POLICY AND PROCEDURE

DEPARTMENT: Population Health Clinical Operations (PHCO)	**REFERENCE NUMBER: CA.UM.20**
EFFECTIVE DATE:9/26/2025	**P&P NAME: Continuity of Care- Non Clinical**
REVIEWED/REVISED DATE: 12/19/2025	**RETIRED DATE:**
BUSINESS UNIT: Public Programs COC	**PRODUCT TYPE: Health Net Medi-Cal**
REGULATOR MOST RECENT APPROVAL DATE(S): 7/13/2021	

SCOPE:
This policy applies to all directors, officers, and employees of Health Net, Community Health Plan of Imperial Valley (CHPIV) its affiliates, health plans, other health plan contractors and subsidiary companies (collectively, the "Plan") who are responsible for providing Continuity of Care (COC) benefits to Plan's qualifying Medi-Cal Members who transition from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care.

PURPOSE:
The purpose of this policy and procedure is to identify how the Plan provides Medi-Cal Members with COC benefits in compliance with all federal and state regulatory requirements and guidance on COC for Members who are mandatorily transitioned from Medi-Cal FFS.

DEFINITIONS:
Active Course of Treatment: An ongoing treatment for Members in which discontinuity could cause a recurrence or worsening of their condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.
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 is provided for the duration of the acute condition or 12 months from the effective date of coverage for a newly covered Member.
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 Medi-Cal.
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/Transition of Care Form: The form used by Members, their authorized representative or provider to request consideration and assistance during the transitional 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 and Disease Management.
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 Care Management, Pharmacy Management, Behavioral Health Management, credentialing, and re-credentialing.

Department of Managed Health Care Services (DHCS): DHCS is the federally designated single state agency responsible for financing and administering the state's Medicaid program, Medi-Cal, which provides health care services to low-income persons and families who meet defined eligibility requirements. Medi-Cal is authorized and funded through a federal-state partnership. Medi-Cal programs cover physical health, mental health, substance use disorder, services, pharmacy, dental, and long-term services and supports. DHCS is also the single state agency for Substance Abuse and the State Mental Health Authority, and administers county-operated community mental health and substance use disorder programs, together known as behavioral health.

Diagnostic/Diagnosis: A condition, illness or disease identified by a doctor.

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

Enhanced Care Management (ECM): ECM is a Medi-Cal benefit that provides comprehensive care management services to Medi-Cal Members with complex health and/or social needs. Services are provided in the Member's community by contracted ECM provider agencies who serve the Member's specific population of focus. The goal is to improve the health and social outcomes of the ECM-enrolled Member.

Enroll/Enrollment: The process by which a Member joins the Plan's Medi-Cal Plan.

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

Existing Relationship/Ongoing Relationship (specific to this policy): This is when the Member has seen the requested out-of-network Provider (PCP or Specialist) at least once for a non-emergency visit during the 12 months prior to the date of the Member's initial enrollment in the Managed Care Plan (MPC). The Plan determines if a relationship exists using data provided by DHCS, such as Medi-Cal FFS utilization data. The Member, authorized representative, or his/her Provider may also provide information to the Plan which demonstrates a pre-existing relationship with a Provider. A Member may not attest to a pre-existing relationship in the place of actual documentation.

Fee-for-Service Medi-Cal, also known as Regular Medi-Cal: The component of the Medi-Cal Program, which Medi-Cal Providers are paid directly by the state for services.

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. (*CA Health & Safety Code § 1373.96 (n) (2)*).

Medical Necessity: means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under *W&I section 14059.5(a) and 22 CCR section 51303(a)*. Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the Medi-Cal for Kids and Teens standard of Medical Necessity set forth in *42 USC section 1396d(r)(5)*, as required by *W&I sections 14059.5(b) and 14132(v)*. Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the

Member's current health condition. The Plan determines Medical Necessity on a case-by-case basis taking into account the individual needs of the child.

A service need not cure a condition to be covered under Medi-Cal for Kids and Teens. Services that maintain or improve the child's current health condition are also covered under Medi-Cal for Kids and Teens because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child. (*APL 23-005*).

New Member: A newly enrolled person 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.

Other Health Coverage (OHC): Private health insurance. Services may include medical, dental, vision, pharmacy, and/or Medicare supplemental plans (Part C & D).

Out-of-Network Providers (OON): A licensed health care professional or facility which does not have a service contract with Health Net or respectively, with an affiliated Delegated Partner or contracted facility, which is responsible for arranging or providing health care services for the Member who is seeking to complete 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): Participating Physician Group – A group of physicians organized as a legal entity with an agreement in effect with the Plan to furnish medical services to Plan Members.

Pregnancy: The three trimesters of pregnancy and the immediate postpartum period

Prior Authorization: means a formal process requiring a Provider to obtain advance approval the amount, duration, and scope of non-emergent Covered Services.

Provider: 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.

Public Programs Department/Specialist: A specialized group of associates within the Plan's State Health Programs that assists with questions related to Medi-Cal Member eligibility, assists new Members with Continuity of Care requests, answers inquiries, provides information regarding California Children's Services, Community Based Organizations, and other Medi-Cal services.

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

Seniors and Persons with Disabilities (SPDs): Medi-Cal Members who enrolled in the Plan's Medi-Cal Plan directly from the Medi-Cal FFS program and who are in one of the following aid codes:

1. Disabled (Medi-Cal only – Not Medicare eligible): 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V

2. Aged (Medi-Cal only – Not Medicare eligible): 10, 14, 16, 1E, 1H

Beneficiaries in these aid codes were formally referred to as the "Aged, Blind and Disabled (ABD)" population.

Sensitive Services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

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.

Special Populations: Members living with complex or chronic conditions that require specialized 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 death within one year or less (*California Health & Safety 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.

