Policy:	MA.6021a
Title:	**Continuity of Care for New Members**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 05/09/2024*
Effective Date:	09/01/2008
Revised Date:	05/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health ensures Continuity of Care for a newly enrolled Member.

II. POLICY

A. CalOptima Health and a Member's Health Network shall provide Continuity of Care for a newly enrolled Member to prevent the delay, or interruption, of Medically Necessary Covered Services if the following circumstances exist:

1. The Member has an existing relationship with a primary or specialty care provider.

    a. An existing relationship means the member has seen an out-of-network Primary Care Provider (PCP) or a specialty care provider at least once during the twelve (12) months prior to the date of their initial enrollment for a non-emergency visit and may be determined through but not be limited to:

        i. The Health Risk Assessment (HRA) process; or

        ii. Review of prior utilization data; or

        iii. Member request.

2. The Provider is willing to accept, at a minimum, payment based on the current Medicare fee schedule, as applicable; and

3. The Provider does not have any documented quality of care concerns that would exclude the Provider from the network.

B. CalOptima Health or a Health Network shall provide Continuity of Care for Primary and Specialty Providers upon request by member, Authorized Representatives, or their Providers.

C. CalOptima Health or a Health Network shall consider approving the completion of Covered Services without interruption for a Member who has one of the following conditions in accordance with the terms and conditions of this policy:

1. An Acute Condition;

2. A Serious Chronic Condition;

3. A pregnancy;

4. A Terminal Illness; or

5. A performance of a surgery or other procedure that has been authorized as part of a documented course of Treatment and has been recommended and documented by a Practitioner to occur within one hundred and eighty (180) calendar days after the effective date of the Member's enrollment in OneCare.

D. CalOptima Health or a Health Network shall provide Continuity of Care for twelve (12) months from the date of enrollment, upon approval of the request.

E. CalOptima Health and a Member's Health Network shall provide Continuity of Care for Durable Medical Equipment (DME) and medical supply providers according to the process outlined in section III.C. of this policy.

F. For Members already receiving Medi-Cal Enhanced Care Management, (ECM) CalOptima Health or a Health Network shall provide ongoing Continuity of Care in accordance with CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration.

G. If the Member leaves OneCare and later rejoins, CalOptima Health and a Member's Health Networks must offer the Member a twelve (12)- month Continuity of Care period based on the date of re-enrollment, regardless of whether the Member received Continuity of Care in the past.

1. If the Member leaves OneCare a second time (or more), the Continuity of Care period does not start over, meaning CalOptima Health or the Health Network is not required to offer the Member a new twelve (12) month period.

H. A Member, a Member's Authorized Representative, a Provider, or a Practitioner may appeal a Health Network's Continuity of Care decision in accordance with CalOptima Health Policies MA.9003: Standard Pre-Service Appeal, MA.9004: Expedited Pre-Service Appeal, and MA.9006: Contracted Provider Complaint Process.

I. CalOptima Health or a Health Network shall process a Prior Authorization request for Continuity of Care in accordance with CalOptima Health Policies GG.1508: Authorization and Processing of Referrals and MA.6042: Integrated Organization Determinations.

III. PROCEDURE

A. Request for Continuity of Care

1. On and after the effective date of enrollment in OneCare, a newly enrolled Member, their authorized representatives, or their Providers may contact the OneCare Customer Service Department to request Continuity of Care.

a. Only Providers who treat the Member may make a request for Continuity of Care.

b. Requests may be made telephonically.

c. Retro requests will be accepted for review.

i. Services must have occurred after the Member's enrollment.

2. CalOptima Health or the Health network must approve any retroactive Continuity of Care requests that:

a. Have dates of service within thirty (30) calendar days of the first dates of service for which the Provider is requesting, or has previously requested, Continuity of Care retroactive reimbursement; and

b. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is being requested or denial from another entity when the claim is incorrectly submitted.

c. Retroactive requests that are submitted more than thirty (30) days after the first service if the Provider can document that the reason for the delay is that the Provider unintentionally sent the request to the incorrect entity and the request is sent within thirty (30) days of the denial from the other entity.

i. The Continuity of Care process begins when CalOptima Health or a Health Network starts to determine if there is a pre-existing relationship and enters into an agreement with the Provider.

3. When a request for Continuity of Care is made, CalOptima Health or a Health Network must process the request within five (5) working days after receipt of the request.

a. The Continuity of Care process begins when CalOptima Health or a Health Network starts to determine if there is a pre-existing relationship and enters into an agreement with the Provider.

4. The OneCare Customer Service Department shall assist an affected Member in completing a request for Continuity of Care and transmit such request to CalOptima Health's Case Management Department for coordination with a Health Network.

5. CalOptima Health's Case Management Department shall forward the request for Continuity of Care to the Health Network that the affected Member selected.

6. CalOptima Health or a Health Network shall provide Case Management to a Member who requests Continuity of Care in accordance with CalOptima Health Policy MA.6009: Care Management and Coordination Process.

B. Authorization of Continuity of Care

1. Upon receipt of a Member's request for Continuity of Care, CalOptima Health or a Health Network shall collect Medical Records and other information necessary to review the request for Continuity of Care.

