blue california
Promise Health Plan

Policy Title: Continuity of Care for Medi-Cal Members		POLICY #: 10.2.40 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 1/01/14	**Effective Date** 11/22	**Revision Date** 12/01/18, 8/01/20, 6/25/21, 12/21, 3/22, 10/22, 12/22, 1/23
VP Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date of Approval:** 2/17/2023
Medical Services/P&T Committee: (If Applicable) PHP CMO			**Date of Committee Review:** 2/9/2023

A. PURPOSE

I. To define the policy and procedure and provide guidance on how Blue Shield Promise Health Plan (BSCPHP) has established a Continuity and Coordination of Care (COC) program for:

a. Qualified newly enrolled BSCPHP members.

b. Established BSCPHP member when their benefits or insurance coverage is scheduled to end, and they will require continued care.

c. Established BSCPHP members when an in-network provider is terminated for administrative reasons and the member is undergoing treatment for an acute or serious chronic medical condition, terminal illness, pregnancy, or newborn care.

d. Established Medi-Cal Fee for Service (FFS) members who were transferred to BSCPHP and are no longer permitted to remain in the Medi-Cal FFS plan.

i. The following populations will transition from FFS to Medi-Cal managed care no sooner than January 1, 2022:

1. Trafficking and Crime Victims Assistance Program, except share of cost (non-dual and dual)
2. Individuals participating in accelerated enrollment (non-dual and dual)
3. Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual)
4. Beneficiaries with other health coverage (non-dual)
5. Beneficiaries living in rural ZIP codes (non-dual))

ii. American Indian/Alaska Native beneficiaries have the option to opt in or opt out of managed care enrollment in Non-COHS counties only. In COHS counties, American Indian/Alaska Native beneficiaries do not have the option to opt out of mandatory managed care enrollment.

iii. In addition, DHCS will transition Omnibus Budget Reconciliations Act (OBRA)

and SOC beneficiaries (except institutional long-term care SOC beneficiaries) that are currently enrolled in the Medi-Cal managed care delivery system into Medi-Cal FFS.

iv. Skilled Nursing Facility (SNF) Long Term Care (LTC) Benefit Standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care

e. Medi-Cal FFS members who were mandatorily transitioned to BSCPHP from MCPs with contracts that are expiring or terminating

II. BSCPHP members undergoing treatment through a pre-existing provider relationship during the previous 12 months prior to enrollment into BSCPHP, 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:

B. DEFINITIONS

"Acute Conditions" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration

1. "Authorized Surgery/ Procedure" means surgery or another procedure which has been recommended and documented by the provider and scheduled to take place within 180 days of the enrollee's effective date or provider termination date and authorized for continued care by BSCPHP .

2. "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).

3. "Continuity of Care" is defined as the lack of interruption in needed care as it pertains to APL 18-008 and Health & Safety Code §1373.96

5. "Member with existing relationship" where a member has seen an out of network primary care provider (PCP) , specialist, or select ancillary provider at least once during the 12 months prior to the date of his or her initial enrollment into BSCPHP for a non-emergency visit.

6. "Newborn/Infants" are newborn to 36 months of age general pediatric or specialist care until the earlier of 12 months from the effective/provider termination date or the date the child is 36 months of age.

7. "Non-participating provider (non-contracted provider)" is a provider who is not contracted with BSCPHP , or a provider group contracted with BSCPHP .

8. "Pregnancy" is 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.
9. Defined as an imminent and serious threat to the health of the beneficiary.

10. "Risk of Harm" 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.

11. "Specialist" is 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.

12. "Select Ancillary Providers" include physical therapy, occupational therapy, respiratory therapy, behavioral health treatment, and speech therapy providers.

13. "Terminal Illness" is an incurable or irreversible condition that has a probability of causing death within one year or less. Terminal illness is covered for the duration of the terminal illness.

C. POLICY

I. BSCPHP recognizes that a strong doctor-patient relationship, particularly for members with serious medical and behavioral health conditions, may enhance the healing process. Maintaining continuity of care as members change doctors and health plans is an important aspect of this relationship. The BSCPHP COC program complies with National Committee for Quality Assurance (NCQA) standards, and Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) regulatory requirements in accordance with the Continuity of Care (CoC) requirements set forth in Health & Safety Code §1373.96.

