PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPCP2014 (previously MCCP2014)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Continuity of Care</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/19/2015
Effective Date: 12/29/2014 per DHCS</td><td colspan="4">Next Review Date: 08/13/2026
Last Review Date: 08/13/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/13/2025</td></tr>
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I. RELATED POLICIES:

A. MPUP3039 – Direct Members
B. MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
C. MCCP2007 – Complex Case Management
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MPBP8003 – Mental Health Services
F. CGA024 – Medi-Cal Member Grievance System
G. MCCP2032 – CalAIM Enhanced Care Management (ECM)
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCAP7001 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
J. MCAP7003 – CalAIM Community Supports (CS)
K. MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
L. MCUP3104 - Transplant Authorization Process

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims
D. Administration
E. Provider Relations

III. DEFINITIONS:

A. **Adult Expansion Population:** Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code (W&I) section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS) as required by W&I section 14011.2. SB 184 took effect on January 1, 2024. Impacted populations include:
   1. **New Enrollee Population**: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.
   2. **Transition Population**: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or

are unable to establish SIS for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.

B. **Behavioral Health Treatment (BHT):** BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

C. **California Children's Services (CCS):** A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

D. **Dual Eligible Special Needs Plans (D-SNPs):** A type of Medicare Advantage (MA) plan designed specifically for individuals who qualify for both Medicare and Medi-Cal. These plans offer specialized care that addresses the unique health needs of dual-eligible beneficiaries, providing enhanced care coordination, comprehensive services, and additional benefits not typically covered by standard Medicare or Medi-Cal. D-SNPs aim to integrate and streamline medical, behavioral, and long-term care services to improve health outcomes and reduce costs for individuals with complex care needs.

E. **Existing Relationship with Provider (for services other than Behavioral Health Treatment [BHT]):** is defined as the situation where a Member has seen an out of network Primary Care Provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into Partnership HealthPlan of California (Partnership) for a non-emergency visit.

F. **Existing Relationship with Provider (for individuals receiving BHT):** is defined as the situation where a Member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of responsibility for BHT services from the Regional Center to Partnership, or the date of the Member's initial enrollment with Partnership if enrollment occurred on, or after, July 1, 2018.

G. **Managed Care Plan (MCP):** Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services

H. **Medical Exemption Request (MER):** A request for a Medi-Cal beneficiary to be temporarily exempt from mandatory enrollment into an MCP, and to instead remain in fee for service (FFS) Medi-Cal. This allows the beneficiary to maintain access to providers who are not enrolled as network providers with the MCP until the Member's medical condition has stabilized to a level that would enable the Member to transfer to a network provider of the same specialty without deleterious medical effects.

I. **Medical Necessity for EPSDT Services**: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services.

J. **Partnership Advantage:** Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

K. **Risk of Harm:** An imminent and serious threat to the health of the Member.

L. **Special Populations:** Members most at risk for harm from disruptions in care or who are least able to

access COC protections by request and who are identifiable in DHCS data or Previous MCP data.

M. **Whole Child Model (WCM):** A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

A. Continuity of Care Data Sharing Information
B. Continuity of Care (CoC) Data Template – 1) Data Elements for All Members
C. Continuity of Care (CoC) Data Template – 2a) Special Populations Specifications
D. Continuity of Care (CoC) Data Template – 2b) Special Population Member File
E. Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data

V. PURPOSE:

The purpose of this guideline is to define the process by which a Member may request to be allowed to continue to receive services by an out-of-network provider in the event that the Member has an established relationship with the provider who is providing ongoing care to the Member prior to their enrollment or re-enrollment into Partnership HealthPlan of California (Partnership). This policy applies to the following populations:

A. Medi-Cal Members assigned a mandatory aid code that transitions them from Medi-Cal fee-for-service into a Medi-Cal managed care plan (Partnership), i.e. Covered California to Partnership
B. Members newly enrolled directly into Partnership
C. Members from MCPs with contracts expiring or terminating into Partnership on or after January 1, 2023
D. Members newly enrolled and eligible for the Seniors and Persons with Disabilities aid code
E. Members receiving BHT services
F. Members with CCS-eligible conditions transitioning into WCM
G. Members receiving non-specialty (mild-to-moderate) mental health services
H. Members who have been denied for a Medical Exemption Request (MER)
I. Members transitioning to new MCPs on January 1, 2024 (Partnership will ensure that transitioning members are able to access assistance from Partnership's call center starting November 1, 2023 and will be offering the same level of support for transitioning Members who seek assistance before January 1, 2024 while not enrolled in Partnership)
J. Members classified as Adult Expansion Population, which includes New Enrollee and Transition Populations
K. Members newly enrolled in Partnership Advantage's Dual Eligible Special Needs Plans (D-SNP)