POLICY:

The Plan abides by the provisions of DHCS APL 23-022, and provides eligible Members with COC with their existing providers for the completion of medically necessary services covered by Medi-Cal (*APL 18-008*). The Plan will offer COC for up to 12 months (*APL 23-022*).

The Plan focuses their attention and resources on transitioning Members in Special Populations to minimize the risk of harm from disruptions in their care. The Plan reviews all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding or within 30 calendar days of receiving data for Special Populations, whichever is sooner. Upon receiving data for Special Populations, the Plan proactively begins the Continuity of Care for Providers Process.

The Plan abides by the provisions of *APL 23-022*, where applicable, to provide Continuity of Care for Medi-Cal beneficiaries who transition from FFS Medi-Cal into Medi-Cal Managed Care or mandatorily transitioning from Medi-Cal Managed Care with its contracts expiring or terminating to a new Medi-Cal Managed care. The Plan will offer up to 12 months Continuity of Care in accordance with *APL 23-022*.

In these instances, active prior treatment authorizations are honored without a request by the Member, authorized representative, or Provider. These authorizations will be maintained for no less than the length of time originally authorized by the Previous Plan, regardless of whether Members are actively receiving ECM. If the Plan confirms that the Member's existing ECM Provider is part of its network, agrees to join its network, or participates under a COC for Provider agreement, the Plan assigns the Member to their existing ECM Provider

to ensure the Member's relationship with their ECM Provider is not disrupted. If the Plan does not bring the ECM provider into its network or establish an agreement with the ECM Provider, the Plan transitions the Member to an in-network ECM Provider for outreach activity and continuation of ECM. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until a new assessment by the MCP, whichever is shorter. If the Plan does not complete a new assessment, the active treatment authorization remains in effect, and after 90 days, the MCP may reassess the Member's Prior Authorization treatment authorization at any time. A new assessment is considered complete by the Plan if the Member has been seen in person and/or via synchronous Telehealth by a Network Provider and this 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. If the Plan is reassessing ECM authorizations after 90 days, the Plan must reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria. If a pre-existing Provider relationship exists, the Plan will accept information provided by the Member, authorized representative or Provider. If the Previous Plan's ECM Provider does not wish to enter into a contract with the Plan's network, or if both parties cannot come to an agreement, the Plan will offer a COC for Provider agreement with the ECM Provider for up to 12 months. If the Plan's efforts do not result in an agreement with the ECM Provider, the Plan explains in writing to DHCS why the Provider and the Plan could not execute a contract or COC for Provider agreement.

The Receiving Plan maintains all authorizations for no less than the length of time originally authorized by the Previous Plan. When both the Previous and Receiving Plans offer the same Community Support, the Receiving Plan honors the Community Support authorization made by the Previous Plan in alignment with DHCS' Community Supports, or in Lieu of Services, Policy Guide. For Community Supports not offered by both the Previous and Receiving Plans, if the Receiving Plan does not continue the Previous Plan's authorization for a Member's Community Support, the Receiving Plan assesses the Member's needs that are addressed by the Community Support and coordinates care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.

If the Previous Plan's Community Supports Provider does not wish to enter into a contract with the Receiving Plan's network, or if both parties cannot come to an agreement, the Receiving Plan offers a COC for Provider agreement with the Community Supports Provider for up to 12 months. If the Receiving Plan's efforts do not result in an agreement with the Community Supports Provider, the Receiving Plan explains in writing to DHCS why the Provider and the Plan could not execute a contract or COC for Provider agreement and transitions the Member to an in-network Community Supports Provider. If the Receiving Plan confirms the Member's existing Community Supports Provider is part of its network, agrees to join its network, or participates under a COC for Provider agreement, the Receiving Plan ensures the Member is connected with their existing Community Supports Provider to ensure the Member's relationship with their Community Supports Provider is not disrupted.

Additionally, in an instance 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 to

retroactively cover the service.

For Members that are transitioning from Covered California to Medi-Cal Managed Care coverage, the Plan will ask these Members if there are upcoming health care appointments or treatments scheduled and assist them. If the Member requests COC, the Plan will help initiate the process at that time according to requirements in *APL 23-022*. The Plan will contact the new Member by phone, letter or other preferred method of communication, no later than 15 calendar days after enrollment. The request for information regarding upcoming healthcare appointments or treatments will be included in this initial Member contact. The Plan will make a good faith effort to learn and obtain information from the Member in order to honor active prior treatment authorizations with a Network Provider and/or to establish Continuity of Care.

The Plan will honor any active prior treatment authorization 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 an OON 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 Member, authorized representative, or Provider's request, offer up to 12 months COC in accordance with the requirements of *APL 23-022*.

The Plan abides by the provisions of *APL 20-017*, where applicable, existing metrics related to any continuity of care provisions outlined in state law and regulations, or other state guidance documents to provide reporting as required by the Requirements for Reporting Managed Care Program Data (MCPD). The Plan transfers supportive information important for Members' care coordination and management. Additionally, the Plan works with the Previous Plan to transfer and share supportive information important for Members' care coordination and management. Additionally, the Previous Plan transfers supportive information that includes, but is not limited to, results of available Member screening and assessment findings, and Member Care Plans. The Plan will continue to report on existing metrics related to any COC provisions outlined in state law and regulations or other state guidance documents.

The Plan abides by the provisions of *APL 21-003*, Medi-Cal Network Providers and Subcontractor Terminations.

In addition to the requirements for COC noted above, the Plan abides by the provisions of *California's Health and Safety Code (H&S Code) Section 1373.96* to provide for the completion of covered services by a terminated Provider, or by a non-participating Provider; subject to certain conditions, and at the request of a beneficiary.