2. CalOptima Health or a Health Network shall give reasonable consideration to the potential clinical effects on an affected Member's Treatment caused by a change in Provider, or Practitioner, and shall consider the following criteria in adjudicating a request for Continuity of Care:

    a. Determine if the affected Member has one (1) of the conditions described in Section II.C. of this policy;

    b. Determine if the affected Member is in active Treatment for such condition including but not limited to actively seeing the Provider and following the Course of treatment;

    c. Determine if the affected Member can safely transition to a participating Provider, or Practitioner, instead of continuing care with the terminated Provider, or Practitioner; and

    d. Determine if transitioning the affected Member to a new Provider, or Practitioner, would compromise the Treatment plan, or worsen the condition of the affected Member.

3. When a Member has an existing relationship with a PCP and at least one specialist that is in CalOptima Health's or a Health Network's network, and the Member wishes to continue to seek treatment from each of these Providers, CalOptima Health or a Health Network shall allow the Member to continue treatment with each of these Providers for the Continuity of Care period. This is regardless of whether these Providers are, or are not, in the delegated network of the primary plan's delegated entity to which the Member is assigned, as long as the Continuity of Care requirements are met.

4. CalOptima Health or a Health Network shall make a decision on the request for Continuity of Care within the time frames specified:

    a. Thirty (30) calendar days from the date the request received; or

    b. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention; or

    c. Three (3) calendar days if there is risk of harm to the Member.

5. CalOptima Health or a Health Network shall notify an affected Member of its decision to approve, or deny, a request for Continuity of Care within seven calendar days of approved Continuity of Care requests that include the following:

    a. A statement of decision;

    b. Duration of the Continuity of Care arrangement;

    c. The process that will occur to transition the Member's care at the end of the Continuity of Care Period; and

    d. The Member's right to choose a different network Provider.

6. If CalOptima Health or a Health Network approves Continuity of Care for an affected Member, the Health Network shall provide Continuity of Care for as long as Medically Necessary as follows:

a. If CalOptima Health or a Health Network approves Continuity of Care for an episode of care for an Acute Condition, the Health Network will provide Continuity of Care for the duration of that episode of care.

b. If CalOptima Health or a Health Network approves Continuity of Care for a Serious Chronic Condition, CalOptima Health or the Health Network will provide Continuity of Care for the period of time necessary to complete a course of Treatment and to arrange for a safe transfer to a participating Provider, or Practitioner, as determined by CalOptima Health or the Health Network, in consultation with the affected Member and the Non-Contracted Provider, or Practitioner, and consistent with good professional practice, not to exceed twelve (12) months from the affected Member's effective date of coverage with the Health Network.

c. If CalOptima Health or a Health Network approves Continuity of Care for a pregnancy, CalOptima Health or the Health Network will provide Continuity of Care for the duration of the pregnancy.

d. If CalOptima Health or a Health Network approves Continuity of Care for a Terminal Illness, CalOptima Health or the Health Network will provide Continuity of Care for the duration of the Terminal Illness.

e. CalOptima Health or a Health Network may approve Continuity of Care for the performance of a surgery, or other procedure, that has been authorized as part of a documented course of Treatment and has been recommended and documented by a Provider, or Practitioner, to occur within one hundred and eighty (180) calendar days after the Member's effective date of coverage with CalOptima Health or the Health Network.

7. If CalOptima Health or a Health Network denies Continuity of Care for an affected Member, CalOptima Health or the Health Network shall request an affected Member's Medical Records from the Non-Contracted Provider, or Practitioner, and shall coordinate the transfer of such Medical Records and the transition plan to the participating Provider, or Practitioner, to whom the affected Member is transitioning. CalOptima Health or a Health Network shall ensure that there is no delay in the affected Member's care.

C. A Continuity of Care request is considered completed when:

1. The Member is informed of their right to continued accessor if CalOptima Health or a Health Network and the out-of-network provider are unable to agree to terms;

2. CalOptima Health or a Health Network has documented quality of care issues with the Provider; or

3. CalOptima Health or a Health Network makes a good faith effort to contact the Provider and the Provider is non-responsive for thirty (30) calendar days.

D. If CalOptima Health, or a Health Network are unable to reach an agreement on terms or a reimbursement rate, or there is documented quality of care issues with the Provider, CalOptima Health, or a Health Network shall offer the Member an in-network Provider alternative.

E. CalOptima Health, or the Health Network shall notify the Member thirty (30) calendar days before the end of the Continuity of Care period about the process that will occur to transition the Member's care at the end of the Continuity of Care period. This process shall include engaging with the

Member and Provider before the end of the Continuity of Care period to ensure continuity of services to the new Provider.

F. Continuity of Care for DME and medical supply Providers

1. CalOptima Health or a Health Network shall allow a Member with existing DME rental to keep their existing rental equipment as follows:

   a. After ninety (90) days and until the Member can be reassessed;

   b. If Medically Necessary, authorize a new rental; and

   c. Have an in-network Provider deliver the Medically Necessary rental.

