blue california
Promise Health Plan

Policy Title: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care		POLICY #: 10.2.40 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 1/01/14	**Effective Date** 5/01/19	**Revision Date** 12/01/18, 8/01/20, 6/25/21, 12/21, 3/22,9/22
Department Head: Sr. Director, UM		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 10/22**	

PURPOSE

To define and establish mechanisms for Blue Shield of California Promise (Blue Shield Promise) Health Plan in accordance with APL 18-008, APL 21-015, and Health & Safety Code 1373.96 to grant the completion of covered services for Medi-Cal members undergoing treatment through a pre-existing provider relationship during the previous 12 months prior to enrollment into Blue Shield Promise, to continue receiving care at the time of enrollment with a non-participating provider for up to 12 months, provided the following criteria are met:

Current BSC PHP members

- When a member is currently receiving a specific course of treatment from a Blue Shield Promise network provider, and the provider leaves the network, the member is entitled to apply for continuity of care with the same provider throughout the course of the treatment.

Newly enrolled members

- If a new Blue Shield Promise Medi-Cal member has a pre-existing provider relationship during the previous 12 months prior to enrollment who is not in Blue Shield Promise's Medi-Cal network, the member is entitled to apply for continuity of care to continue receiving services to complete the treatment plan.
  NOTE: Medical Exemption Requests ***Please refer to P&P 10.2.95***

MEDI-CAL POPULATIONS AFFECTED BY THIS POLICY

1. Medi-Cal beneficiaries assigned mandatory aid codes that are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP).
2. Medi-Cal beneficiaries with mild to moderate impairment resulting from a mental health diagnosis in need of continued access to out-of-network Medi-Cal FFS.
3. Former Low-Income Health Plan (LIHP) beneficiaries transitioned into Medi-Cal managed care requesting continued access to out-of-network LIHP providers for up to 12 months.
4. Populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a beneficiary's eligibility circumstances that may occur at any time throughout the year. These requirements **are limited** to these transitioning beneficiaries.
5. Newly enrolled Seniors and Persons with Disabilities (SPD).

6. Pregnant, individuals with documented maternal mental health conditions, and Post-Partum Medi-Cal beneficiaries who are assigned a mandatory code and transitioning from Medi-Cal FFS into a MCP have the right to request out-of-network provider continuity of care.
7. Behavioral health treatment coverage for Medi-Cal managed care children ages 0-21 years that are diagnosed with Autism Spectrum Disorder.
8. Newly enrolled Medi-Cal managed care beneficiaries in need of continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the Blue Shield of California Promise Health Plan, until the prescribed therapy is no longer prescribed by the contracted provider.
9. Trafficking and Crime Victims Assistance Program, Except share of cost (non-dual and dual)
10. Individuals participating in accelerated enrollment (non-dual and dual)
11. Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual)
12. Medical Exemption Requests ***Please refer to P&P 10.2.95***
13. Cal MediConnect Members ***Please refer to P&P 90.2.25***

POLICY

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the MCP contracts, with some exceptions.

All MCP members with pre-existing provider relationships who make a continuity of care request to Blue Shield Promise Health Plan must be 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.

DEFINITIONS:

Continuity of Care can be defined as the lack of interruption in needed care as it pertains to APL 18-008 and H&S Code 1373.96

Acute Condition – 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.

Serious Chronic Condition – 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.

Pregnancy – the three trimesters of pregnancy and the immediate post-partum period; including maternal mental health. The postpartum period begins immediately after childbirth and extends for approximately six weeks.

Terminal Illness – an incurable or irreversible condition that has a high probability of causing death within one year or less.

Newborn – child between birth and 36 months.

Non-participating provider (Non-contracted provider) – a provider who is not contracted with Blue Shield Promise Health Plan or a Provider Group contracted with Blue Shield Promise Health Plan.

Provider Group – Medical Group, an IPA, or any other similar organization.