In circumstances in which the Member does not continue receiving services from their pre-existing Provider, The Plan will arrange for Continuity of Care for Covered Services without delay to the Member with a Network Provider, or if there is no Network Provider to provide the Covered Service, with an OON Provider.

Additionally, the Plan offers continued access to Out-of-Network Providers of Behavioral Health Treatment (BHT) services for up to 12 months.

In an instance where a Member would like their OON Provider to provide a service and they have a pre-existing relationship with the OON Provider, they may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal FFS to an MCP, transitioning from an MCP with its contracts expiring or terminating to a new MCP, or if the conditions in *HSC section 1373.96* are met. The Plan must make a good faith effort to negotiate and enter into a Network Provider Agreement or a COC for Providers agreement if all Continuity of Care requirements are met. Upon receiving the COC Provider request, the Plan confirms whether the request meets the following requirements:

- the provider is providing a service that is eligible for Continuity of Care for Providers
- the Member has a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding
- Medi-Cal FFS rates;
- the provider meets the Receiving Plan's applicable professional standards and has no disqualifying quality of care issues; and
- the provider is a California Medicaid State Plan approved provider.

The Plan informs Members of the Continuity of Care protections and includes information about these protections in Member information packets, handbooks, and on the Plan website. This information includes how a Member, authorized representative, or Provider may initiate a COC request with the Plan. The Plan will accept continuity of care requests from the Member, authorized representative, or Provider over the telephone, electronically, or in writing, according to the requestor's preference, and does not require the requestor to complete and submit a paper or online form if the requestor prefers to make the request by telephone. In accordance with *DHCS APL 21-004* or subsequent iterations of the APL, the Plan translates these documents into threshold languages and makes them available in alternative formats, upon request. The Plan provides training about COC protections to Call Center and other staff who come into regular contact with Members.

NOTES:

1) For CBAS Continuity of care, see CA.LTSS.04- Coordination with Community-Based Adult Services (CBAS) Providers
2) For requirements specific to CBAS Emergency Remote Services pursuant to *APL 22-020* CBAS Emergency Remote Services, please see CA.LTSS.16-CBAS Authorization Process.
3) The Continuity of Care processes outlined in this policy applies to Block Transfers when Provider Groups and Hospitals are terminated.

PROCEDURE:

I. Eligibility

A. All Medi-Cal Plan Members with pre-existing Provider relationships have the right to request continuity of care in accordance with state law, and the Plan Medi-Cal contract, with some exceptions.

i. Medi-Cal Members with other health coverage (OHC) must utilize their OHC for covered services prior to utilizing their Medi-Cal benefits (*APL 22-027*)

B. Provider types eligible for COC for Providers include:
- 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
    - Physical therapists
    - Occupational therapists
    - Respiratory therapists
    - Mental health Providers
    - Behavioral health treatment (BHT) Providers
    - Speech therapy Providers
    - Doulas
    - Community Health Workers

C. Members who make a continuity of care request to the Plan are given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal Provider. These eligible Members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP. The Plan will automatically provide 12 months of Continuity of Care for a Member in a Skilled Nursing Facility or for the provision of completing covered services by a terminated or Out of Network Provider regardless of whether the Member has a condition listed in *HSC section 1373.96*.
    - The Plan verifies the provider is providing a service that is eligible for Continuity of Care for Providers (see Figure 3);
    - the Member has a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding.
    - the provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates
    - the provider meets the Receiving MCP's applicable professional standards and has no disqualifying quality of care issues;
    - the provider is a California Medicaid State Plan approved provider.
    - for newly enrolled Seniors and Persons with Disabilities (SPD) Members who request continuity of care, the Plan must provides continued access for up to 12 months to an Out-of-Network Providers that the Member has an ongoing relationship with, as long as the Plan has no quality of care issues with the Provider and the Provider will accept the Plan's rate or the Medi-Cal FFS rate
    - for newly enrolled SPD Members, the Plan will use Medi-Cal FFS utilization data from DHCS to confirm that the SPD Member has an ongoing relationship with the Provider

D. The Plan may choose to work with the Medi-Cal Member's out-of-network Provider past the 12-month approved Continuity of Care period, but the Plan is not required to do so. However, if the Provider is only willing to work with the Plan for a shorter period, the Plan will allow the Member to have access to that Provider for the shorter period, and then safely transition the Member to an in-network Provider.
E. The Plan will use Treatment Authorization Request (TAR) data or Prior Authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. The Plan will pay claims for prior authorizations or existing authorizations when data is incomplete.
F. The Plan will determine if a pre-existing Provider relationship exists through the use of data provided by DHCS or by an MCP with its contract expiring or terminating, such as Medi-Cal FFS utilization data or claims data from an MCP.
G. The Plan will provide COC with an out-of-network specialty mental health services (SMHS) Provider in instances where a Member's mental health condition has stabilized, such that the Member no longer qualifies to receive SMHS from the Plan. At the request of the Member, authorized representative, or Provider up to 12 months of COC with an out of network Non-Specialty Mental Health Services (NSMHS) Plan Provider will be allowed. In this situation, COC requirements only apply to psychiatrists and/or Mental Health Providers that are permitted through California's Medicaid State Plan to provide NSMHS. After the COC period ends the Member must choose a Mental Health Provider in the Plan's network for NSMHS.
H. If all requirements above are met, the Plan contacts the eligible provider and makes a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into a COC for Providers agreement for the Members care within the required timeframes.
I. When a COC for Provider agreement is established, the Plan works with the eligible provider to ensure no disruption of services for the Member.
J. The Provider is directed not to refer the Member to other Out of Network providers without prior approval from the Plan.
K. Upon establishing a COC for Providers agreement with the eligible provider, the Plan reimburses the provider for Covered Services for the appropriate duration in accordance with the Knox-Keen Act and as agreed upon by the provider.

