Policy:	GG.1325
Title:	**Continuity of Care for Members Transitioning into CalOptima Health Services**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 03/06/2025*
Effective Date:	01/01/2015
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Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes the Continuity of Care guidelines and the process to identify newly enrolled Medi-Cal Members who transition into CalOptima Health or existing Members whose Covered Services are transitioned from Medi-Cal Fee-for-Service (FFS) to CalOptima Health.

II. POLICY

A. CalOptima Health shall screen all newly enrolled Members for the need for expedited services upon their enrollment into CalOptima Health as described in Section III.B. of this Policy.

B. Upon disenrollment, CalOptima Health shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

C. The following Members who transition into CalOptima Health or a Health Network on or after January 1, 2023, may request Continuity of Care for up to twelve (12) months after the enrollment date with CalOptima Health or a Health Network:

1. Newly enrolled in CalOptima Health or a Health Network from Medi-Call Fee-For-Service;

2. Transitioned into CalOptima Health or a Health Network;

3. Mandatorily transitioning from Medi-Cal FFS to enroll as a Member to CalOptima Health or a Health Network; or

4. Transitioning from a Managed Care Plan (MCP) with contracts expiring or terminating to CalOptima Health or a Health Network.

5. Aged twenty-six to forty-nine (26-49) Adult Expansion Transition (Adult Expansion Population)

D. CalOptima Health or a Health Network shall ensure starting November 1, 2023, that transitioning Members who seek assistance before January 1, 2024, while not yet enrolled in the CalOptima Health

and a Health Network shall be offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

E. With respect to Kaiser effective January 1, 2024, CalOptima Health and it's Health Networks will ensure an effective transition, facilitate continued access and minimize service interruptions for the following Members subject to the same Continuity of Care protections:

   1. Members enrolled with Kaiser will maintain their enrollment with Kaiser and will have the option to actively choose CalOptima Health or a Health Networks as a plan.

   2. A Member transitioning from Kaiser into CalOptima Health, or a Health Network may opt to change back to Kaiser, subject to Kaiser's eligibility criteria.

   3. A newly enrolled or existing CalOptima Health or a Health Network Member may request Kaiser as a plan subject to Kaiser's eligibility criteria.

F. With respect to the age twenty-six to forty-nine (26-49) Adult Expansion Population, effective January 1, 2024, CalOptima Health or a Health Network shall ensure an effective transition, facilitate continued access, minimize service interruptions, and adhere to all Continuity of Care requirements, in accordance with 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, 2024, for these newly enrolled or transitioning Members.

   1. A Member is not required to request Continuity of Care to maintain their PCP assignment with PCPs that are part of CalOptima Health or a Health Network In-Network Providers.

   2. If the Members PCP is Out-of-Network, CalOptima Health or a Health Network is not required to maintain that agreement.

G. Upon request from the Member, Authorized Representative or Provider (i.e., the requestor) and in accordance with this Policy, CalOptima Health or a Health Network shall ensure Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima Health, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the criteria are met.

H. If CalOptima Health or a Health Network is unable to provide Covered Services through a Network Provider services shall be arranged for an Out-of-Network Provider, in accordance with CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services.

I. CalOptima Health or a Health Network shall provide Continuity of Care to extend to Primary Care Providers (PCPs), specialists, and select ancillary Providers, including:

   1. Dialysis Centers;

   2. Physical Therapy;

   3. Occupational Therapy;

   4. Respiratory Therapy;

5. Behavioral Health Therapy;

6. Speech Therapy Providers;

7. Doulas; and

8. Community Health Workers.

I. CalOptima Health or a Health Network shall provide Continuity of Care for a Member as described in this Policy, except for the following types of Providers:

1. Durable Medical Equipment (DME), excluding Specialized or Customized DME for Members eligible with the CCS Program and transitioned into the WCM program as described in Section III.S.14.b.i.a. of this Policy;

2. Transportation; and

3. Other ancillary services, such as;

a. Radiology;

b. Laboratory; and

c. Non-enrolled Medi-Cal Providers.

J. CalOptima Health or a Health Network shall provide Continuity of Care for a Member seen by a traditional or Safety-Net Provider upon entry into CalOptima Health or a Health Network to the extent possible.

K. Continuity of Care for Members in the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant or receiving a transplant in the previous twelve (12) months is coordinated, in accordance with CalOptima Health Policies GG.1105: Coverage of Organ and Tissue Transplants, and GG.1313: Coordination of Care for Transplant Member.

L. CalOptima Health and Health Networks are also required to comply with existing state law Continuity of Care obligations, which may allow a Medi-Cal Member a longer period of treatment by an Out-of-Network Provider than would be required under DHCS APL 22-032: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Members Who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023.

