
D. The Plan Associate coordinates care with the New Member, Non-Participating Provider, Delegated staff and member's PCP to facilitate continuous care delivery.
E. The Plan Associate documents the member's care coordination activities in medical management system; and also documents the approval decision, the extent and duration of the authorized service with the designated Non-Participating Provider.

X. Denials:

A. When the Plan's Medical Director has denied the Member's request to continue care with the previous Non-Participating Provider, a notice of determination is communicated to Member and Provider in accordance with applicable state and federal guidelines for notification.
   1. The Plan Associate coordinates in-network care with the Member's assigned Delegated Partner and refers the member to appropriate community resources as indicated.
B. The Plan Associate documents the Member's care coordination activities in the medical management system, including documentation of the denial, reason for denial, and the Plan's notice to the Member and provider.

XI. Timeline:

A. The Plan must begin to process non-urgent requests within five working days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request must be completed within the following timelines from the date the Plan received the request:
   1. Non urgent requests: 5 calendar days
   2. Urgent requests: within 72 hours of receipt of request.
B. Before sending any COC determination or related notice, the Plan must review whether the communication involves Sensitive Services, a protected individual, or a confidential communications

request. Subject to those requirements, the Plan must notify the Member of the final determination, by using the Member's known preference of communication or by notifying the Member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:

1. For non-urgent requests, within seven calendar days of the decision.
2. 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.

C. A Continuity of Care request is considered complete when the Plan notifies the Member of the Plan's decision. The Plan must notify the Member of the Continuity of Care decision via the Member's preferred method of communication or by telephone.

D. The Plan must also send a notice by mail to the Member within seven calendar days of the Continuity of Care decision.

E. The Plan must notify the Member 30 calendar days before the end of the Continuity of Care period, using the Member's preferred method of communication, about the process that will occur to transition the Member's care to a Network Provider at the end of the Continuity of Care period.

REFERENCES:

5 U.S.C. § 6103
California (CA) Health and Safety (H&S) Code §1373.65, §1367.01, §1373.95, §1373.96, §1374.72, §1374.73, §1374.721, §121020 and §124260
28 CCR §1300.67
CA Mental Health Parity Act
HR 133 Consolidated Appropriations Act, 2021, Division BB: Private Health Insurance and Public Health Provisions, Title I – No Surprises Act , Section 113: Ensuring Continuity of care
Assembly Bill 1184
California Insurance Code (CIC) §10144.5 to §10144.52 and §10133.56
Business and Professions Code subdivision (a) of Section 805
Family Code Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929 6930

SUPPORT/HELP:

If you need help with this policy, contact: Ed Mariscal, Navdeep Hyare

REVISION LOG

REVIEW TYPE (New, Annual, Ad Hoc)	**REVISION SUMMARY**	**DATE APPROVED**
Annual Review	Policy reference number updated from FS818-141122 to CA.UM.COM.20. References section updated for CA Mental Health Parity Act. Definitions added for medical necessity, mental	11/19/2020

	health and substance use disorder, utilization review and utilization review criteria.	
Ad Hoc Review	Policy Document PDF removed and changed to Word Version Copy.	3/18/2021
Ad Hoc Review	References section updated with: HR 133 Consolidated Appropriations Act, 2021, Division BB: Private Health Insurance and Public Health Provisions, Title I – No Surprises Act, Section 113: Ensuring Continuity of care. Changed to 2021 Template	4/5/2021
Ad Hoc Review	Policy Document PDF removed and changed to Word Version Copy.	3/18/2021
Ad Hoc Review	References section updated with: HR 133 Consolidated Appropriations Act, 2021, Division BB: Private Health Insurance and Public Health Provisions, Title I – No Surprises Act, Section 113: Ensuring Continuity of care. Changed to 2021 Template	4/5/2021
Ad Hoc Review	Benefit Exhaustion Section added. EPO LOB added.	7/15/2021
Ad Hoc Review	PPO exemption removed and added to applicable LOB.	9/10/2021
Ad Hoc Review	Definition for Maternal Mental Health Updated.	2/2/2022
Ad Hoc Review	Updated for Assembly Bill 1184, definition of Sensitive Services added	5/18/2022
Ad Hoc Review	P&P updated to align with Knox-Keene Act	10/03/2025
Annual	Moved to new template, formatting for clarity, changed “Care/Case Manager to “Plan associate”, removed reference to IFP	6/30/2023
Annual	Minor formatting	7/5/2024
Annual	No changes	7/18/2025
Annual	Re-write to include Non-Clinical COC	6/24/2026

POLICY APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.