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

Specialist – means 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.

Behavioral Health Treatment Services: are services such as Applied Behavioral Analysis and other evidenced based intervention services that develop, to the maximum extent practicable, the functioning of beneficiaries diagnosed with Autism Spectrum Disorder (ASD).

1. Conditions and Timeframes for Completion of eligible covered services, as set forth in Section 1373.96(c)
    a. **Acute condition**: completion of covered services shall be provided for the duration of the acute condition.
    b. **Serious chronic condition**: 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 Blue Shield Promise Health Plan, in consultation with the enrollee and the terminated provider or non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
    c. **Pregnancy**: Completion of covered services shall be provided for the duration of the pregnancy and the immediate postpartum care; individuals with a documented maternal mental health condition, and undergoing a course of treatment for a specified condition, require completion of covered services for that condition, not exceeding 12 months.
    d. **Terminal illness**: 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.
    e. **Newborn**: completion of covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly-covered enrollee.
    f. **Performance of surgery or other procedure**: that is authorized by Blue Shield Promise Health Plan, as part of a documented course of treatment and has been recommended and documented by the provider shall 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.

g. **Members with an existing relationship means**: the beneficiary has seen an out of network primary care provider (PCP) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit.

2. Conditions and Timeframes for Access to Continuity of Care Providers
    a. Validate an existing relationship
        1) the beneficiary has seen an out-of-network PCP or specialist at least once during the 12 months prior to the date of his or her initial enrollment in to Blue Shield Promise for a non-emergency visit.
        2) If a beneficiary changes MCPs, the 12-month continuity of care period may start over one time. If the beneficiary changes another MCPs a second time (or more), the continuity of care period does not start over, meaning that the beneficiary does not have the right to a new 12 months of continuity of care.
        3) If the beneficiary returns to Medi-Cal FFS and later re-enrolls in an MCP, the continuity of care period does not start over. If a beneficiary changes MCPs, this continuity of care policy does not extend to providers that the beneficiary accessed through their previous MCP.
    b. Validate if Behavioral Health
        1) Medi-Cal (MCP) beneficiaries with mild to moderate impairment resulting from a mental health diagnosis in need of continued access to out-of-network Medi-Cal FFS for up to 12 months.
        2) Behavioral Health Treatment for Members Under the Age of 21 upon MCP Transition: Blue Shield Promise will ensure that members under 21 receive Early and Periodic Screening, Diagnostic, and Treatment services.
        3) Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.
            1. Continued access to out-of-network BHT providers for up to 12 months if all policy requirements are met.
                a. An existing relationship for BHT means a member has seen the out-of-network provider at least one time during the six months prior to either the transition of services from a RC to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018.
    c. If this this request from a transition of BHT Services from a Regional Center to an MCP
        1) At least 45 days prior to the transition date, DHCS will provide a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member specific utilization and assessment data.
        2) If the beneficiary has an existing BHT service relationship, as defined above, with an in-network provider, the MCP must assign the beneficiary to that provider to continue BHT services.
        3) DHCS utilizing data that is supplied to the Plan will be used to identify each beneficiaries BHT provider and proactively contact the provider or providers to begin the continuity of care process, regardless of whether a beneficiary's parent or guardian files a request for continuity of care.
        4) If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the MCP should attempt to contact the beneficiary's parent or guardian to determine his or her preference.