M. CalOptima Health or a Health Network shall not provide Continuity of Care for:

1. Services not covered by Medi-Cal; and

2. Services carved-out of CalOptima Health's contract with the DHCS.

N. If a Member changes Medi-Cal Managed Care Plans (MCP), the twelve (12) month Continuity of Care period may start over one (1) time. If a Member changes MCPs a second time (or more), the Continuity of Care period does not start over, meaning that the Member does not have the right to a new twelve (12) months of Continuity of Care. If a beneficiary changes MCPs, this Continuity of Care Policy does not extend to Providers that the beneficiary accessed through their previous MCP. If the Member returns to

Medi-Cal FFS and later reenrolls in CalOptima Health, the Continuity of Care period does not start over, but may be completed only if the Member:

1. Returned to FFS for less than the twelve (12) month Continuity of Care period; and

2. Was eligible for and elected to receive Continuity of Care during the previous CalOptima Health enrollment period.

O. An existing Out-of-Network Provider approved to provide continuing treatment must work with CalOptima Health and its contracted network and cannot refer the Member to another out-of-network Provider without prior authorization from CalOptima Health or the Member's Health Network.

P. CalOptima Health shall inform Members of the Continuity of Care protections and how to initiate a Continuity of Care request in written Member materials, including but not limited to, the Member Handbook, available by request and on the CalOptima Health website at www.caloptima.org, and Member newsletter.

Q. CalOptima Health or a Health Network shall provide training to call center staff who come into regular contact with Members about the Continuity of Care requests and protections.

R. Continuity of Care for Medicare Providers of dually eligible Members is coordinated, in accordance with CalOptima Health Policy MA.6021a: Continuity of Care for New Members.

III. PROCEDURE

A. CalOptima Health shall make three attempts to contact a Member using available modalities to conduct an initial screening or assessment of each Member's needs within ninety (90) days of enrollment.

1. A Health Information Form (HIF) will be included in each new Member welcome packet mailing with a postage paid envelope.

2. Additional outreach, case management, and care coordination activities may occur in accordance with CalOptima Health Policies GG.1201: Health Education Programs and GG.1301: Comprehensive Care Management Process.

3. Upon disenrollment, CalOptima Health shall make screening results available to a Member's new Medi-Cal Managed Care Plan upon request.

B. Upon request from the Member, Authorized Representative, or Provider and in accordance with this Policy, CalOptima Health or a Health Network shall ensure no disruption of services for Continuity of Care for a Medi-Cal beneficiary transitioning from Medi-Cal FFS, another Medi-Cal Managed Care Plan, or existing Members whose Covered Services are transitioned from Medi-Cal FFS to CalOptima Health, with his or her Existing Out-of-Network Provider for a period of no more than twelve (12) months, unless otherwise provided in Section III.C. of this Policy, if the following criteria are met:

1. A Member has an existing relationship with one (1) of the following:

a. An Out-of-Network Primary Care Practitioner/Physician (PCP) or Specialty Care Provider if the Member has seen the out-of-network PCP, or Specialty Care Provider for a non-emergency visit at least once during the twelve (12) months prior to the date of enrollment in CalOptima Health;

b. An Out-of-Network California Children's Services (CCS) Provider if the CCS-eligible Member has seen the out-of-network CCS Provider for a nonemergency visit at least once during the twelve (12) months immediately preceding the date CalOptima Health or a Health Network assumed responsibility for the Member's CCS care under the Whole Child Model (WCM) program;

c. An Out-of-Network Behavioral Health Treatment (BHT) Service Provider if the Member has seen the out-of-network BHT Service Provider for a non-emergency visit at least once during the six (6) months prior to either the transition of services from the Regional Center of Orange County (RCOC) to CalOptima Health or the date of the Member's initial enrollment in CalOptima Health if the enrollment occurred on or after July 1, 2018;

d. An Out-of-Network nursing facility if the Member has resided in the out-of-network nursing facility prior to enrollment in CalOptima Health, or prior to receiving long term care benefits from CalOptima Health; or

e. A County Mental Health Plan Provider for non-specialty mental health services in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima Health.

2. The Existing Out-of-Network Provider will accept the higher of CalOptima Health's or a Health Network's rates, the Medi-Cal FFS rates, or the CCS FFS rates (which apply only to the existing out-of-network CCS Provider), as applicable. Notwithstanding the foregoing, the Existing Out-of-Network Provider may enter into an agreement on an alternative payment methodology mutually agreed to by the Existing Out-Of-Network Provider and CalOptima Health or a Health Network, as applicable.

3. The Existing Out-of-Network Provider meets applicable professional standards, including, as applicable, CCS standards (which apply only to the existing out-of-network CCS Provider providing treatment to a CCS-eligible Member for a CCS-Eligible Condition).