II. New Members

A. All Plan Medi-Cal Members with a pre-existing Provider relationship who make a COC request are given the option to continue treatment with an out-of-network Medi-Cal Provider for up to 12 months if all requirements are met.
B. COC Protections extend to Primary Care Providers (PCPs), Specialists and ancillary Providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment, and speech therapy Providers.
C. Transitioning Members are able to access assistance from the Plan's call center, prior to their enrollment with the Plan If a prospective request for COC for Provider is made in advance of January

1, 2024, then the Plan completes the processing request by January 1, 2024 or according to the timeframes below, whichever is later.

i. Once a Member is known to the Plan as being in inpatient hospital care, either through the Previous Plan or via other means, the Plan will contact the hospital to provide for completion and coordination of the Member's care.

ii. The Plan will also contact the impatient Member's Primary Care Provider responsible for the patient's care while they are admitted.

III. Scheduled Specialist Appointments

A. The Plan ensures that transitioning Members not yet enrolled in the Plan are offered the same level of support they would receive enrollment date.

B. At the Member, authorized representative, or Provider's request, the Plan will allow transitioning Members to keep authorized and scheduled Specialist appointments with OON Providers when Continuity of Care has been established and the appointments occur during the 12-month Continuity of Care period.

C. If a Member, authorized representative, or Provider contacts the Plan to request to keep an authorized and scheduled Specialist appointment with an OON Provider that the Member has not seen in the previous 12 months and there is no established relationship with the OON Provider, the Plan may arrange for the Member to keep the appointment or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider.

D. If the Plan is unable to arrange a Specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider, the Plan will make a good faith effort to allow the Member to keep their appointment with the OON Provider. However, since the appointment with the OON Provider occurs after the Member's transition to the Plan, it does not establish the requisite pre-existing Provider relationship for the Member to submit a Continuity of Care request.

IV. Requirements

A. The Plan will determine that a pre-existing relationship exists with the requested Provider (self-attestation is not sufficient to provide proof of a relationship with a Provider);

1. An existing relationship means the Member has seen an out-of-network primary care Provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into the Plan for a non-emergency visit.

B. The requested Provider is willing to accept the of Plan's contracted rates or Medi-Cal FFS rates;

C. The requested Provider has no quality-of-care concerns;

D. The requested Provider is a California State Plan approved Medi-Cal Provider;

E. The requested Provider supplies all relevant treatment information to determine medical necessity and current treatment plan, as long as it is allowed under the federal and state privacy laws and regulation.

V. Retroactive Requests

A. The Plan will retroactively approve a Continuity of Care request and reimburse Providers for services that were already provided if the request meets all Continuity of Care requirements, including the Provider being willing to accept the Plan's contract rates or Medi-Cal FFS rates, and the services that are the subject of the retroactive request meet the following requirements:
   1. Occurred after the Member's enrollment into the Plan.
   2. Have dates of service that are within 30 calendar days of the first service for which the Provider requests retroactive reimbursement (i.e., the first date of service is not more than 30 calendar days from the date of the reimbursement request).

B. Retroactive requests cannot be considered urgent or immediate.

VI. Limits

A. Per *APL 23-022*:
   1. If Member changes plans by choice following the initial enrollment, or if a Member loses and then later regains Plan eligibility the during 12-month continuity of care period, the 12-month COC period for a pre-existing Provider may start over ***one*** time.
   2. If Member changes plans a second time or loses and then later regains MCP eligibility a second time (or more), the COC period does ***not*** start over.
   3. If Member returns to Medi-Cal FFS and later re-enrolls in the Plan, the COC period does ***not*** start over.
   4. If Member changes plans, this Continuity of Care policy does ***not*** extend to in-network Providers that the Member accessed through their previous MCP.

B. In addition to the requirements for COC noted above, the Plan abides by the provisions of California's *Health and Safety Code (H&S Code) Section 1373.96* which offers additional protections for Members to continue seeing a terminated or non-participating Provider at the request of a Member, authorized representative, or Provider to provide for the completion of covered services for specific conditions.

C. The Plan also allows for completion of covered services as required by *Section 1373.96*, 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 under the terms of *APL 23-022*.

VII. Completion of Services

A. COC cases are considered for completion of services based on:
   1. Plan benefits
   2. Medical appropriateness
   3. Member needs
   4. Qualifying medical condition, where applicable
   5. Hospice: For Members who have elected hospice care, the Plan arranges for continuity of medical care, including maintaining established patient-Provider relationships, to the greatest extent possible. The Plan shall cover the cost of all hospice care provided. The Plan is also responsible for all medical care not related to the terminal condition (*Per DHCS Contract*).
   6. Transplant: The Plan ensures that all Members accessing the transplant benefit are provided

services and/or treatments as expeditiously as possible. The Plan will make a good faith effort to enter into a COC for Providers agreement with the hospital at which a Transplant Program is located as described in Section V.C and according to the following terms:

- Make explicit the existing statutory requirement that Receiving MCPs are to pay, and transplant providers are to accept, FFS rates (*section 14184.201(d)(2) of the Welfare and Institutions Code*)
- (b) Permit the CoC for Providers agreement to continue for the duration of the Member's access to the transplant benefit.
    i. The Plan starts reassessments for clinical necessity for Members to continue accessing the transplant benefit no sooner than six months after the transition date.

