KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	DSNP-Continuity of Care	**Policy #**	30.91-P
Policy Owner	Utilization Management	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	01/20/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

A. To outline the process for providing continuity of care for Kern Health Systems (KHS) Dual Special Needs Members (DSNP) receiving a single benefit package that includes a full continuum of acute, primary, institutional, and home and community-based Medicare and Medi-Cal services delivered through an organized service delivery system when they are newly enrolled with KHS or are affected by a provider contract termination.

B. To prevent any disruption in care, KHS will ensure that newly enrolled dual-eligible Members and those who were receiving treatment from a terminated provider at the time of the contract's termination, receive continuity of care for the following treatment and services:

1. On-going treatment of a current acute or serious chronic condition, pregnancy, chronic mental health condition, or terminal illness

2. Documented maternal mental health condition for a period not exceeding twelve (12) months from diagnosis or end of pregnancy, whichever occurs later

3. Previously authorized surgery or other procedure from an out-of-network provider.

4. Long Term Support Services (LTSS)

5. California Integrated Care Management (CICM)

II. POLICY

KHS will follow continuity of care requirements for Medicare-Medicaid Plan - Dual Special Needs (MMP-DSNP) Members in accordance with established current law as defined in Welfare & Institutions Code §14132.275(k)(2)(A) and §14182.17 Section 1373.96 of the Knox Keene Act.

KHS will perform an assessment process within ninety (90) days of a Member's enrollment into the DSNP program to ensure that continuity of care and coordination of care requirements are met for MMP Members.

KHS will ensure continuity of care for medical, behavioral health, and long-term services and supports (LTSS), upon new enrollment and attempt to determine if beneficiaries have pre-existing provider relationships through previous utilization data, the Health Risk Assessment (HRA) process, and contact with the beneficiary and/or their providers.

A. KHS will allow enrollees to maintain their current providers and service authorizations at the time of enrollment for:

    1. A period, up to twelve months, for primary and specialty Medicare and/or Medi Cal (other than in-home supportive services (IHSS), services if all the following criteria are met:

    2. The enrollee demonstrates an existing relationship with the provider, prior to enrollment,

    3. KHS will determine whether the Member has had at least one visit with the requested out-of-network primary or specialty provider within the twelve (12) months preceding the date of the request.

    4. The provider is willing to accept payment from KHS based on the current Medicare or Medi-Cal fee schedule as applicable.

    5. KHS would not otherwise exclude the provider from their provider network due to documented quality of care concerns.

    6. Medicare- Medicaid Plan (MMP) Plan changes and new or Continued Continuity of Care Coverage Provisions.

    If a Member changes D-SNPs, the continuity of care period may start over one time. If the Member changes D-SNPs a second time (or more), the continuity of care period does not start over, meaning the D-SNP is not required to offer the Member a new twelve (12)-month period.

B. Payments

    1. The amount of, and the requirement for payment of, co-payments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a non-participating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by KHS.

C. Exclusions

    1. KHS will not, nor is required to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, or fraud or other criminal activity.

D. Other Exclusions Include

Services not covered by Medicare or Medi-Cal:

1. Providers of Durable Medical Equipment (DME), transportation, other ancillary services or carved out services.
    a. However, KHS will ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and Long-term supportive services (LTSS) providers.

2. The provider is not willing to accept payment from KHS based on the current Medicare or Medi-Cal fee schedule.

3. The provider does not agree to abide by KHS's utilization management policies.

4. There is no evidence of an existing relationship between the provider and the Member.

5. There is documentation regarding quality-of-care concerns regarding the provider.

E. Exceptions

1. A Member who is a long-term resident of a nursing facility prior to enrollment will not be required to change from a nursing facility during the duration of the Duals Demonstration Project if the facility meets the following conditions:
    a. Is licensed by the California Department of Public Health,
    b. Meets acceptable quality standards,
    c. The facility and the KHS agree to Medi-Cal rates in accordance with the three-way contract.

III. DEFINITIONS

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 is limited for the duration of the acute condition, but shall not exceed twelve (12) months from enrollment or the contact termination date for Medi-Cal and up to six (6) months, for primary and specialty Medicare services.
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 and is limited to the duration of the chronic condition but shall not exceed twelve (12) months from enrollment or the contract termination date for Medi-Cal and up to six (6) months, for primary and specialty Medicare services

Pre-Existing Relationship	A Member has seen an out-of-network primary or specialty care provider at least once during the twelve (12) months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit.
Pregnancy	The three trimesters of pregnancy and the immediate postpartum period. Care shall be provided for the duration of the pregnancy and the immediate postpartum period, including maternal mental health
Terminal Illness	An individual's medical condition, as certified by a physician, results in a prognosis of life of one year or less if the disease follows its natural course.
Performance of a Surgery or Other Procedure	The performance of a surgery or other procedure that has been authorized by the previous plan as part of a documented course of treatment and has been recommended and documented by the Provider to occur within one hundred and eighty (180) days of the effective date of coverage for a newly eligible Member
Long Term Support Services (LTSS)	A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives.
Specialist	A physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified or recognized by a board of physicians or like peer group, or an organization offering qualifying examinations (board certified) as having special expertise in that clinical area of practice
Terminated Provider	A provider whose contract to provide services to Members is terminated or not renewed by KHS or one of KHS's contracting provider groups, or by the provider.
Non-Contracted Provider	A provider who is not contracted with KHS or a Provider Group contracted with KHS
Medicare-Medicaid Plan (MMP)	A type of Medicare Advantage Plan that provides fully integrated Medicare and Medicaid benefits to Members who are dually eligible.