5) If the MCP does not have access to beneficiary data that identifies an existing BHT provider, the MCP must contact the beneficiary's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist it in offering continuity of care.
6) If the Regional Center is unwilling to release specific provider rate information to the MCP, then the MCP may negotiate rates with the continuity of care provider without being bound by the usual requirement that the MCP offer at least a minimum FFS – equivalent rate.
7) If the MCP is unable to complete a continuity of care agreement, the MCP must ensure that all ongoing services continue at the same level with an MCP in-network provider until the MCP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.
8) MCPs may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding Continuity of Care for transitioning members receiving BHT.
9) Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into an MCP, or the date of the member's enrollment into the MCP, if the enrollment date occurred after the transition.
10) Blue Shield Promise will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

d. Former Low Income Health Plan (LIHP) beneficiaries transitioned into Medi-Cal managed care can request continued access to out-of-network LIHP providers for up to 12 months.
e. Pregnant and Post-partum Medi-Cal beneficiaries Blue Shield Promise will provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period) and care of a newborn child between birth and age 36 months, by a terminated or non-participating health plan provider. These requirements will apply for pregnant and post-partum beneficiaries and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.
    ii. Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into Blue Shield Promise have the right to request out-of-network provider continuity of care for up to twelve (12) months in accordance with plan contracts and the foregoing requirements.
    iii. This includes individuals with documented maternal mental health conditions; completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
f. Newly Enrolled Senior and Persons with Disabilities (SPDs) that have any active FFS Treatment Authorization Requests (TARs). The TARs will be honored for up to 60 days or until a new assessment is completed by the Blue Shield Promise Health Plan.
    iv. And when meeting the requirements of COC defined by current law, the COC will be arranged for a period of up to 12 months.
g. Covered California to Medi-Cal Managed Care;
    v. Blue Shield Promise shall contact the beneficiary by telephone call, letter, or other resources no later than 15 days after enrollment.
    vi. Blue Shield Promise shall ask the beneficiary if they are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the continuity of care process at that time.

vii. Blue Shield Promise will honor any active Prior Treatment Authorizations for up to 60 days or until a new assessment is completed by Blue Shield Promise.
viii. A new assessment is considered completed if the member has been seen by a contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
ix. The prior treatment authorizations must be honored without a request by the beneficiary or the provider.
x. At the beneficiary's or provider's request, Blue Shield Promise will offer up to 12 months of continuity of care with out-of-network providers, in accordance with the DHCS policy requirements listed APL 13-023.
    1. And then COC will be up to 12 months as defined by APL 18-008 and Health & Safety Code Section 1373.96

3. Terms and Conditions with Non-Participating Provider:
    a. Blue Shield Promise Health Plan may require a non-participating provider whose services are continued for a newly-covered enrollee to agree in writing to be subject to credentialing, utilization review, peer review, and quality improvement requirements.
    b. If the non-participating provider does not agree to comply or does not with these contractual terms and conditions, Blue Shield Promise Health Plan is not required to continue the provider's services.
    c. Unless otherwise agreed upon by the non-participating provider and Blue Shield Promise Health Plan, the services rendered shall be compensated at Medi-Cal fee-for-service rate.
    d. Neither Blue Shield Promise Health Plan nor the provider group is required to continue the services of a non-participating provider if the provider does not accept the payment rates provided for in this section.
    e. Blue Shield Promise Health Plan shall provider Medi-Cal beneficiaries' access to an out-of-network provider for up to 12 months if:
        i. The beneficiary has an ongoing, prior relationship with the provider that can be documented using Medi-Cal fee-for-service claims data;
        ii. The provider accepts Medi-Cal fee-for-service rates or the same rates and methods of payment as those used by Blue Shield Promise Health Plan for currently contracting providers providing similar services and who are practicing in the same or a similar geographic area as the terminated provider. AND
        iii. The provider has no quality of care issues and meets all credentialing requirements.
    f. Blue Shield Promise Health Plan shall provide newly-enrolled SPD beneficiaries access to an out-of-network provider for up to 12 months if:
        i. The beneficiary has an ongoing, prior relationship with the provider that can be documented using Medi-Cal fee-for-service claims data;
        ii. The provider accepts Blue Shield Promise rate or Medi-Cal fee-for-service rates, whichever is higher, in accordance with W and I Code 14182(b)(13)(14); and
        iii. The provider has no quality of care issues and meets all credentialing requirements.
    g. If a member was residing in an out-of-network skilled nursing facility (SNF) when the beneficiary transitioned to Blue Shield Promise, Blue Shield Promise shall offer

the member the opportunity to return to the out-of-network SNF after a medically necessary absence.

iv. This requirement does not apply if the member is discharged from the SNF into the community or a lower level of care.

v. A member who is a resident of a Nursing Facility (NF) prior to enrollment under CCI will not be required to change NFs during the duration of CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and MCP agree to Medi-Cal rates in accordance with the MCP contract with DHCS.