4. The Existing Out-of-Network Provider has no disqualifying quality of care issues. For purposes of this subsection, a quality of care issue means CalOptima Health, or a Health Network can document its concerns with the Existing Out-of-Network Provider's quality of care to the extent the Provider would not be eligible to provide services to any other Members of CalOptima Health or a Health Network.

5. The Existing Out-of-Network Provider has not been terminated, suspended, or decertified from the Medi-Cal program by DHCS.

6. The Existing Out-of-Network Provider is a California State Plan-approved Provider.

7. The Existing Out-of-Network Provider provides CalOptima Health or a Health Network, with all relevant assessment, diagnosis, and treatment information, for the purposes of determining Medical Necessity as well as a current treatment plan to the extent allowed under federal and state privacy laws and regulations.

8. The Member, Authorized Representative of the Member, or the Existing Out-of-Network Provider requests Continuity of Care. For a Member residing in an out-of-network nursing facility prior to

enrollment in CalOptima Health or receiving BHT services at RCOC, Continuity of Care is guaranteed and need not be requested.

C. Upon request from the Member, Member's Authorized Representative, or Provider, and in accordance with the requirements of this Policy, CalOptima Health or a Health Network shall provide the completion of Covered Services by an Out-of-Network nursing facility, PCP, Specialty Care Provider, or CCS Provider when the Member presents with any of the following:

1. An Acute Condition: For the duration of treatment of the acute condition;

2. A serious Chronic Health Condition: Up to twelve (12) months;

3. Pregnancy: For the duration of the pregnancy and post-partum;

4. Terminal Illness: For the duration of the terminal illness, which may exceed twelve (12) months;

5. Care of a newborn child between birth and thirty-six (36) months: Up to twelve (12) months;

6. Surgery that is part of a documented course of treatment and has been recommended and documented by the Out-of-Network PCP, or Specialty Care Provider, to occur within one hundred-eighty (180) calendar days of the effective date of coverage for a new Member; or

7. Residing in an out-of-network nursing facility prior to enrollment in CalOptima Health, or prior to receiving long term care benefits from CalOptima Health: Up to twelve (12) months.

D. CalOptima Health or a Health Network shall accept requests for Continuity of Care over the telephone, by facsimile, or by mail, according to the requestor's preference, from the following sources:

1. Member;

2. Authorized Representative of the Member; or

3. Provider.

E. Upon receiving a request for Continuity of Care, CalOptima Health's Customer Service, Information Services, Utilization Management, and Case Management Departments shall initiate the following actions, as appropriate:

1. Assist the Member with requests to change the Member's Health Network and PCP, if the Member is requesting a PCP outside of his or her current Health Network and the PCP is contracted with another Health Network.

2. Establish the existence of an ongoing relationship with the requested Provider.

   a. CalOptima Health shall utilize FFS data provided by DHCS, or utilization data from another Medi-Cal program administrator such as another Medi-Cal Managed Care Plan, if available.

   b. If CalOptima Health does not receive FFS data from DHCS, or if the data does not support a pre-existing relationship, and the Member has seen a Provider in accordance with the criteria included in Section III.C. of this Policy, a Provider shall submit a signed attestation to CalOptima Health that confirms the Provider saw the Member for a medical visit within the

qualifying period stated in Section III.C. and include the last date upon which services were provided.

i. A self-attestation from a Member is insufficient to provide proof of a relationship with the Provider.

ii. The Continuity of Care process shall begin when CalOptima Health or the Health Network begin the process to determine if the Member has a pre-existing relationship with the Provider.

iii. If it is determined that the Provider is a Network Provider, CalOptima Health or a Health Network shall allow the Member to continue seeing the Provider.

3. Refer the Member to his or her Health Network for a request to change the Member's PCP within the Member's Health Network. The Health Network shall process this request pursuant to this Policy.

4. Refer the Member to the CalOptima Health Behavioral Health Line for Behavioral Health Treatment (BHT) and outpatient mental health services.

5. Refer the case to CalOptima Health's Case Management Department for access to care issues.

6. If DHCS has notified CalOptima Health of a Provider suspension, termination, or decertification, CalOptima Health or a Health Network shall not approve the Continuity of Care request.

F. For access to care issues, CalOptima Health's Case Management and Customer Service Departments shall work with one another and the Member's Health Network to outreach and connect the Member with his or her requested PCP, Specialty Care Provider, or other healthcare Provider, in accordance with this Policy.

G. If the PCP, Specialty Care Provider or other Provider specified in this Policy is an Out-of-Network Provider, CalOptima Health or the Health Network shall make a good faith effort to enter into a contract, letter of agreement (LOA), or single-case agreement, to establish a Continuity of Care relationship for the Member. Upon the execution of a Continuity of Care agreement, CalOptima Health or a Health Network shall establish a Member care plan with the Existing Out-of-Network Provider.