7. If the Plan is unable to enter into a COC for Provider agreement, the Plan:
    - Arranges for the hospital at which the Transplant Program is located to continue to deliver services to a Member as an OON provider.
    - Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement. Guidance regarding written explanations will be clarified in the forthcoming Section, Transition Monitoring and Related Reporting Requirements, of the *2024 Medi-Cal Managed Care Plan Transition Policy Guide*.
8. The Plan will provide for the completion of covered services for a terminated/non-participating Provider under the following conditions as outlined in *Health & Safety Code 1373.96*. Furthermore, the Plan complies with *APL 23-022* to provide these services for the completion of a course of treatment for that specific condition by a terminated/noncontracted Provider at the Member's request:
    i. **Acute Condition:** Completion of covered services will be provided for the duration of the acute condition.
    ii. **Serious Chronic Condition:** Completion of covered services for an approved Serious Chronic Condition will be provided for a period of time necessary to complete the course of treatment and to arrange for a safe transfer to another Provider, as determined by the Plan in consultation with the Member and the terminated Provider or non-participating Provider and will be consistent with good professional practice. Completion of covered services under this approved condition will not exceed 12 months from the Provider contract termination date or 12 months from the effective date of the coverage for the newly eligible Plan Medi-Cal Member.
    iii. **Pregnancy:** Completion of covered services for an approved Pregnancy case will be provided for the duration of the pregnancy and immediate postpartum period of 12 months by a terminated or non-participating provider as outlined in *APL 23-022*. For purposes of an individual who presents written documentation of being diagnosed with a Maternal Mental Health (MMH) condition from the individuals treating health care Provider, completion of covered services for the MMH condition will not exceed 12 months from the diagnosis or the end of pregnancy, whichever occurs later.

iv. **Terminal Illness:** *HSC Section 1373.96* requires the Plan to, at the request of a Member, authorized representative, or Provider provide completion of covered services for an approved Terminal Illness case for the duration of the terminal illness, even if it exceeds 12 months from the contract termination or 12 months from the effective date of coverage for the new Member.

v. **Care of Newborn:** Completion of covered services for an approved Newborn child between birth and age 36 months will not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for the newly covered Member. *HSC Section 1373.96* requires the Plan at the request of a Member, authorized representative or Provider to provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after delivery (the postpartum period which is 12 months) and care of a newborn child between birth and age 36 months by a terminated or non-participating Plan Provider. These requirements apply before pregnant and postpartum Members and newborn children could transition from Covered California to Medi-Cal due to eligibility requirements.

vi. **Performance of a surgery:** Completion or performance of a surgery or other procedure that is authorized by the Plan as part of the documented continuation of services and course of treatment that 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.

vii. **Contracts:** In accordance with *HSC Section 1373.95* and *DHMC APL 19-013 Block Transfer Notices*, the Plan is required to submit a DMHC block transfer filing of a terminated provider group or hospital. The Plan will send the Member an Enrollee Termination Notice (ETN) which informs the Member of the right to completion of covered services. The Plan will follow the Continuity of Care process outlined in this policy for the completion of a course of treatment. **Note:** If the Plan is not able to come to an agreement with the terminated/non-contracted Provider or if the Member, authorized representative, or Provider does not submit a request for Completion of Services by said Provider, the Plan will *not* continue the Provider's services.

9. The Plan honors active Prior Authorizations when data are received from the Previous Plan and/or when requested by the Member, Authorized Representative, or Provider and the Plan obtains documentation of the Prior Authorization within the 6-month COC for Services period.
10. During the 90-day 6-month COC for Services period, the Plan examines Utilization Data of Special Populations to identify any Active Course of Treatment that requires authorization and contacts those providers to establish any necessary Prior Authorization.

B. Per *APL 23-022* Completion of Covered Services extend to the following:
   1. Durable Medical Equipment (DME) Rentals and Medical Supplies:
      The Plan allows transitioning Members to keep their existing DME rentals and medical supplies from their existing Provider, under the previous Prior Authorization for a minimum of 90 days following Plan enrollment 6 months after the 2024 Plan transition and until the Plan is able to reassess, the new equipment or supplies are in possession of the Member, and ready for use. Continuity of DME and medical supplies will be honored without a request by the Member,

authorized representative or Provider. Additionally, if DME or medical supplies have been arranged for a transitioning Member but the equipment or supplies have not been delivered, the Plan will allow the delivery and for the Member to keep the equipment or supplies for a minimum of 6 months and until reassessed.

2. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): For NEMT and NMT, the Plan will allow Members to keep the modality of transportation under the previous Prior Authorization with a Network Provider until the Plan is able to reassess the Member's continued transportation needs. If a network provider is not available to provide the transitioning Member's scheduled NEMT/NMT Service, then the Plan makes a good faith effort to allow the transitioning Member to keep the scheduled transportation service with an Out-Of-Network NEMT/NMT provider.
3. The Plan works together with the Previous Plan to support continuation of NEMT/NMT services for the transitioning Members by:
    - Providing authorization data as described in Section V.G;
    - Transmitting all NEMT/NMT schedule data and the data elements of the Physician Certification Statement (PCS) to the Plan and refresh weekly.

VIII. Coverage

A. This policy does not require the Plan to cover services or provide benefits to a Member that is not otherwise covered under the Plan's Medi-Cal plan. In addition, Provider COC protections do not extend to the following Providers:
    1. Radiology
    2. Laboratory
    3. Dialysis Centers
    4. Transportation
    5. Other Ancillary Services
    6. Carved-Out Services
B. Following identification of a pre-existing relationship, the Plan will determine if the Provider is an out-of-network Provider. If the Provider is a network Provider, then Plan will allow the Member to continue seeing the Provider. If so, the Plan will contact the Provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a Continuity of Care relationship for the Member. Neither the Plan nor the Provider is required to continue services if the Provider does not accept the payment rates proposed by the Plan.
C. The Plan requires the terminated/non-contracting Provider whose services are continued to agree to compensation rates and methods of payment similar to payments to Providers of similar services practicing in the same or similar geographic area. The Plan reserves the right to apply the same Provider contractual terms and conditions that are imposed on contracted Providers including, but not limited to:
    1. Credentialing,
    2. Hospital privileges, and

3. Utilization review.

D. An approved Continuity of Care out-of-network Provider must work with the Plan and cannot refer the Member to another out-of-network Provider without prior authorization. In such cases, the Plan will review the referral request, assess for medical necessity, and, if the Plan or Provider Group does not have an appropriate Provider within the network, make an initial determination on the referral request. Neither the Plan nor the Provider is required to continue services if the Provider does not accept these terms and conditions.