Exclusions:

a. Blue Shield Promise Health Plan is not required to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason or fraud or other criminal activity.
b. Blue Shield Promise Health Plan is not required to cover services or provide benefits that are not otherwise covered under Medi-Cal or the terms and conditions of Blue Shield Promise Health Plan's contract.
c. This section shall not apply to a newly-covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had an option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

4. Retroactive Request for Continuity of Care
   a. Retro requests that meet all continuity of care requirements the following:
      1) The services that are the subject of the request must have occurred after the beneficiary's enrollment into Blue Shield Promise, and the Blue Shield Promise must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider prior to the beneficiary's enrollment into Blue Shield Promise.
      2) Have a date of service after March 2, 2018.
      3) Have dates of service within 30 days of the first service for which retroactive continuity of care is being requested
      4) Validation that the relationship exists through use of data provided by DHCS to the documentation must be provided.
      5) An existing relationship may be determined:
         i. Through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data.
         ii. A beneficiary or his or her provider may also provide information to the MCP which demonstrates a pre-existing relationship with a provider.

5. Request Completion Timelines
   a. Upon a member or authorized representative for the member on file, request for continuity of care, the process for COC will be initiated within five working days following the receipt of the request; unless there is a risk for harm then the COC request will be completed in three calendar days
   b. Blue Shield Promise Health Plan will complete continuity of care requests within the following timelines:
      i. Thirty calendar days from the date the Blue Shield Promise Health Plan received the request;
      ii. Fifteen calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
      iii. Three calendar days if there is a risk of harm to the beneficiary

c. A continuity of care request of care request is considered completed when:
   i. The beneficiary is informed of his or her right of continued access
   ii. Blue Shield Promise Health Plan and out-of-network FFS or prior MCP provider are unable to agree to a rate;
   iii. Blue Shield Promise Health Plan has documented quality of care issues; or
   iv. Blue Shield Promise Health Plan has made and adequately documented a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

PROCEDURE

I. Member requests for Continuation of Covered Services:

a. Beneficiaries, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to for continuity of care. Members may file requests through Blue Shield Promise for continuation of covered services via facsimile, telephonically or by mail.
   i. Blue Shield Promise will accept requests for continuity of care over the telephone, according to the requester's preference, and will not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, Blue Shield Promise will take any necessary information from the requestor over the telephone.

b. Member information shall include:
   i. Member Name
   ii. Date of Birth
   iii. Member ID#
   iv. Telephone Number
   v. Medical Condition
   vi. Services requested
   vii. Treating provider's address, phone and specialty

c. UM staff shall document the request in MHC database.

II. Assessing the Non-Participating for Quality of Care Issues:

a. The UM Department shall assess the request to:
   i. Determine whether the member's condition is consistent with conditions set forth in Section 1373.96 (c), conditions eligible for covered services (may be subject to MD review);
   ii. Determine whether the member's condition is consistent with conditions or circumstances are set forth in APL 18-008;
   iii. Determine prior relationship with the requested provider through review of
   iv. Medi-Cal fee-for-service claims data from the State;
   v. Medi-Cal active FFS Treatment Authorization Requests (TARs)

b. If the above are established, and the provider meets criteria and agrees to accept the higher of Blue Shield Promise Health Plan rates or Medi-Cal FFS rates, Blue Shield Promise Health Plan shall offer a letter of agreement for:
   i. Conditions and Timeframes for Completion of eligible covered services, as set forth in Section 1373.96
   ii. Conditions and Timeframes for Completion of eligible covered services, as set forth in APL 18-008.