II. **Program Goals** The goals of the BSCPHP COC program are to:

a. Promote continuous and appropriate care for members transitioning into BSCPHP by ensuring Member's IPA/Medical Group and both UM and CM are involved in the process, as necessary.
b. Strengthen continuity between medical and behavioral health care. BSCPHP facilitates timely communication, sharing of necessary information and coordination of care between and among member's mental health providers and between medical and mental health providers.
c. Provide a timely review of new enrollee requests to continue services with an existing health care provider who does not belong to Blue Shield's provider network.
d. Ensure a smooth transition of care to the new enrollee's BSCPHP contracted provider(s) at appropriate levels of care. If a Case Management need is identified, UM will ensure appropriate Clinical staff are involved.
e. Ensure that existing members who are in a course of treatment with a provider who is terminating as a BSCPHP contracted provider, including general acute care hospital and skilled nursing facilities, continue to receive timely and appropriate authorization and treatment.

D. PROCEDURES

I. **Qualified newly enrolled BSCPHP members** New BSCPHP Medi-Cal member has a pre-existing provider relationship during the previous 12 months prior to enrollment who is not in BSCPHP's Medi-Cal network. The member is entitled to apply for continuity of care to continue receiving services to complete the treatment plan for up to 12 months after the enrollment date

a. Established BSCPHP member when their benefits or insurance coverage is scheduled to end, and they will require continued care. An active course of treatment typically involves regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Treatment Record Review (TRR) providers only apply to behavioral health.

b. Discontinuing an active course of treatment resulting from the exhaustion or termination of a benefit or health coverage could cause a recurrence or worsening of the member's condition under treatment and interfere with anticipated outcomes. BSCPHP will act to ensure continuity of care, despite discontinuation of benefits or disenrollment from continued coverage for any member receiving an active course of treatment for an acute episode, or long term or chronic illness.

II. **Continued Coverage of Care with Terminated Network Providers** BSCPHP shall, at the request of the enrollee, provide the completion of covered services by a terminated or out of network provider, in accordance with the Continuity of Care (CoC) requirements set forth in Health & Safety Code §1373.96.

a. The completion of covered services shall be provided by the terminated provider to an enrollee who at the time of the contract's termination was receiving services from that provider for one of the conditions eligible for completion of covered services.
b. The completion of covered services shall be provided by a non-participating provider to a newly covered enrollee who at the time his or her coverage became effective was receiving services from that provider for one of the conditions eligible for completion of covered services.
c. Transition of care shall be implemented to members affected by a termination of provider/facility but are still in need of care.
d. Members who are in active course of treatment and who request for continuity of care due to termination of provider shall be granted.

III. **Medi-Cal Members currently enrolled in State Medi-Cal Transitioning to BSC**

a. Medi-Cal members that were enrolled in Medi-Cal FFS with DHCS transitioned to BSCPHP that have a pre-existing provider relationship during the previous 12 months prior to enrollment who is not in BSCPHP's Medi-Cal network. The member is entitled to apply for continuity of care to continue receiving services to complete the treatment plan for up to 12 months after the enrollment date.

b. Medi-Cal members in Skilled Nursing Facilities (SNF)
Effective January 1, 2023 through June 30, 2023, BSCPHP will automatically provide members residing in a SNF with 12 months of continuity of care for the SNF placement if the following conditions are met:

i. There is evidence of the member's SNF residency and a pre-existing relationship with the SNF
ii. The facility is enrolled and licensed by CDPH;
iii. The facility is enrolled as a Medi-Cal provider;
iv. The SNF and BSCPHP agree to payment rates that meet state statutory requirements, and
v. The facility meets BSCPHPs standards and does not have disqualifying quality-of-care issues.

c. Following the initial 12-month automatic COC period, members who require additional COC or members who enroll after June 30th ,2023 may request SNF COC in accordance with APL 18-008.

IV. **Conditions and Timeframes**

a. Acknowledgement of Receipt of COC Request
   i. BSCPHP will acknowledge receipt of the enrollee's COC request by notifying the enrollee in their preferred method of communication. Notices shall include acknowledgement that COC request has been received, the date of receipt, and the estimated timeframe for resolution.

b. Request Completion Timeframe
   i. 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
   ii. BSCPHP will complete continuity of care requests within the following timelines:
      1. Thirty (30) calendar days from the date the BSCPHP received the request;
      2. Fifteen (15) calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
      3. Three (3) 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; or
   ii. The member is notified of the denial. A clear and concise explanation of the denial decision will be provided, along with information on the member's appeal or grievance rights.

      1. A denial is issued If BSCPHP and out-of-network FFS or prior managed Care Plan (MCP) provider are unable to agree to a rate or BSCPHP has documented quality of care issues, BSCPHP will offer the member an in network alternative. If the member does not select a provider, an in-network provider will be assigned. The member retains the right to file a grievance if they disagree with the decision.

d. Member Notification of decision
   i. For non-urgent requests, BSCPHP will provide written provider and member notification within seven calendar days of decision.
   ii. For urgent requests, BSCPHP will provide written provider and member notification as expeditiously as possible, but not to exceed three calendar days from the date of decision.