H. CalOptima Health or a Health Network shall accommodate all requests they receive directly from Members who wish to be reassigned to an Existing Out-of-Network Provider in accordance with this Policy.

I. CalOptima Health or a Health Network shall initiate the review process within five (5) working days after receiving the Continuity of Care request.

J. CalOptima Health or a Health Network shall complete the Continuity of Care request review process within the following timelines:

1. Thirty (30) calendar days from the date of request (Non-Urgent);

2. Fifteen (15) calendar days if the Member's medical condition requires more immediate attention, such as there are upcoming appointments, or other pressing care needs (Immediate); or

3. As soon as possible, but no longer than three (3) calendar days if there is risk of harm to the Member. For purposes of this Policy, risk of harm means an imminent and serious threat to the health of the Member (Urgent).

K. For prospective transition requests made in advance of January 1, 2024, then CalOptima Health or a Health Network shall complete processing the request by January 1, 2024, or according to timeframes in Section III.J.1-3. of this Policy whichever is later.

L. CalOptima Health or a Health Network shall notify the Member of the following, in writing, and as required and in accordance with All Plan Letter (APL) 22-032: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Members Who Transition into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023 within seven (7) calendar days of the completion of a Continuity of Care request.

1. Acknowledgement of receipt of the Continuity of Care request, which includes:

   a. Date of receipt.

   b. Estimated timeframe notifications:

      i. For non- urgent requests within seven (7) calendar days of the receipt; and

      ii. For urgent requests within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three (3) days of receipt of the Continuity of Care request.

2. CalOptima Health or a Health Network shall provide acknowledgement notification of Continuity of Care requests using the following methods of communication; telephone calls, text message, mail or according to the requestor's preference;

3. The outcome of the request (approval or denial) sent to the Member by U.S. Mail, or via the requestor's preferred method of communication or by telephone;

4. The duration of the Continuity of Care arrangement, if approved;

   a. For any Continuity of Care response for which a Provider is only willing to continue providing services for less than twelve (12) months, CalOptima Health or a Health Network shall allow the Member to have access to that Provider for the shorter period of time.

5. The process that will occur to transition the Member at the end of the Continuity of Care period, if approved;

6. The Member's right to choose a different Provider from CalOptima Health's Provider network; and

7. If CalOptima Health and the Existing Out-of-Network Provider are unable to reach an agreement on the rate, or CalOptima Health has documented quality of care issues with the Provider, CalOptima Health will offer the Member an in-network alternative. If the Member does not make a choice, the Member will be assigned to an in-network Provider.

M. Members shall be notified of a denied continuity of care decision, in accordance with CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

N. If the Member does not agree with the result of the Continuity of Care process, he or she retains the right to pursue a grievance, in accordance with CalOptima Health Policy HH.1102: Member Grievance.

O. Thirty (30) calendar days prior to the end of the Continuity of Care period, CalOptima Health or a Health Network shall notify, in writing via U.S. Mail, the Member, using the Member's preferred method of communication, and the Existing Out-of-Network Provider of the transition of the Member's care to an in-network Provider to ensure continuity of services through the transition to a new Provider, non-transitioning Kaiser members, except as provided in Section III.S.14.c. for Members in the WCM program.

P. A Member transitioning from Kaiser into CalOptima Health, or a Health Network shall receive notification sixty (60) calendar days prior to the end of the Continuity of Care period, CalOptima Health or a Health Network shall identify a network Provider, and engage the Member, eligible Provider, and the Member's new network Provider, and ensure the Member's record is transferred within sixty (60) calendar days to ensure continuity of Covered Services through the Transition to the network Provider.

Q. CalOptima Health or a Health Network shall accept and approve retroactive requests for Continuity of Care, subject to the provisions of this Policy and that:

1. The Provider is willing to accept Medi-Cal FFS rates;

2. Occurred after the Member's enrollment into CalOptima Health;

3. Have dates of service(s) that occur on or after January 1, 2023;

4. Have dates of service(s) within thirty (30) calendar days of the first date of service for which the Existing Out-of-Network Provider requested Continuity of Care retroactive reimbursement; and

5. Are submitted within thirty (30) calendar days of the first service for which retroactive Continuity of Care is requested.

R. The Continuity of Care request shall be considered complete when:

1. The Member is informed of the outcome of the request;

2. CalOptima Health or a Health Network and the Provider are unable to agree to a rate;

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

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

5. CalOptima Health or a Health Network is not able to come to an agreement with the terminated Provider or nonparticipating Provider; or

6. The Member, Authorized Representative, or Provider does not submit a request for the completion of Covered Services by said Provider, CalOptima Health or a Health Network is not required to continue the Provider's services.