VI. POLICY/ PROCEDURE:

A. Medi-Cal Members assigned a mandatory aid code who are transitioning into a Medi-Cal managed care plan (MCP) have the right to request continuity of care in accordance with federal and California law and managed care plan contracts with some exceptions.
   1. Consistent with federal law, Members must:
      a. Have access to services consistent with the access they previously had
      b. Be permitted to have continued access to services during a transition from FFS to Partnership, or a transition from a different MCP to Partnership
      c. Be permitted to retain their current provider for a period of time if that provider is not in Partnership's network when the Member, in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization.
   2. All Partnership Members with verifiable pre-existing provider relationships who make a continuity of care request to Partnership must be given the opportunity to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible Members may require continuity

of care for services they have been receiving through Medi-Cal FFS or through another MCP.

3. At the Member's request, Partnership will provide continuity of care for the completion of treatment by a terminated provider or by a non-participating provider, if the Member has one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96):
    a. An 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 that has a limited duration.
        1) Completion of covered services shall be provided for the duration of the acute condition
    b. A serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
        1) Completion of the covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for newly covered Member.
    c. A pregnancy – the three trimesters of pregnancy and the immediate postpartum period (which is 12 months).
        1) Completion of covered services shall be provided for the duration relating to the pregnancy
    d. A terminal illness – an incurable or irreversible condition that has high probability of causing death within one year or less
        1) Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date of 12 months from effective date of coverage for a new Member.
    e. The care of a newborn between birth and age 36 months.
        1) Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
    f. Performance of a surgery or other procedure that is authorized by the MCP as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.
4. Partnership must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding (Implemented January 1, 2024) or within 30 calendar days of receiving data for Special Populations. To minimize the risk of harm for disruptions in care, Partnership will focus their attention, resources, and provide continuity of care for transitioning Members in the following Special Populations that include:
    a. Adults and children with authorizations to receive ECM service
    b. Adults and children with authorizations to receive CS
    c. Adults and children receiving CCM
    d. Enrolled in 1915(c) wavier programs
    e. Receiving In-Home Supportive Services (IHSS)
    f. Children and youth enrolled in CCS/CCS Whole Child Model
    g. Children and youth receiving foster care, and former foster youth through age 25
    h. In active treatment for the following chronic communicable diseases: HIV/AIDS, Tuberculosis, Hepatitis B and C
    i. Taking immunosuppressive medications, immunomodulators, and biologics
    j. Receiving treatment for end-stage renal disease (ESRD)
    k. Living with an intellectual or developmental disability (I/DD) diagnosis

l. Living with a dementia diagnosis
m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
o. Receiving specialty mental health services (adults, youth, and children)
p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
q. Receiving hospice care (for duration of the terminal illness)
r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care (for duration of the acute condition)
v. Post-discharge from inpatient hospital, SNF or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (Implemented January 1, 2024)
x. Members receiving Community-Based Adult Services

5. Enhanced protections for Members accessing the Transplant benefit
   a. If the MCP is unable to bring a Transplant Program in Network, the Receiving MCP must make a good faith effort to:
      1) Enter into a CoC for Providers agreement with the hospital where a Transplant Program is located as described in Section V.C and according to the following terms:
         a) Make explicit the existing statutory requirement that Receiving MCPs must pay, and transplant providers must accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code.
         b) Permit the CoC for Providers agreement to continue for the duration of the Member's access to the transplant benefit.
      2) If the MCP is unable to enter into a CoC for Providers agreement, the MCP must:
         a) Arrange for the hospital where the Transplant Program is located to continue to deliver services to a Member as an out-of-network (OON) provider, in accordance with the timeline in 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
         b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement, per guidance in the Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

