Policy:	MA.6021
Title:	**Continuity of Care for Members Involuntarily Transitioning Between Providers or Practitioners**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 01/29/2024*
Effective Date:	08/01/2005
Revised Date:	01/01/2024
Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health ensures Continuity of Care for a Member involuntarily transitioning between Providers or Practitioners.

II. POLICY

A. A Member may be required to transition between Providers or between Practitioners due to circumstances including, but not limited to, termination, or non-renewal, of a contract between CalOptima Health, or a Health Network, and a Provider, or a Practitioner.

B. CalOptima Health, and a Member's Health Network shall provide Continuity of Care for a Member involuntarily transitioning between Providers, or between Practitioners, in accordance with the terms and conditions of this policy.

C. CalOptima Health or a Health Network shall consider approving the completion of Covered Services without interruption for a Member who has one (1) of the following conditions in accordance with the terms and conditions of this policy:

1. An existing relationship means the Member has seen 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 limited to:

   i. The Health Risk Assessment, HRA process;

   ii. Review of prior utilization data; or,

   iii. Member request.

2. An existing DME rental;

3. Open authorization to receive medical supplies;

4. An Acute Condition;

5. A Serious Chronic Condition;

6. A pregnancy;

7. A Terminal Illness; or

8. 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 Provider's, or Practitioner's contract termination date.

D. A Member, a Member's Authorized Representative, a Provider, or a Practitioner may appeal CalOptima Health's or 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.

III. PROCEDURE

A. CalOptima Health shall notify an affected Member of a Provider, or Practitioner, termination in accordance with CalOptima Health Policy MA.4011: Notice of Change in Location and Availability of Covered Services.

B. Identification of Continuity of Care Needs

1. Upon termination of a Provider or Practitioner, CalOptima Health or a Health Network shall identify a Member with Continuity of Care needs through methods including, but not limited to, the Case Management process and authorization logs.

   a. In the event of a Health Network terminating its contract, the terminating Health Network shall identify Members with Continuity of Care needs and communicate this to CalOptima Health.

2. Upon notice of a Provider or Practitioner termination, or non-renewal of a contract, an affected Member, Authorized Representatives, or their Providers may request Continuity of Care to CalOptima Health, or a Health Network.

3. CalOptima Health or a Health Network shall assist an affected Member in completing a request for Continuity of Care, as needed.

4. CalOptima Health or a Health Network shall develop a Transition of Care plan upon identifying an affected Member with a need for Continuity of Care, or upon receipt of a Member's request for Continuity of Care, regardless of whether CalOptima Health, or a Health Network, approves, or denies, such request.

   a. In the event of a Health Network terminating their contract, the terminating Health Network shall develop the transition care plan for Members requesting Continuity of Care.

C. Authorization of Continuity of Care

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

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

        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.

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 of the conditions described in Section II.C. of this policy;

    b. Determine if the affected Member is in active Treatment for such condition;

    c. Determine if the affected Member can safely transition to a contracted Provider, or Practitioner, instead of continuing care with the Non-Contracted 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. 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 .

4. 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 (7) calendar days and 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.

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

    a. If CalOptima Health or a Health Network approves Continuity of Care for an episode of care for an Acute Condition, CalOptima Health or the Health Network shall 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 shall 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 contracted Provider, or Practitioner, as determined by CalOptima Health or the Health Network, in consultation with the affected Member and the Non-Contracting 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 shall 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 shall provide Continuity of Care for the duration of the Terminal Illness.

    e. CalOptima Health or the 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 Practitioner to occur within one hundred and eighty (180) calendar days after the Provider's, or Practitioner's, contract termination date.

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

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

1. The Member is informed of their right to continued access or 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.

E. If CalOptima Health, or the 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.

F. 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.

G. 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

H. 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 contracting Provider or Practitioner providing similar services, who are not capitated, and who are practicing in the same, or similar, geographic area as a 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 Non-Contracted Provider's or Practitioner's services.

3. CalOptima Health or a Health Network shall pay continuation 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 contracting Provider, or Practitioner, providing similar services, who are not capitated, and who are practicing in the same, or similar, geographic area as a 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.D.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.D.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. CalOptima Health or a Health Network 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 Non-Contracted Provider or Practitioner as would be paid by a Member if receiving care from a contracting Provider or Practitioner.

6. CalOptima Health or a Health Network shall not provide for the completion of Covered Services by a Non-Contracted Provider or Practitioner if such Non-Contracted Provider's or Practitioner's contract has been terminated for reasons relating to a medical disciplinary cause of reason, as defined in paragraph six (6) of subdivision (a) of Section 805 of the Business and Profession Code, Fraud or other criminal activity.

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

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Profession Code, Section 805
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Policy MA.4011: Notice of Change in Location and Availability of Covered Services
D. CalOptima Health Policy MA.9003: Standard Pre-Service Appeal
E. CalOptima Health Policy MA.9004: Expedited Pre-Service Appeal
F. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
G. Department of Health Care Services All Plan Letter (APL) 23-022: Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Revised)
H. Department of Health Care Services All Plan Letter (APL) 21003: Medi-Cal Network Provider and Subcontract Terminations (supersedes APL 16-001)
I. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract year 2023 November 2023
J. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract year 2024 December 2023

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	08/01/2005	MA.6021	Continuity of Care for Members Transitioning between Providers or Practitioners	OneCare
Revised	09/01/2008	MA.6021	Continuity of Care for Members Transitioning between Providers or Practitioners	OneCare
Revised	01/01/2016	MA.6021	Continuity of Care for Members Transitioning between Providers or Practitioners	OneCare
Revised	01/01/2017	MA.6021	Continuity of Care for Members Transitioning between Providers or Practitioners	OneCare
Revised	10/01/2017	MA.6021	Continuity of Care for Members Transitioning between Providers or Practitioners	OneCare
Revised	08/01/2018	MA.6021	Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners	OneCare
Revised	02/01/2020	MA.6021	Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners	OneCare
Revised	09/01/2021	MA.6021	Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners	OneCare
Revised	11/01/2022	MA.6021	Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners	OneCare
Revised	01/01/2024	MA.6021	Continuity of Care for Members Involuntarily Transitioning between Providers or Practitioners	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	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 Health Policy HH.3009: Access, Use, and Disclosure of PHI to a Member's Authorized Representative.
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.
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	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; and 4. Is appropriate for use in or out of the patient's home.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Network	A Physician Hospital Consortium (PHC), physician group 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.
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
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.
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.
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.
Primary Care Practitioner/Physician (PCP):	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
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	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.