S. Other Continuity of Care Requirements and Special Populations

1. Transitioning Members in special populations will be identified using DHCS or Previous MCP data, including program enrollment, specific pharmacy claims. DME claims, screening, utilization data i.e. diagnostic codes, procedure codes, or aid codes as defined in the DHCS Medi-Cal Managed Care Plan Transition Policy Guide.

    a. By January 1, 2024, or within thirty (30) calendar days of receiving data, whichever is sooner, Kaiser shall utilize all available data including the DHCS-provided Special Populations Member File and the CalOptima Health's Transitioning Member Special Population Information Data File to identify special population Member providers during the twelve (12) months preceding January 1, 2024, for provider outreach to ensure Continuity of Care.

2. Members transitioning to CalOptima Health, or a Health Network shall be allowed to keep their existing DME rentals until a new assessment or reassessment is completed. Continuity of Care Requests for DME shall be coordinated, in accordance with CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.

3. Continuity of Care Requests for transportation shall be coordinated in accordance with CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

4. Continuity of Care requests where Member has no established relationship and no visit in previous twelve (12) months with the requested Provider.

    a. CalOptima Health or a Health Network may arrange for Member to keep or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the Out of Network Provider.

5. Continuity of Care Requests following mandatory transition

    a. CalOptima Health or a Health Network shall honor any active prior treatment authorizations for six (6) months, or until a new assessment is completed by a CalOptima Health contracted Provider or a Health Network.

    b. A new assessment is considered complete if:

        i. The Member has been seen in-person and/or via Telehealth by a network Provider; and

        ii. Network Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified in the pre-transition active prior treatment authorization.

6. Former Covered California Enrollees

    a. CalOptima Health shall outreach by telephone, letter, or other preferred method of communication to all former Covered California enrollees within fifteen (15) calendar days of their enrollment into CalOptima Health to inquire if the Member has upcoming appointments, or scheduled treatments. CalOptima Health shall assist the Member in making a Continuity of Care request at that time, as appropriate.

b. CalOptima Health or a Health Network shall honor any active prior treatment authorizations for a former Covered California Member for up to ninety (90) calendar days, or until a new assessment is completed by a CalOptima Health contracted Provider or a Health Network.

c. CalOptima Health or a Health Network shall offer up to twelve (12) months of Continuity of Care with out-of-network PCP, or Specialty Care Providers, in accordance with Section III.C. of this Policy.

d. CalOptima Health or a Health Network shall provide Continuity of Care for pregnant and post-partum Members and newborn children who transition from Covered CA with terminated or out-of-network Providers in accordance with Health & Safety Code Section 1373.96 and Section III.C. of this Policy.

7. Seniors and Persons with Disabilities (SPD)

a. CalOptima Health or a Health Network shall honor, without request by the Member or the Member's Out-of-Network PCP or Specialty Care Providers, any active FFS Treatment Authorization Request (TAR) for a newly enrolled Seniors and Persons with Disabilities (SPDs) Member for sixty (60) calendar days from enrollment, or until a new assessment is completed by a CalOptima Health contracted Provider to the extent FFS TAR data is available from DHCS.

i. CalOptima Health or a Health Network shall provide continued access for newly enrolled SPD Members for up to twelve (12) months in accordance with the Policy.

b. CalOptima Health shall further identify an SPD Member's health care needs by conducting a Health Risk Assessment in accordance with CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment.

8. Members Under Twenty-One (21) Years of Age Receiving BHT Services

a. CalOptima Health shall provide continued access to an out-of-network BHT Service Provider in accordance with Section III.C. of this Policy for up to twelve (12) months beginning on the date of the Member's enrollment in CalOptima Health, provided the Member has an existing relationship with the Provider as defined in this Policy.

b. Retroactive requests for BHT service Continuity of Care reimbursement are limited to services provided after a Member's transition date into CalOptima Health, or the date of the Member's enrollment into CalOptima Health, if enrollment date occurred after the transition.

9. Children Receiving BHT Services at the RCOC

a. For a Member receiving BHT services at RCOC Continuity of Care need not be requested and shall be automatic.

b. CalOptima Health shall provide continued access to BHT services for a Member who transitions from RCOC to CalOptima Health for BHT services.

c. If a Member is receiving BHT services from a non-contracted BHT Service Provider, CalOptima Health shall utilize diagnosis, utilization information, and assessment data provided by RCOC, or DHCS, to proactively identify the current BHT Service Provider(s). If the data indicates that the Member has multiple BHT Service Providers, CalOptima Health shall contact the Member's

parent(s) or guardian be telephone, letter, or other resource and make a good faith effort to obtain information that will assist in offering Continuity of Care. Once a preferred current Provider has been identified, CalOptima Health shall proactively contact such BHT Service Provider(s) to begin the Continuity of Care process.