c. Blue Shield Promise Health Plan will work with the provider in establishing a treatment plan for the member.

i. The treatment plan will be utilized through the continuum of the member's treatment and as appropriate when the member is transitioning at the end of the authorized treatment time frame or to an in-network provider

d. If the provider refuses the rate, member is notified verbally and assisted by a Blue Shield Promise UM representative to continue care with an in-network provider who is qualified to evaluate and treat the member's condition.
    i. The member will have the option to select a contracted in-network provider of his or her choice.
e. Blue Shield Promise Health Plan shall document COC request outcomes in member file.
f. Blue Shield Promise shall notify the member of the decision following the customary process of authorization determinations and notifications as they apply to Medi-Cal requirements
    i. In the case of an adverse determination and the member disagrees with Blue Shield Promise Health Plan, the member can:
        1. File a grievance or Appeal
        2. Request a Medical Exemption from DHCS – assuming the request is within the first 90 days of enrollment in Blue Shield Promise Health Plan.
g. Other elements within the notification process will include the following:
    i. The services approved
    ii. The duration of the COC arrangement
    iii. The process that will occur to transition the member's care at the end of the continuity care period.
        1. This will include informing the member that 30 days before the COC ends he/she will be contacted by a Blue Shield Promise representative to assist the member.
        2. The member's right to choose a different provider from the Plan's network
        3. A list of contracted providers in the network will be provided for the member to select from.

III. Continuity of Care Transitions

a. COC members will be notified 30 calendar days before the end of the continuity of care period.
b. COC transition reports will be generated by the UM Department to identify members requiring the need for transition arrangements 30 days prior to the expiration of the approved services.
c. An automated letter will be sent to the member that will include the following clause:
    i. **YOUR CONTINUITY OF CARE PERIOD WILL BE COMPLETED IN 30 DAYS:** *In accordance with your continuity of care rights, the purpose of this letter is to notify you that the continuity of care period of 12 months for services authorized on <Insert Date> will expire on <Insert Date>. Please contact your Blue Shield of California Promise authorized representative to assist you before the end of your continuity of care so we may assist you in transitioning your care to an in-network provider. A list of providers within the same specialty will be provided to you to select from. If you choose not to select a provider, we will select one for you. Please call 800-605-2556 and ask for the Continuity of Care Department.*
d. Members will also be contacted by phone to assist them.
    i. This will include up to two telephonic outreaches.

IV. Delegated Oversight

a. Blue Shield Promise Health Plan shall ensure the delegates meet the requirements of HSC Section 1373.96 and APL 18-008.
b. Providers and delegates will be educated on COC provisions through:
    i. Webinars
    ii. Dissemination of Blue Shield Promise COC policy
    iii. Provider Manual updates
    iv. Individual Group onsite trainings
c. Delegated IPAs are bound to follow the requirement of COC in accordance with APL 18-008 provisions. Compliance will be monitored through reporting. The IPAs will be required to submit pre-established periodic reports to the Plan of all COC activities to include:
    i. Time frames for processing
    ii. Copies of Organization Determination Notices
    iii. Transition activities

V. Member Outreach and Education

a. Members will be informed of COC provisions through:
    i. Enrollment materials
    ii. Member Handbook
    iii. Welcome Calls
    iv. HRA process
    v. Member Services outreach activities
b. Education materials will include the availability of COC materials in threshold languages and other alternative formats at the request of the member

This Policy and Procedure does not apply to Continuity of Care for New Enrollees Transitioned to Managed Care after Requesting a Medical Exemption.

REFERENCES

Health & Safety Code, Section 1373.96
APL 18-008
APL 18-006
APL 21-015
Welfare & Institutions Code Section 14185 (b)
AB 577