E. This policy does not require the Plan to provide completion of covered services by a Provider whose contract with the Plan, or PPG, was terminated or not renewed for reasons relating to a medical disciplinary cause or action, as noted in the *California Business and Professions Code, Section 805*, or for fraud and/or other criminal activity.

F. The Plan may, through its delegated PPGs, delegate the responsibility of implementing and complying with Plan's approved Continuity of Care service plan. However, the Plan will remain responsible for ensuring that the requirements of Plan's approved completion of services coverage plan and requirements are met.

1. If the Care Manager identifies benefit exhaustion or benefit limitation, the enrollee may be provided with information about available resources through local and state funded agencies, and/or alternative care options for the enrollee in the hospital or skilled nursing facility.
   i. Enrollees may be identified by discharge planning staff or from a daily census report or requests for extension of previously approved services.
2. If the Prior Authorization staff identifies the benefit exhaustion for a specific service or level of care, and the enrollee needs continued services, the enrollee may be referred to the Care Management Department. The Care Manager is responsible for identifying available resources within the local community and social services that are generally available including nursing homes and other community-based services.
3. If a request for continuation or extension of a previously approved service is requested and subsequently cannot be approved due to no longer meeting coverage criteria or benefit exhaustion, the Denial Notification will include identification of alternative resources and any transition care approved for the enrollee. Clear documentation of transition care, such as home health post-acute discharge is critical to support ongoing continuity of care.
4. During the PPG's annual Delegation Oversight Audit, the following protocols will be observed to ensure requirements are met:
   i. A sample of up to 5 COC denials (as available) will be reviewed.
5. Denials for OON will result in a finding and corrective action for the PPG as appropriate.
   i. Policies and Procedures are consistent with Plan policy and adhere to APL requirements.
   ii. Policies and Procedures include the provision for beneficiaries who are residents of a nursing facility or a Skilled Nursing Facility (SNF)

G. If the Plan and the out-of-network Fee For Service Provider are unable to reach an agreement because of inability to agree to a rate, or Plan has documented quality of care issues with the Provider (identified via Plan Credentialing Dept.), the Plan will offer the Member an in-network alternative. If

the Member does not make a choice, the Member will be assigned to an in-network Provider in a timely manner so the Member's service is not disrupted. Members maintain the right to pursue an appeal through the Plan Medi-Cal Member Appeal processes.

H. The Plan supports the Medi-Cal Member's right to change their Provider regardless of whether or not a Continuity of Care relationship has been established. When a Continuity of Care agreement has been established, the Plan will work with the Provider to establish a care plan for the Member.

IX. Decision Timelines

A. Urgent Requests: Continuity of care requests are completed as soon as possible, or within three (3) calendar days if there is risk of harm to the Member.

B. Continuity of care requests are completed within fifteen (15) calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.

C. Non-Urgent requests: Thirty calendar days from date the Plan received the request.

X. Notification Requirements

A. The Plan provides acknowledgment of the continuity of care request advising the Member that the continuity of care request has been received, whether the request was considered Urgent, Immediate, or Non Urgent and why, the date of receipt, and the estimated timeframe for resolution as follows:
   1. For non-urgent requests, within seven calendar days of receipt of the continuity of care request.
   2. For immediate requests, (the Member's medical condition requires more immediate attention, such as provider appointment or other pressing services) within 7 calendar days.
   3. For urgent requests, within the shortest applicable timeframe, but no longer than (3) three calendar days of receipt of the continuity of care request.
   4. For acknowledgement of continuity of care, the Plan will notify the Member 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 (electronically), and then notice by mail.

B. The Plan notifies Members and Providers of COC decisions as follows:
   1. For non-urgent requests, within seven (7) 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 (3) calendar days of the decision.

C. Upon determination of a COC request, the Plan will notify the Member using the Member's known preferred method of communication, or by using one of these methods in the order below, followed by notification by mail:
   1. Telephone call
   2. Text message
   3. Email

D. Notification of approval to the Member and the Member's Care Manager includes:
   1. If the Member's provider is in Network or is brought in Network as a result of the Receiving MCP's outreach, then the Receiving MCP must send notification that the Member may continue with his or her provider.
   2. If the Member's provider is OON and the Receiving MCP establishes a CoC for Providers agreement, then the Receiving MCP must notify the Member that the length of time that they can stay with their provider.
   3. The process for transitioning the Member's care at the end of the Continuity of Care period.
   4. The Member's right to choose a different Network Provider.

E. Notification of approval to the Provider additionally includes:
   1. Requirements on letter of agreement.
   2. Referral and authorization processes.

F. Notification of Denial includes:
   1. A statement of the Plan's decision.
   2. A clear and concise explanation of the reason for denial.
   3. The Member's right to file a grievance or appeal.
   4. If the provider is OON and cannot establish a COC for Providers agreement, the Receiving Plan must send notification that the Member must change to a Network Provider and assign the Member a new Network Provider.
   5. For Community Health Plan of Imperial Valley (CHPIV), the Plan issues an Administrative COC Denial Letter that contains:
      i. A statement of the Plan's decision.
      ii. A clear and concise explanation of the reason for denial.
      iii. The Member's right to file a grievance or appeal.
      iv. If the provider is OON and cannot establish a COC for Providers agreement, the Receiving Plan must send notification that the Member must change to a Network Provider and assign the Member a new Network Provider.