d. CalOptima Health shall make a good faith effort to enter into a Continuity of Care agreement with a Member's existing BHT Service Provider prior to the transition of the Member. CalOptima Health shall ensure Continuity of Care for a period of no more than twelve (12) months from the date of the Member's transition, if the criteria as described in Section III.C. of the Policy are met.

e. If CalOptima Health and the Member's existing BHT Service Provider(s) are unable to reach a Continuity of Care agreement, CalOptima Health shall contact the Member's parent(s), or guardian, to transition to an in-network BHT Provider through a warm hand off transfer to ensure there are no gaps in access to services. CalOptima Health shall ensure BHT services continue at the same level until a comprehensive diagnostic evaluation (CDE) and assessment, as appropriate, is conducted and a treatment plan established.

10. Pregnant and Post-Partum Members

a. CalOptima Health or a Health Network shall provide continued access to Out-of-Network Providers in accordance with Section III.C. of this Policy for up to twelve (12) months.

11. Skilled Nursing Facility Services

a. CalOptima Health or a Health Network shall offer a Member residing in an Out-of-Network skilled nursing facility (SNF) when the Member transitioned into CalOptima Health the opportunity to return to the Out-of-Network SNF after a Medically Necessary absence, such as a hospital admission, for the duration of the Coordinated Care Initiative (CCI). CalOptima Health or a Health Network is not required to honor a request to return to an out-of-network SNF if the Member is discharged from the SNF into the community, or a lower level of care.

b. CalOptima Health or a Health Network shall maintain Continuity of Care by recognizing any TARs made by DHCS for nursing facility services that were in effect when a Member enrolled into CalOptima Health to the extent DHCS provides FFS TAR data to CalOptima Health. CalOptima Health or a Health Network shall honor such TARs for twelve (12) months, or for the duration of the treatment authorization if the remaining authorized duration is less than twelve (12) months, following the enrollment of the Member into CalOptima Health.

c. CalOptima Health or a Health Network shall not require a Member who is a resident of a nursing facility prior to enrollment in CalOptima Health to change nursing facilities during the duration of the CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and CalOptima Health agree to Medi-Cal rates.

12. Non-Specialty Mental Health Services

a. CalOptima Health shall provide Continuity of Care with an Out-of-Network Specialty Mental Health Provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive Specialty Mental Health Services (SMHS) from the County Mental Health Plan and instead becomes eligible to receive non-specialty mental health services from CalOptima Health. In this situation, the Continuity of Care requirement only

applies to psychiatrists and/or mental health Provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services, referred to in the State Plan as "Psychology."

b. CalOptima Health shall allow, at the request of the Member, the Member's Specialty Mental Health Provider, or the Member's Authorized Representative, up to twelve (12) months Continuity of Care with the out-of-network County Mental Health Plan Provider in accordance with the requirements of this Policy.

c. After the Continuity of Care period ends, the Member must choose a mental health Provider in CalOptima Health's network for non-specialty mental health services. If the Member later requires additional SMHS from the County Mental Health Plan to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to CalOptima Health for non-specialty mental health services, the twelve (12)-month Continuity of Care period may start over one (1) time. If the Member requires SMHS from the County Mental Health Plan subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to CalOptima Health or changes MCPs (i.e., the Member does not have the right to a new twelve (12) months of Continuity of Care).

13. Enhanced Care Management (ECM) Continuity of Care based on discontinuation criteria, in accordance with CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management Service Delivery.

14. Whole Child Model (WCM) Program

a. CalOptima Health or a Health Network shall provide Continuity of Care rights for a Member eligible with the California Children's Services (CCS) Program and transitioned into the WCM program with the eligible Member's existing CCS Provider for up to twelve (12) months in accordance with Section III.C. of this Policy. At its discretion, CalOptima Health or a Health Network may extend the Continuity of Care period beyond the twelve (12) months.

b. For Members eligible with the CCS Program and transitioned into the WCM program, CalOptima Health or a Health Network shall also provide Continuity of Care for the following:

i. Specialized or Customized DME

a) If an eligible Member has an established relationship with a Specialized or Customized DME Provider, CalOptima Health or a Health Network must provide access to that Specialized or Customized DME Provider for up to twelve (12) months.

b) CalOptima Health or a Health Network shall pay the Specialized or Customized DME Provider at rates that are at least equal to the applicable CCS FFS rates, unless the Specialized or Customized DME Provider and CalOptima Health or Health Network enter into an agreement on an alternative payment methodology that is mutually agreed upon.

c) CalOptima Health or a Health Network may extend the Continuity of Care period beyond twelve (12) months for Specialized or Customized DME still under warranty and deemed Medically Necessary by the treating Provider.