2. CalOptima Health or a Health Network shall allow a Member with an open authorization to receive medical supplies to keep their existing Provider as follows:

   a. For ninety (90) days and until Member is reassessed;

   b. If Medically Necessary, authorize supplies; and

   c. Have an in-network Provider deliver the Medically Necessary supplies.

G. Provision of Covered Services

1. CalOptima Health or a Health Network shall allow a Member to change Providers at any time regardless of whether or not a Continuity of Care relationship has been established.

2. CalOptima Health or a Health Network may require a Non-Contracted Provider, or Practitioner, whose services are continued pursuant to this policy to accept the terms and conditions that are imposed upon a participating Provider or Practitioner providing similar services who are not capitated and who are practicing in the same, or similar, geographic area as the Non-Contracted Provider, or Practitioner, including but not limited to, rate of payment, Credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If a Non-Contracted Provider, or Practitioner, does not agree to comply, or does not comply, with these contractual terms and conditions, CalOptima Health, or a Health Network, shall not continue such terminated Provider's, or Practitioner's, services.

3. CalOptima Health or a Health Network shall pay Continuity of Care services for an affected Member at rates and methods of payment similar to those used by CalOptima Health, or a Health Network, for a participating Provider, or Practitioner, providing similar services who are not capitated and who are practicing in the same, or similar, geographic area as the Non-Contracted Provider, or Practitioner, unless some other mutually agreed upon rate prevails between a Non-Contracted Provider, or Practitioner, and CalOptima Health, or a Health Network. CalOptima Health, or a Health Network, shall not continue the services of a Non-Contracted Provider, or Practitioner, if such Provider, or Practitioner, does not accept the contract rate offered by CalOptima Health, or a Health Network.

4. If a Non-Contracted Provider or Practitioner does not agree to comply, or does not comply, with the contractual terms and conditions as described in Section III.C.1. of this Policy, or if such Provider, or Practitioner, does not accept the contract rate offered by a Health Network as described in Section III.C.2. of this Policy, the Health Network shall notify CalOptima Health of the Provider's or Practitioner's refusal prior to transitioning an affected Member's care.

5. An affected Member shall pay the same amount of, and the requirement for payment of, co-payments, deductibles, or other cost sharing components during the period of completion of Covered Services with a terminated Provider, or Practitioner, as would be paid by a Member if receiving care from a participating Provider, or Practitioner.

6. CalOptima Health, or a Health Network, shall not cover services, or benefits, that are not otherwise covered under the OneCare program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Assembly Bill (A.B.) 133 (Chapter 143, Statutes of 2021), the Health Omnibus Budget Trailer Bill, Welfare and Institutions Code (WIC) §14184.208
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy GG.1356: CalAIM Enhanced Care Management Administration
D. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
E. CalOptima Health Policy MA.6009: Care Management and Coordination Process
F. CalOptima Health Policy MA.6042: Integrated Organization Determinations
G. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
H. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
I. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontract Terminations (Supersedes APL 16-001)
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care From Medi-Cal Fee-For-Service, On Or After January 1, 2023 (Supersedes APL 22-032)
L. Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plans (D-SNP) Policy Guide, CY24
M. Title 42, Code of Federal Regulations (C.F.R.) §§422.100(l)(2)(iii), 422.112(b)(8)(i)(A) & 422.112 (b)(8)(ii)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2008	MA.6021a	Continuity of Care for New Members	OneCare
Revised	01/01/2016	MA.6021a	Continuity of Care for New Members	OneCare
Revised	01/01/2017	MA.6021a	Continuity of Care for New Members	OneCare
Revised	10/01/2017	MA.6021a	Continuity of Care for New Members	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2018	MA.6021a	Continuity of Care for New Members	OneCare
Revised	02/01/2020	MA.6021a	Continuity of Care for New Members	OneCare
Revised	09/01/2021	MA.6021a	Continuity of Care for New Members	OneCare
Revised	12/31/2022	MA.6021a	Continuity of Care for New Members	OneCare
Revised	01/01/2024	MA.6021a	Continuity of Care for New Members	OneCare
Revised	05/01/2024	MA.6021a	Continuity of Care for New Members	OneCare

IX. GLOSSARY

Term	Definition
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.
Authorized Representative (HIPAA)	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009: Access by Member's Personal Representative.
Continuity of Care	Continuity of Care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Course of Treatment	A prescribed order or ordered course of treatment for a specific individual with a specific condition is outlined and decided upon ahead of time with the patient and provider. A course of treatment may but is not required to be part of a treatment plan.
Covered Services	Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Enhanced Care Management	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
Health Risk Assessment	A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period. The weighted score of the answers stratifies care management level based on the overall score.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medically Necessary	The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Non-Contracted Provider	A Provider that is not obligated by written contract to provide Covered Services to a Member on behalf of CalOptima Health or a Health Network.
Practitioner	A licensed independent Practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services as described in OneCare Policies.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
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 either 1. Persists without full cure or worsens over an extended period, or 2. Requires ongoing Treatment to maintain remission or to prevent deterioration.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.