IV. PROCEDURES

A. Requests for Continuation of Covered Services:

1. Members, their authorized representatives, or their providers may file requests through KHS for continuation of covered services via facsimile, telephone, or mail. Requests for continuation of covered behavioral health services may be made directly to the Kern County delegated managed behavioral health organization (MBHO) and will be processed by the MBHO as delegated.

2. When a continuity of care request is made, KHS will initiate the process within five (5)

3. days of receiving the request; However, the request must be completed in three (3) days if there is a risk

4. of harm to the beneficiary.

5. The continuity of care begins when KHS determines that there is a pre-existing relationship and has entered into an agreement with the provider.

6. The process is documented in the KHS database.

7. The Utilization Management (UM) Department shall assess the request to determine whether the Member's condition is consistent with Health and Safety Code 1373.96 and Welfare Institution Code 14182(b)(13) and (15) to continue

8. services with a non-participating provider.

9. The UM department will determine whether the member has seen the requested out-of-network specialty provider, by reviewing Medicare and Medi-Cal fee-for-service claims data from the state to establish a prior relationship as of the date of the request. Documentation of providing services to the Member within the preceding twelve (12) months establishes a prior relationship.

10. KHS will evaluate the provider for quality-of-care issues through a brief credential assessment.

11. If the above is established, KHS shall offer a rate for the service offered or applicable Medi-Cal rate or Medicare rate, and letter of agreement for up to the twelve (12)month continuity of care period.

12. If the provider agrees, the Member may continue to see the provider for up to a twelve (12) month period with prior authorization based on medical necessity.

13. If the provider refuses the rate, Member is verbally notified and then re-directed to an in-network provider who is qualified to evaluate and treat the Member's condition.

14. KHS shall document the outcome in the Members' file and shall notify the Member of the decision.

B. Assessing the Non-Participating Provider:

1. The Credentialing Department shall notify the UM Department for approval of a terminated or non-participating provider by completing a Credentialing Check to confirm the provider is not listed on the OIG or Medi-Cal/Medicare exclusion lists and holds a current license in good standing with the Medical Board of California.

2. If the requested terminated or non-participating provider meets the credentialing preliminary criteria, KHS will process the Letter of Agreement (LOA).

3. If the credentialing criteria are not met, the information will be forwarded to the UM Medical Director or physician designee for review.

4. If not approved, the requested terminated or non-participating provider and the Member shall be notified by the UM Department, and an alternate provider shall be assigned.

C. Delegated Providers:

1. KHS shall ensure the delegates meet the requirements of this policy.

D. Member and Provider Outreach and Education:

1. Members will be informed of Continuity of Care provisions in enrollment materials and the member handbook.

2. The Member Services Department staff will be in-serviced on Continuum of Care (COC) provisions to assist Members when they call KHS to request information about or assistance with a COC request.

3. Out of network providers that will provide services to KHS Members will complete Model of Care (MOC) training

KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS, Department of Health Care Services (DHCS), and or Department of Managed Health Care (DMHC) guidance, including applicable All Plan Letters (APLs), Health Plan Management Systems (HPMS) memos, Policy Letters, and Dual Plan Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type:	Specific Reference
Regulatory	Health & Safety Code 1373.96(C) NCQA (National Committee for Quality Assurance) Standards and Guidelines.
Other KHS Policies	DSNP Model of Care
Other	Welfare and Institutions Code, Section W&I Code §14132.275(k)(2)(A) and §14182.17 Duals Plan Letter 16-002 “Continuity of Care” Three-way contract (CMS, DHCS, MMPs)
Regulatory	42 CFR § 438.62 Continued services to enrollees: eCFR :: 42 CFR 438.62 -- Continued

	services to enrollees
Regulatory	2024 Medicare Advantage and Part D Final Rule (CMS-4201-F): 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) | CMS (Revisions to 42 CFR , 422.112 and 422.138
Regulatory	42 CFR § 438.208 Coordination and continuity of care
APL	APL 23-022
Other KHS Policies	Policy 3.22

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	UM

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
Choose an item.		
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Regulatory Agencies (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		
Choose an item.		
Choose an item.		

Leadership Approval *		
Title	**Signature**	**Date Approved**
Choose an item.		
Choose an item.		
Director of		
Director of		
*Signatures are kept on file for reference but will not be on the published copy		