B. For Members with written documentation of being diagnosed with a maternal mental health condition from the treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
C. Partnership is not required to provide continuity of care for services that are not covered by Medi-Cal.
D. Continuity of care protections extend to primary care providers (PCPs), specialists, ECM providers, CS Providers, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), Community-Based Adult Services (CBAS) providers, and select ancillary providers, including dialysis centers, physical therapist, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment (BHT) providers, speech therapy providers, doulas, and community health workers (CHW). They do not extend to all other ancillary providers such as radiology, laboratory, non-emergency medical transportation (NEMT), non-medical transportation (NMT), and non-enrolled or carved-out service providers.
E. Partnership will provide continuity of care with an out-of-network provider when the following criteria

are met:

1. Partnership is able to determine that the Member has an ongoing relationship with the provider (defined as at least one non-emergency visit during the preceding 12 months or prior to the date of the Members' initial enrollment in the D-SNP for a non-emergency visit).
    a. Self-attestation is not sufficient to provide proof of an established relationship with a provider.
2. The provider is providing a service that is eligible for COC, and
3. The provider is willing to accept the higher of Partnership's contract rates or Medi-Cal Fee For Service (FFS) rates or current Medicare fee schedule, and
4. The provider meets Partnership's applicable professional standards and has no disqualifying quality of care issues and,
5. The provider is a California State Plan approved provider, and
6. The provider supplies Partnership with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
7. Partnership Advantage Members:
    a. D-SNPs are network based for Partnership Advantage Members, with the following exceptions:
        1) Partnership Advantage Members are allowed to continue receiving care from an out of network provider for up to 12 months after enrolled if they have an acute or serious chronic medical condition as referenced in VI.A.3.
        2) Partnership Advantage Members must submit a request to Partnership including documentation from current medical provider.

F. If a Member changes managed care plans or D-SNP by choice following the initial enrollment into Partnership, or if a Member loses or leaves D-SNP and then later regains Partnership eligibility or rejoins D-SNP, the 12-month continuity of care period may start over one time. If the Member changes managed care plans or D-SNP or loses and regains Partnership eligibility a second time or more, the continuity of care (COC) period does not start over and the Member does not have the right to a new 12-month period of continuity of care. If the Member returns to Medi-Cal fee-for-service and later re-enrolls in Partnership, the COC period does not start over.
    1. Partnership must accept COC requests made over the telephone, electronically, or in writing, according to the requester's preference.
    2. Partnership informs Members of their continuity of care protections through the Member welcome packet and the Partnership provider website. This information includes how the Member, Member's authorized representative, and/or provider may initiate continuity of care requests with Partnership. All information provided is made available in threshold languages and alternative formats upon request.
    3. Partnership also provides on-going training regarding continuity of care to both the Care Coordination and Member Services staff who interact regularly with Members and/or providers.
G. Behavioral Health Treatment
    1. For Members under 21 years of age transitioning from a Regional Center (RC), Partnership must automatically generate a continuity of care request. Members do not have to independently request continuity of care from Partnership. The State of California Department of Health Care Services (DHCS) will provide Partnership with a list of transitioning Members whose services will transfer from the Regional Center to Partnership. Partnership will make a good faith effort to proactively contact the current treating provider(s) to begin the continuity of care process. For all Members assigned to Partnership on or after July 1, 2018, who were not receiving BHT services from a Regional Center, Partnership will offer the same continuity of care as outlined below.
    2. Continuity of Care for an out-of-network BHT provider can be granted for a Member for up to 12 months when all the following DHCS criteria is met:
        a. The Member has an existing relationship with a qualified provider of BHT services. An existing

relationship means the Member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from the RC to Partnership or the date of the Member's initial enrollment with Partnership if enrollment occurred on or after July 1, 2018.

b. The provider and Partnership can agree to a rate, with the minimum rate offered by Partnership being the established Medi-Cal FFS rate for the applicable BHT service.
c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Partnership's network.
d. The provider is a California State Plan approved provider.
e. The BHT provider supplies Partnership with relevant treatment information, including the current treatment plan, for the purpose of determining medical necessity, provided it complies with federal and state privacy laws and regulations.