G. The Plan will work with the approved OON Provider and communicate its requirements on Letters of Agreement including referral and authorization processes to ensure that the OON Provider does not refer the Member to another OON Provider without authorization from the Plan. In such cases, the Plan will work in coordination with the Referring Provider to make the referral if medically necessary and if the Plan does not have an appropriate Provider within its network. If the Plan and the OON Provider are unable to reach an agreement because they cannot agree to a rate, or the Plan has documented quality of care issues with the Provider, the Plan must offer the Member a Network Provider alternative. If the Member does not make a choice, the Member must be referred to a Network Provider. If the Member disagrees with the Continuity of Care determination, the Member maintains the right to file a grievance.

H. The Plan notifies the Member 30 calendar days before the end of the COC period about the process that will occur to transition the Member's care to an In-Network Provider at the end of the COC Period. The Plan will engage with the Member, eligible provider, and the Member's new Network Provider, and ensure the Member's record is transferred within 30 days to ensure continuity of

Covered Services through the transition to the Network Provider.

I. If the Provider meets all of the necessary requirements including entering into a Letter of Agreement or Contract with the Plan, the Plan 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 the Plan for a shorter time frame. In this case, the Plan will allow the Member to have access to that Provider for a shorter period of time.

J. In all cases, the notification includes that the Member may choose to change Providers and comply with the notification requirements in Section V.C. Expectations of the Receiving Plan, and with the required timeline in *Figure 6 of the 2024 MCP Transition Policy Guide*.

XI. Medical Exemption Requests

A. A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into the Plan only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to a Network Provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from Plan enrollment that only applies to Members transitioning from Medi-Cal FFS to the Plan. A MER should only be used to preserve Continuity of Care with a Medi-Cal FFS Provider under the circumstances described in this paragraph.

B. The Plan considers MERs that have been denied as automatic Continuity of Care request to allow Members to complete courses of treatment with OON Providers in accordance with *APL 17-007* or subsequent iterations of that APL. The Plan processes the Continuity of Care request in accordance with *APL 23-022*, including the validation of a pre-existing relationship with the Provider, and makes a good faith effort to come to an agreement with the OON Provider for the duration of the treatment. If the Plan reaches an agreement with the Provider, the Plan allows the Member Continuity of Care for up to 12 months after the enrollment date with the Plan.

XII. Managed Care Program Data (MCPD)

A. The Plan Prior Authorization- COC unit and the Public Programs Department run a monthly report in compliance with the MCPD reporting requirements under the schema version 3.07, including data related to monthly MER, other COC requests, and Out-of-Network requests.

B. MCPD generated by the Plan includes:
   1. MER denial reports and other continuity of care data include all continuity of care requests received by the MCP Plan;
   2. Out-of-Network request data includes all out-of-network requests received by the Plan.

C. Monthly reports in compliance with *APL 20-017* are sent to Plan Compliance for submission to DHCS.

XIII. Data Sharing

A. The Plan utilizes information provided in the standard monthly Plan Data Feed to implement COC protections.

B. The Plan receives confirmation from the Previous Plan to ensure that they completed all data transfer sharing activities as described in the Continuity of Care Data Sharing Policy

- DHCS will require the Previous Plan to transmit utilization 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 the Plan.

C. The receiving Plan will use both the DHCS-provided Special Populations Member File and the Previous Plan provided Transitioning Member Special Population Information Data file to identify Special Populations Members' Providers and begin outreach, a key tenet of the COC policies for Special Populations.

D. The Previous Plan must share Transitioning Member Special Populations Information Data files with the Receiving Plan in accordance with required transmission method and frequency outlined in *Sections VIII.C-VIII.D of the Medi-Cal Managed Care Plan Transition Policy Guide*. The Previous Plan must also share a copy of this data to DHCS to facilitate DHCS' oversight of the transition.

E. The Previous Plan completes all data sharing requirements outlined in the summary of Plan provided data files as noted below. This guidance outlines a standardized set of "minimum necessary" data elements for data shared from the Previous Plan to the Receiving Plan, as well as standard file formats, transmission methods and transmission frequencies.

1.

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning Members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Utilization Data	Claims and encounter information for transitioning Members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Authorization Data	Prior authorization information for transitioning Members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December

Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning Members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Special Populations Information Data	Transitioning Members who meet Special Populations criteria and relevant accompanying data elements	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Special Populations Member Supportive Information Data	Transitioning Member screening and assessment findings, and Member Care Management Plans	Receiving MCPs and DHCS	Within 15 days of Member changing to a new Care Manager or by January 1, 2024, whichever is later

F. The Plan uses the COC Data Template "Data Elements for All Members" to prepare Member level data files for transitioning Members in accordance with requirements outlined in *Sections VIII.B.1-VIII B.4 of the Medi-Cal Managed Care Plan Transition Policy Guide*.

G. The Previous Plan will use the COC Data Template 2a- "*Special Populations Specifications*" to identify relevant Members and prepare Transitioning Member Special Populations Data using the COC Data Template 2b-"*Special Population Member File*" and CoC Data Template 2c-"Special Populations Accompanying Data workbooks for transmittal to Receiving Plan."

H. The Previous Plan uses the COC Data Template 2b- "*Special Population Member file*" to prepare a file identifying Members that meet the criteria outlined in COC Data Template 2a-"*Special Populations Specifications for transmittal to Receiving Plan*."