ii. Authorized Prescription Drugs

a) An eligible Member shall be permitted to continue use of any currently prescribed medication that is part of a prescribed therapy for the Member's CCS-Eligible Condition or conditions immediately prior to the date of enrollment into CalOptima Health in accordance with CalOptima Health Policy GG.1401: Physician Administered Drug (PAD) Prior Authorization Process.

c. A Member transitioning from Kaiser into CalOptima Health or a Health Network shall receive notification sixty (60) calendar days and thirty (30) calendar days prior to the end of the Continuity of Care period. CalOptima Health or a Health Network shall identify a network Provider, and engage the Member, eligible Provider, and the Member's new network Provider, and ensure the Member's record is transferred to ensure continuity of Covered Services through the Transition to the network Provider.

d. Appealing Continuity of Care Limitations

i. CalOptima Health or a Health Network must provide an eligible Member with information regarding the WCM appeal process for Continuity of Care limitations, in writing, sixty (60) calendar days prior to the end of their authorized Continuity of Care period. The notice must explain the Member's right to petition CalOptima Health or a Health Network for an extension of the Continuity of Care period, the criteria used to evaluate the petition, and the appeals process if CalOptima Health or a Health Network denies the petition. The appeals process notice must include the following information:

a) The eligible Member must first appeal a Continuity of Care decision with CalOptima Health in accordance with CalOptima Health Policy GG.1510: Member Appeal Process; and

b) CalOptima Health or a Health Network shall inform a Member, during the appeal process, of their right to request a State Hearing after the internal appeal process has been exhausted or should have been exhausted in accordance with CalOptima Health Policy HH.1108: State Hearing Process and Procedures.

15. Developmental Disabilities ICF/DD

a. CalOptima Health or a Health Network shall provide Continuity of Care for a Member residing in an Intermediate Care Facility with Developmental Disabilities ICF/DD.

T. Health Networks shall report all requests and outcomes from former Medi-Cal FFS and former Covered California enrollees asking to remain with their PCPs, or Specialty Care Providers, to CalOptima Health's Health Network Relations Department in a format and at a frequency prescribed by CalOptima Health.

U. CalOptima Health's Customer Service and Case Management Departments shall compile and maintain a log of Continuity of Care requests and outcomes made directly to CalOptima Health.

V. CalOptima Health's Customer Service, Health Network Relations, and Case Management Departments shall submit their Continuity of Care reports to CalOptima Health's Regulatory Affairs & Compliance Department. The Regulatory Affairs & Compliance Department shall submit the data to DHCS, in a manner and with a frequency prescribed by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1105: Coverage of Organ and Tissue Transplants
C. CalOptima Health Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
D. CalOptima Health Policy GG.1201: Health Education Programs
E. CalOptima Health Policy GG.1301: Comprehensive Care Management Process
F. CalOptima Health Policy GG.1313: Coordination of Care for Transplant Members
G. CalOptima Health Policy GG.1323: Seniors and Persons with Disabilities and Health Risk Assessment
H. CalOptima Health Policy GG.1330: Case Management – California Children's Services/Whole Child Model
I. CalOptima Health Policy GG.1353: CalAIM Enhanced Care Management – Service Delivery
J. CalOptima Health Policy GG.1401: Physician Administered Drug (PAD)Prior Authorization Process
K. CalOptima Health Policy GG.1502: Criteria and Authorization Process for Durable Medical Equipment (DME), Excluding Wheelchairs.
L. CalOptima Health Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
M. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
N. CalOptima Health Policy GG.1508: Authorization and Processing of Referrals
O. CalOptima Health Policy GG.1510: Member Appeal Process
P. CalOptima Health Policy GG.1539: Authorization for Out-of-Network and Out-of- Area Services
Q. CalOptima Health Policy HH.1102: Member Grievance
R. CalOptima Health Policy HH.1108: State Hearing Process and Procedures
S. CalOptima Health Policy MA.6021a: Continuity of Care for New Members
T. California Health and Safety Code, §1374.73
U. California Health and Safety Code, §1373.96
V. California Welfare and Institutions Code (WIC), §14094.13
W. Department of Health Care Services (DHCS)All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect
X. 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)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the 26-49 Adult Expansion Transition
Z. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
AA. Title 42, Code of Federal Regulations (CFR), §438.208