3. If Partnership and the existing Member's provider are unable to reach a continuity of care agreement by the date of transition to Partnership, Partnership will reach out to the Member to transition through a warm handoff to an in-network BHT provider to ensure no gaps in services will apply.
4. Additionally, if a Member has an existing relationship (as defined above) with an in-network BHT service provider, Partnership will allow the Member to continue BHT services with that provider.
5. BHT services will not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by Partnership, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Partnership provider.
6. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a Member's transition date to Partnership, or the date of the Member's enrollment into Partnership, if the enrollment date occurred after the transition.

H. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition:
1. Partnership provides outpatient non-specialty mental health services for Members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition as defined by the current Diagnostic and Statistical Manual.
2. County Behavioral Health Plans (BHPs) are required to provide specialty mental health services (SMHS) for Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073. These criteria are less stringent for Members under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit so children with a lower level of impairment may meet medical necessity criteria for SMHS services (see III.G. above).
3. Partnership will provide continuity of care with an out-of-network SMHS provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies for SMHS service from the county BHP. Continuity of Care for SMHS services applies only to psychiatrists and/or mental health provider types permitted though California's Medicaid State Plan to provide outpatient non-specialty mental health services.
4. Continuity of care requests for non-specialty mental health services must meet all criteria outlined in section VI.A-F.
5. If the Member later requires additional SMHS services from the county BHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to Partnership for non-specialty mental health services, the 12-month continuity of care period may start over one time.
6. If the Member requires subsequent SMHS services from the county BHP after the continuity of care period has ended, the continuity of care period does not start over when the Member returns to Partnership or changes managed care plans (i.e., the Member does not have the right to a new

12 months of continuity of care).

I. WCM and CCS Members:
   1. Please see policy MCCP2024 Whole Child Model for California Children's Services for continuity of care guidelines.

J. Pregnancy and Post-Partum Members:
   1. Pregnant and post-partum Medi-Cal Members who are assigned a mandatory aid code and who are transitioning from Medi-Cal FFS into Partnership or from MCPs with contracts expiring or terminating to Partnership on or after January 1, 2023 have the right to request continuity of care per criteria outlined in VI.A.3. These requirements will apply for pregnant and postpartum Members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.

K. Adult Expansion Population Members:
   1. For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, Partnership is required to maintain that assignment. Adult Expansion Population Members are not required to request COC to maintain their PCP assignment with PCPs that are in Partnership's Network. If the PCP is out-of-Network, Partnership is not expected to maintain that assignment; however, Partnership must adhere to all Continuity of Care requirements in accordance with APL 23-022.

L. Continuity of Care (COC) Process:
   1. Members, their authorized representative, or their provider may make a direct request to Partnership for continuity of care. Partnership will begin to process the request within five (5) business days of receipt of the request. The COC process begins when Partnership starts to determine if the Member meets the criteria outlined in section VI.A-K and has a pre-existing relationship with the provider. Partnership will complete non-urgent request within 30 calendar days from the date Partnership receives the request, or 15 calendar days if an immediate request or if the Member's medical condition requires more immediate action such as upcoming appointments or other pressing care needs, or three (3) calendar days if this is an urgent request or if there is risk of harm to the Member (as defined above).
   2. For Members that have one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96), once Partnership has established a COC for Providers agreement with an eligible provider, Partnership must reimburse the provider for covered services for the appropriate duration (as defined above) and as agreed upon with the provider.
   3. For Members under the Special Population (as defined above), Partnership will initiate the COC process within 30 calendar days from receipt of the Special Populations data.
   4. If the COC request is made in advance of January 1, 2024, Partnership will provide the same level of support and will process the request by January 1, 2024 or according to the timeframes in VI.K.1, whichever is later.
   5. Partnership will accept requests for COC over the telephone, electronically, or in writing, according to the requester's preference and will not require that the requester complete and/or submit paper or computer form if the requester prefers to make the request by telephone. Partnership will collect any necessary information from the requester over the telephone. Partnership will consider any Medical Exception Request (MER) that has been denied as an automatic COC request.
   6. Partnership will utilize the following criteria to determine if a relationship exists:
      a. FFS utilization data provided by DHCS, or
      b. FFS utilization or claims data from an MCP with its contract expiring or terminating, or
      c. Documentation from the Member and/or provider which demonstrates a pre-existing relationship, or
      d. Partnership claims data