I. The Previous Plan uses the COC Data Template 2c- "*Special Populations Accompanying Data*" to prepare Special Populations accompanying data for certain Special Population groups for transmittal to the Receiving Plan.

J. The Previous Plan shares Transitioning Member Data files with Receiving Plan and DHCS in accordance with the required Data Elements below:

1.

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code	Numeric 3-digit, Text
Member Homelessness Indicator	Numeric, 1 digit, Text
Member Residential Address	Alpha-numeric, Text
Member Residential City	Alpha-numeric, Text
Member Residential Zip Code	Alpha-numeric, Text
Member Mailing Address	Alpha-numeric, Text
Member Mailing City	Alpha-numeric, Text
Member Mailing Zip Code	Numeric, 5-digit
Member Phone Number	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact	Alpha-Numeric, Text
Description of Member's Selected Alternative Format	Alpha-Numeric, Text

2.

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider/Clinic Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider/Clinic National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider/Clinic Phone Numbe[68]	Numeric, 10-digit
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date	MM/DD/YYYY, Date

K. Previous Plan shares Transitioning Member Utilization Data files directly with Receiving Plans and DHCS in accordance with the required transmission method and frequency outlined in *Sections VIII.C-VIII-D. of the Medi-Cal Managed Care Plan Transition Policy Guide*.

L. The Previous Plan shares Transitioning Member Utilization Data files with Receiving Plan and DHCS in accordance with the required data elements and format outlined below:

1.

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code and Description	Alpha-Numeric, Text
HCPCS Modifier	Alpha-Numeric, Text
Revenue Code and Description	Alpha-Numeric, Text
Place of Service	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
National Provider Identifier (NPI)	Numeric, 10-digit, Text
Provider First Name	Alpha-Numeric, Text
Provider Last Name	Alpha-Numeric, Text
Provider Phone Number	Numeric, 10-digit
Provider Specialty Type	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1	Alpha-Numeric, Text
Diagnosis Code 2	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

M. The Previous Plan uses Transitioning Member Authorization Data files with the Receiving Plan and DHCS in accordance with the required data elements and format outlined in the transitioning Member authorization information below:

1.

B. Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Referring Provider Name	Alpha-numeric, Text
Referring Provider NPI	Numeric, 10-digit, Text
Referring Provider Phone Number[71]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units (as applicable)	Numeric 7-digit, Text
Level of Service	Alpha-Numeric, Text
Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text
Diagnosis Code	Alpha-Numeric, Text

Diagnosis Description	Alpha-Numeric, Text
Prior Authorization Status	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text

N. The Plan identifies scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedules a network provider or an OON provider to transport the Member.

O. The Previous Plan shares Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data files with the Receiving Plan and DHCS in accordance with the required data elements and format noted below:

1. Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Days of Week of Scheduled Service	Alpha-Numeric, Text
Time of Scheduled Service	Alpha-Numeric, Text
Member Phone Number	Numeric, 10-digit
Pickup Location	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number	Numeric, 10-digit
Mode of Transport	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes	Alpha-Numeric, Text

2. Transitioning Member PCS Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Standing Orders	Alpha-Numeric, Text
Mode of Transportation	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number	Numeric, 10-digit

POLICY AND PROCEDURE

DEPARTMENT: Population Health Clinical Operations (PHCO)	**REFERENCE NUMBER: CA.UM.20**
EFFECTIVE DATE:9/26/2025	**P&P NAME: Continuity of Care- Non Clinical**
REVIEWED/REVISED DATE: 12/19/2025	**RETIRED DATE:**
BUSINESS UNIT: Public Programs COC	**PRODUCT TYPE: Health Net Medi-Cal**
REGULATOR MOST RECENT APPROVAL DATE(S): 7/13/2021	

REFERENCES:

Section 1373.95(a)(2)(A): Section II, Policy
Subdivision G: Subdivision A of Section 1373.95(a)(2)(A)
California Health & Safety Code Section 1373.96
California Code of Regulations (CCR), Title 22, Sections 53887 and 53923.5
California Health and Safety Code Section 1373.95
Title 22 CCR 51340 and 51340.1
Title 42, CFR, Section 418.3
DHCS APL 17-007 "Continuity of Care for New Enrollees Transitioned to Managed Care after Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting"
DHCS APL 18-008 "Continuity of Care form Medi-Cal Beneficiaries who Transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care
DHCS APL 21-003 (March 3, 2021), Medi-Cal Network Providers and Subcontractor Terminations
DMHC APL 19-013 Block Transfer Enrollee Transfer Notices
DHCS APL 20-017 Requirements for Reporting Managed Care Program Data
DHCS APL 21-004 Standards for determining threshold languages, non discrimination requirements and language assistance services
DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Care
DHCS APL 22-020 CBAS Emergency Remote Services
DHCS APL 22-027 Cost avoidance and post payment recovery for other health coverage
DHCS APL 23-022 Continuity of Care
DHCS Medi-Cal Managed Care Plan Transition Policy Guide
DHCS APL 23-005 Requirements of coverage for EPSDT
California Business and Professions Code, Section 805
CA PP 07 – CHPIV Administrative CoC Denials

SUPPORT/HELP:

If you need Help with this Policy, contact: Ed Mariscal

REVISION LOG

REVIEW TYPE (New, Annual, Ad Hoc)	REVISION SUMMARY	DATE APPROVED
Ad Hoc	Removal of COC Non Clinical info from core policy	12/19/2025
Ad Hoc	Updated to Administrative Denials and added a new reference	03/11/2026

Please note: This Microsoft Word File is not 36 CFR 1194, Section *508 Compliant and not meant for electronic distribution. For an electronic PDF file of this policy, please refer to the Medical Management Remediation Work Process (MM.PM.03)*

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POLICY APPROVAL

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