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/15/2015	Department of Health Care Services (DHCS)	Approved as Submitted
08/23/2016	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
07/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted
01/31/2018	Department of Health Care Services (DHCS)	Approved as Submitted
06/26/2018	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/18/2018	Department of Health Care Services (DHCS)	Approved as Submitted
01/18/2019	Department of Health Care Services (DHCS)	Approved as Submitted
04/14/2020	Department of Health Care Services (DHCS)	Approved as Submitted
03/12/2021	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted
12/14/2023	Department of Health Care Services (DHCS)	Approved as Submitted
05/16/2024	Department of Health Care Services (DHCS)	Approved as Submitted
02/21/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/06/2020	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care	Medi-Cal
Revised	09/01/2015	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	04/01/2016	GG.1325	Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima	Medi-Cal
Revised	07/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	11/01/2017	GG.1325	Coordination of Care for Newly Enrolled Medi-Cal Members into CalOptima	Medi-Cal
Revised	10/04/2018	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	02/06/2020	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal
Revised	06/03/2021	GG.1325	Continuity of Care for Members Transitioning into CalOptima Services	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2022	GG.1325	Continuity of Care for Members Transitioning into CalOptima Health Services	Medi-Cal
Revised	04/01/2023	GG.1325	Continuity of Care for Members Transitioning into CalOptima Health Services	Medi-Cal
Revised	10/01/2023	GG.1325	Continuity of Care for Members Transitioning into CalOptima Health Services	Medi-Cal
Revised	04/01/2024	GG.1325	Continuity of Care for Members Transitioning into CalOptima Health Services	Medi-Cal
Revised	03/01/2025	GG.1325	Continuity of Care for Members Transitioning into CalOptima Health Services	Medi-Cal

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. Completion of covered services shall be provided for the duration of the acute condition.
Adult Expansion Population	An expansion population as defined by amended Welfare and Institutions Code (W&I) Section 14007.8 for full scope Medi-Cal to individuals who are twenty-six (26) through forty-nine (49) years of age, and who do not have satisfactory immigration status (SIS) as required by W&I Section 14011.2.
Authorized Representative	A person designated by the Member or 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.
Behavioral Health Treatment (BHT)	Services approved in the State Plan such as Applied Behavior Analysis (ABA) and other evidence-based behavioral interventions to prevent or minimize the adverse effects of ASD and promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat ASD, and include a variety of evidence-based behavioral interventions identified by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.
Behavioral Health Treatment (BHT) Service Provider	Providers that are State Plan-approved to render Behavioral Health Treatment services, including Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals.
California Children's Services (CCS)-Eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations Sections 41515.2 through 41518.9.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services (CCS) Provider	Include any of the following: (1) A medical Provider that is paneled by the CCS Program to treat a CCS-Eligible Condition, pursuant to Article 5 of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code (commencing with Section 123800); (2) A licensed acute care hospital approved by the CCS Program to treat a CCS-Eligible Condition; or (3) A special care center approved by the CCS Program to treat a CCS-Eligible Condition.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Continuity of Care	Services provided to a Member rendered by an out-of-network Provider with whom the Member has a pre-existing Provider relationship.

Term	Definition
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any medically necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Existing Out-of-Network Provider	For purposes of this Policy, a non-contracted out-of-network nursing facility, Primary Care Practitioner (PCP), Specialty Care Provider, Behavioral Health Treatment (BHT) Service Provider, CCS Provider, Specialized or Customized Durable Medical Equipment (DME), or Specialty Mental Health Provider with whom the Member has established care and continues to be engaged in care at the time of transition to CalOptima Health services.
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 (HRA)	A health questionnaire used to provide Members with an evaluation of their health risks and quality of life.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medi-Cal Managed Care Plan	A health plan contracted with the Department of Health Care Services (DHCS) that provides Covered Services to Medi-Cal beneficiaries.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.
Out-of-Network [HN]	Outside of the selected Health Network's participating Provider network within the Service Area.
Out-of-Network Provider [CalOptima Health]	A Provider that does not participate in CalOptima Health's Network.

Term	Definition
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	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary Provider, or other person or institution that furnishes Covered Services.
Safety-Net Provider	Any Provider of comprehensive Primary Care or acute hospital inpatient services that provides services to a significant number of Medi-Cal recipients, patients who receives charity, and/or patients who are medically underinsured, in relation to the total number of patients served by the Provider.
Specialized and Customized Durable Medical Equipment	DME that is uniquely constructed from raw materials or substantially modified from the base material solely for the full-time use of a specific Member, according to a physician's description and orders; is made to order or adapted to meet the specific needs of the Member; and is so uniquely constructed, adapted, or modified that it is unusable by another individual, and is so different from another item used for the same purpose that the two could not be grouped together for pricing purposes.
Specialty Care Provider (SCP)	Provider of Specialty Care given to Members by referral by other than a Primary Care Provider.
Specialty Mental Health Services	Rehabilitation services, which include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services and psychiatric health facility services. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

Term	Definition
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.
Treatment Authorization Request (TAR)	The form a Provider uses to request authorization from Medi-Cal Fee-for-Service. Authorization is granted by a designated Medi-Cal consultant obtained through submission and approval of a TAR.
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS Program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-Eligible Conditions.