7. If a pre-existing relationship has been established with an out-of-network provider, Partnership will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the Member. Specifically, for ECM and CS Providers, if Partnership does not come to an agreement, Partnership must explain in writing to DHCS why Partnership and the ECM Provider could not execute a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship. Refer to policy MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) and MCAP7003 CalAIM Community Supports (CS) for more details.
8. Partnership will accept and review retroactive COC requests for services that were already provided if the request meets all the COC requirements in VI.A.- J. and the services that are subject to the request meet the following requirements:
    a. Have dates of service that occur after the Member's assignment to Partnership or dates of service that occur after July 1, 2018.
    b. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or the date from which they have previously requested COC retroactive reimbursement, and
    c. Are submitted to Partnership within 30 calendar days of the first date of service for which retroactive continuity of care is being requested.
    d. D-SNP retroactive requests for Partnership Advantage Members must be accepted if submitted more than 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 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), a Medicare Advantage plan, another D-SNP, or the primary plan instead of the delegate.
9. Each COC request is considered complete when the Member is notified of the COC decision via Member's preferred method of communication or by telephone. A written notice will also be mailed to the Member within seven calendar days of the COC decision when:
    a. Partnership and the out-of-network FFS or prior plan provider are unable to agree to a rate
    b. Partnership has documented quality of care issues; or
    c. Partnership makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days
10. Member Notifications
    a. Partnership will provide acknowledgment of the COC request within the time frames specified below, advising the Member that the COC request has been received, the date of receipt, whether the request was considered urgent, immediate, or non-urgent (as defined in Section VI.L.1.), and the estimated timeframe of resolution. Partnership will notify the Member using the Member's known preference of communication or by using one of these methods in the following order: telephone call, email and then notice by mail.
        1) For non-urgent, immediate, and Special Population requests, acknowledgment of the COC request will be provided within seven calendar days of the decision.
        2) For urgent requests, acknowledgment of the COC request will be provided within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.
    b. Member Notification of Denial
        1) When a COC request is denied, the Member will be offered an in-network alternative. If the Member does not make an alternate choice, the Member will be referred or assigned to an in-network provider. When a COC request is denied and/or a Member disagrees with the

result of the process, a notice by mail will be sent within seven calendar days of the COC decision to include the following information:

a) A statement of Partnership's decision
b) A clear and concise explanation of the reason for denial
c) The Member's right to pursue a grievance and/or appeal (please see policy CGA024 – Medi-Cal Member Grievance System).

c. Member Notification of Approval
   1) If a provider meets all the necessary requirements, including agreeing to a letter of agreement or contract with Partnership, Partnership will grant the COC request to allow access to that provider for the length of the continuity of care period unless the provider is only willing to work with Partnership for a shorter time frame. Upon approval, a notice by mail will be sent within seven calendar days of the COC decision including the following information:
      a) A statement of Partnership's decision
      b) The duration of the COC agreement
      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 provider from Partnership's provider network
   2) When the COC agreement has been established, Partnership will work with the provider to establish a plan of care for Member.
   3) At any time, Members may change their provider to a network provider regardless of whether or not a COC relationship has been established.

d. Member Notification Prior to End of COC Period
   1) 30 days prior to the expiration of the COC approval, Partnership will notify the Member using member's preferred method of communication about the process that will occur to transition the Member to a network provider at the end of the COC period. Partnership will engage with the Member and provider, including the transferring of the Member's record, before the COC period ends to ensure continuity of services through the transition to a new provider. This serves as the notification that continuity of care will not be extended past the expiration date unless the Member reaches out to Partnership prior to the date on the COC approval letter.
      a) Any request for extension of a COC request may be subject to Medical Director Review.
      b) Although not required by DHCS, Partnership may continue to work with the Member's out-of-network provider past the 12-month COC period.
   2) For Members falling under the transition as outline in V.I, the notification timeframe is 60 days prior to the expiration of the COC approval.