V. Completion of eligible covered services, as set for in Health & Safety Code §1373.96(c) and APL 22-032:

a. Active prior treatment authorizations for services in effect following a member's transition into BSCPHP will be honored for 90 days and the service(s) will be provided by a contracted provider. The member or member representative will

not need to submit a request. After 90 days. The authorization will remain in effect for the duration of the active prior authorization or until a new assessment is completed by the provider, whichever is shorter.

b. Acute Condition: a medical condition that involves a sudden onset of symptoms due to illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
    i. Completion of covered services shall be provided for the duration of the acute condition.
c. 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 or requires ongoing treatment to maintain remission or prevent deterioration.
    i. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by BSCPHP, in consultation with the enrollee and the terminated provider or non-participating provider and consistent with good professional practice.
    ii. 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.
d. Pregnancy: is the three trimesters of pregnancy and the immediate postpartum period, including maternal mental health.
    i. Completion of covered services shall be provided for the duration of the pregnancy; including individuals with documented maternal mental health, the completion of covered services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
    ii. The postpartum period begins immediately after childbirth and extends for 12 months.
e. Performance of surgery or other procedure: that is authorized BSCPHP, 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.
f. Terminal illness: is an incurable or irreversible condition that has a high probability of causing death within one year or less.
    i. 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.
g. The care of a newborn child between birth and age 36 months.
    i. Completion of covered services shall not exceed 12 months from contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
h. Specialty mental health services: up to 12 months continuity of care with the out-of-network Mental Health Plan.

i. Members with an existing relationship: the beneficiary has seen an out of network primary care provider (PCP), specialist, or select ancillary provider at least once during the 12 months prior to the date of their initial enrollment with BSCPHP for a non-emergency visit
j. Coverage of durable medical equipment (DME) rentals and medical supplies for members with an existing provider and a previous authorization, at least 90 days following MCP enrollment and until BSCPHP is able to reassess, the new DME or medical supplies are in possession of the member, and ready for use
k. Coverage of the modality of transportation for Members receiving Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) under a previous authorization until BSCPHP is able to reassess the member's continued transportation needs
l. Active course of treatment is when a member has 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. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

VI. Conditions and Timeframes for Access to Continuity of Care Providers

a. Validate an existing relationship
   i. the beneficiary has seen an out-of-network PCP, specialist, or select ancillary provider at least once during the 12 months prior to the date of his or her initial enrollment into BSCPHP for a non-emergency visit.
   ii. If a beneficiary changes MCPs or loses and then later regains eligibility during the 12 -month period, the 12-month continuity of provider period may start over one time. If the beneficiary changes another MCP or loses and then later regains eligibility 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.
   iii. If the beneficiary returns to Medi-Cal FFS and later re-enrolls in BSCPHP, the continuity of care period does not start over. If a beneficiary changes to BSCPHP, this continuity of care policy does not extend to providers that the beneficiary accessed through their previous MCP.
   iv. The provider is willing to accept Medi-Cal FFS rates or accepts BSCPHP'scontract rates.
   v. The provider meets applicable professional standards and does not have any disqualifying quality of care issues.
   vi. The provider is a California State Plan approved provider.

b. Validate an existing Behavioral Health Treatment relationship
   i. 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 for up to 12 months.

ii. Behavioral Health Treatment for Members Under the Age of 21 upon BSCPHP Transition: BSCPHP will ensure that members under 21 receive Early and Periodic Screening, Diagnostic, and Treatment services.
iii. 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 Regional Center (RC) to BSCPHP or the date of the member's initial enrollment in BSCPHP if enrollment occurred on or after July 1, 2018.

c. If this this request from a transition of BHT Services from a Regional Center (RC) to BSCPHP
    i. 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 BSCPHP, as well as member specific utilization and assessment data.
    ii. If the beneficiary has an existing BHT service relationship, as defined above, with an in-network provider, BSCPHP must assign the beneficiary to that provider to continue BHT services.
    iii. DHCS utilizing data that is supplied to the Plan will be used to identify each beneficiary BHT provider and proactively contact the provider or providers to begin the CoC process, regardless of whether a beneficiary's parent or guardian files a request for CoC.
    iv. If the data file indicates that multiple providers of the same type meet the criteria for CoC BSCPHP should attempt to contact the beneficiary's parent or guardian to determine his or her preference.
    v. If BSCPHP does not have access to beneficiary data that identifies an existing BHT provider, BSCPHP 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 CoC.
    vi. If the RC is unwilling to release specific provider rate information to BSCPHP, then BSCPHP may negotiate rates with the CoC provider without being bound by the usual requirement that BSCPHP offer at least a minimum FFS – equivalent rate.
    vii. If BSCPHP is unable to complete a CoC agreement, BSCPHP must ensure that all ongoing services continue at the same level with an MCP in-network provider until BSCPHP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.
    viii. BSCPHP may refer to the CoC section of APL 18-006 for additional requirements and information regarding CoC for transitioning members receiving BHT.
    ix. Retroactive requests for BHT service CoC reimbursement are limited to services that were provided after a member's transition date into BSCPHP, or the date of the member's enrollment into BSCPHP, if the enrollment date occurred after the transition.
    x. BSCPHP will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.
d. BSCPHP shall provide 12 months of CoC to an OON Mental Health Plan (MHP) provider if the member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the MHP and instead becomes eligible to receive Non-Specialty Mental Health Services (NSMHS) from BSCPHP.
e. 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.
f. Pregnant and Post-partum Medi-Cal beneficiaries BSCPHP 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.

i. Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into BSCPHP have the right to request out-of-network provider CoC for up to twelve (12) months in accordance with plan contracts and the foregoing requirements.
ii. 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.

i. g. Newly Enrolled Senior and Persons with Disabilities (SPDs) that have any active FFS Treatment Authorization Requests (TARs). The TARs will be honored, without a request by the beneficiary or the provider, for up to 60 days or until a new assessment is completed by the BSCPHP And when meeting the requirements of COC defined by current law, the COC will be arranged for a period of up to 12 months.

h. Covered California to Medi-Cal Managed Care.

i. BSCPHP shall contact the beneficiary by telephone call, letter, or other resources no later than 15 days after enrollment.
ii. BSCPHP shall ask the beneficiary if there are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the CoC process at that time.
iii. BSCPHP will honor any active Prior Treatment Authorizations for up to 90 days or until a new assessment is completed by BSCPHP.
iv. 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.
v. The prior treatment authorizations must be honored without a request by the beneficiary or the provider.
vi. At the beneficiary's or provider's request, BSCPHP will offer up to 12 months of CoC with out-of-network providers, in accordance with the DHCS policy requirements listed APL 13-023 and APL 22-032.
    1. And then CoC will be up to 12 months as defined by APL 18-008 and Health & Safety Code §1373.96

VII. Terms and Conditions with Non-Participating Provider:

a. BSCPHP 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, BSCPHP is not required to continue the provider's services.
c. Unless otherwise agreed upon by the non-participating provider and BSCPHP, the services rendered shall be compensated at Medi-Cal fee-for-service rate.
d. Neither BSCPHP 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. BSCPHP 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 BSCPHP 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. BSCPHP 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 BSCPHP 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 BSCPHP, BSCPHP shall offer the member the opportunity to return to the out-of-network SNF after a medically necessary absence.
    i. This requirement does not apply if the member is discharged from the SNF into the community or a lower level of care.

        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.

VIII. **Exclusions**:

a. BSCPHP 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. BSCPHP is not required to cover services or provide benefits that are not otherwise covered under Medi-Cal or the terms and conditions of BSCPHP'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.

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

X. 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 §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 participating Medi-Cal provider meets criteria and agrees to accept the higher of BSCPHP rates or Medi-Cal FFS rates, BSCPHP shall offer a letter of agreement for:
    i. Conditions and Timeframes for Completion of eligible covered services, as set forth in §1373.96
    ii. Conditions and Timeframes for Completion of eligible covered services, as set forth in APL 18-008.
c. BSCPHP will collaborate 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 BSCPHP 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. BSCPHP shall document COC request outcomes in member file.

f. BSCPHP 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 BSCPHP, 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 BSCPHP.
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 BSCPHP 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.

XI. Delegated Oversight
a. BSCPHP shall ensure the delegates meet the requirements of HSC §1373.96 and APL 18-008.
b. Providers and delegates will be educated on COC provisions through:
    i. Webinars
    ii. Dissemination of BSCPHP 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
    iv. Member Outreach and Education

XII. Members will be informed of COC provisions through:
   a. Enrollment materials
   b. Member Handbook
   c. Welcome Calls
   d. Health Risk Assessment process
   e. Member Services outreach activities
   f. Education materials will include the availability of COC materials in threshold languages and other alternative formats at the request of the member

All of BSCPHP authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §438.900, et seq and reference P&P 10.26.3 Behavioral Health Services.

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

E. MONITORING: N/A

F. REPORTING: N/A

G. REFERENCES & ATTACHMENTS

1. 42 CFR §438.900
2. AB 577
3. APL 18-006, APL 21-015, APL 22-018, APL 22-032
4. Health & Safety Code, §1373.96
5. P&P 10.26.3 Behavioral Health Services
6. Welfare & Institutions Code §14185 (b)
7. 10.2.55 Skilled Nursing Facility (SNF)

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
2/2023	Updated Regulatory Requirements DHCS	