11. Referrals
    a. An approved out-of-network provider must work with Partnership and its contracted network and cannot refer the Member to another out-of-network provider without authorization from Partnership. In such cases, Partnership will make the referral if the request meets medically necessity criteria and Partnership does not have an appropriate provider within its network.
    b. At the request of the Member, the Member's authorized representative, or the provider, Partnership will allow transitioning Members to keep authorized and scheduled specialist appointments with out-of-network providers when COC has been established and the appointments occur during the COC period.
       1) If a Member, their authorized representative, or their provider contacts Partnership to request to keep an authorized and scheduled specialist appointment with an out-of-network provider that the Member has not seen in the previous 12 months and there is no established

relationship, Partnership may arrange for the Member to keep the appointment or may schedule an appointment with a network provider on or before the Member's scheduled appointment with the out-of-network provider.

2) If Partnership is unable to arrange a specialist appointment with a network provider on or before the Member's scheduled appointment with the out-of-network provider, Partnership will make a good faith effort to allow the Member to keep their appointment; however, since the appointment occurs after the transition into Partnership, it does not meet criteria for a pre-existing relationship to request COC.

M. Continuity of Covered Services and Prior Treatment Authorizations:

1. Active prior treatment authorizations for services remain in effect for 6 months and must be honored without a request by the Member, Member's authorized representative, or provider. Partnership will arrange for services authorized under the active prior treatment authorization with a network provider, or, if there is no network provider, with an out-of-network provider. Utilization data of Special Populations will be examined to identify active courses of treatment and the MCP will contact providers as needed to establish any necessary prior authorizations.
2. After 6 months, the active treatment authorization remains in effect for the duration of the treatment authorization or until a new assessment is completed, whichever is shorter.
3. If a new assessment is not completed, the active treatment authorization remains in effect. After 6 months, the prior treatment authorization may be reassessed at any time. Reassessments for clinical necessity for Members to continue accessing the transplant benefit will start no sooner than six months after the transition date. A new assessment is considered complete if the Member has been seen in-person and/or via synchronous telehealth by a network provider who has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
4. If reassessing Enhanced Care Management (ECM) authorizations after 6 months, the reassessment must be against ECM discontinuation criteria and not the ECM Population of Focus eligibility criteria. Please refer to policy MCCP2032 – CalAIM Enhanced Care Management (ECM), MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and MCAP7003 CalAIM Community Supports (CS) for more details.
5. Durable Medical Equipment (DME): Partnership will allow transitioning Members to keep their existing DME rentals and medical supplies from their existing provider under the criteria above (VI.L.1- 3). Additionally, if the DME or medical supplies have been arranged for a transitioning Member but have not yet been delivered, Partnership will allow the delivery and permit the Member to keep the equipment or supplies for a minimum of 6 months following Partnership enrollment and until reassessed.
6. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Partnership will allow Members to keep the modality of transportation under the previous prior authorization with a network provider until Member's continued transportation needs are reassessed. Refer to policy MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) for details.
7. Treatment Authorization Request (TAR) data or prior authorization data will be used to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. Partnership will pay claims for prior authorizations or existing authorizations when data is incomplete.

N. Reporting

1. Partnership will report metrics related to COC provisions to DHCS. DHCS may request additional reporting on COC at any time and in a manner determined by DHCS.

VII. REFERENCES:

A. DHCS All Plan Letter 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 (08/15/2023)
B. DHCS All Plan Letter 23-010 *Revised*: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (11/22/2023)
C. Welfare and Institutions Code Sections 14132.03 and 14189
D. Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96)
E. DHCS All Plan Letter 24-015: California Children's Services Whole Child Model Program (12/02/2024)
F. DHCS All Plan Letter 23-018: Managed Care Health Plan Transition Policy Guide (06/23/2023)
G. DHCS All Plan Letter 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition (12/20/2023)
H. DHCS CalAIM Dual Eligible Special Needs Plans Policy Guide- Contract Year 2026 (2025)
I. Medicare Managed Care Manual: Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements, Rev. 83 (04/25/2007)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Health Services

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
08/13/25

Medi-Cal
8/19/15 effective 12/29/14 per DHCS; 11/18/15; 08/17/16; 08/16/17; *06/13/18; 11/14/18; 11/13/19; 09/09/20, 09/08/21; 09/14/22; 09/13/23; 08/14/24; 08/13/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Policy/Procedure Number: MPCP2014 (previously MCCP2014)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Continuity of Care			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/19/2015 **Effective Date:** 12/29/2014 per DHCS			**Next Review Date: 08/13/2026** **Last Review Date: 08/13/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.