KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Care Transitions of Benefits and Services	**Policy #**	30.62-P
Policy Owner	Utilization Management	**Original Effective Date**	9/18/2023
Revision Effective Date	5/2025	**Approval Date**	7/8/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To define how the Kern Health Systems (KHS) Utilization Management (UM), Behavioral Health (BH), and Population Health Management (PHM) Departments will assist with member transitions while a member continues to need care, benefits end, when new members transition into KHS, or when a provider terminates their contract with KHS.

II. POLICY

A. This policy applies to members undergoing an active course of treatment.

An active course of treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medications, or other treatment or modify a treatment protocol. Discontinuing an active course of treatment resulting from the exhaustion or termination of a benefit or health coverage could cause a recurrence or worsening of the member's condition under treatment and interfere with anticipated outcomes. KHS will act to ensure continuity of care through transitional planning and support, despite discontinuation of benefits or disenrollment from continued coverage for members receiving an active course of treatments for acute, chronic, or long-term circumstances.

Examples of circumstances related to active courses of treatment may apply but are not limited to the following:

1. Members who are receiving approved services, but whose benefit coverage of services will end while members are still in need of the medically necessary services.
2. A change in the Member's condition (e.g., a change in the level of care such as acute to skilled, skilled to community) who require treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet the member's health needs.
3. Rehabilitative therapy or skilled home health no longer eligible for the benefit.
4. Specialty Mental Health needs converting to Non-Specialty Mental Health or vice versa,

5. Member requests that could not be granted due to benefit limitations that are no longer available to persons over 21 years of age:
    a. California Children's Services (CCS)
    b. Early Periodic Screening Diagnostic Treatments (EPSDT)
    c. Behavioral Health Treatment (BHT) for autism spectrum disorder or Behavioral Conditions recommended by a psychologist or M.D.
6. Members who transition into KHS and require services that were previously approved via an alternate managed care organization (MCO) or Medicaid Fee-For-Service
7. Members receiving services from a practitioner plan contract that has been discontinued with KHS.

KHS will comply with Health and Safety Code (HSC) section 1373.96, which offers additional protections for members to continue seeing a terminated or nonparticipating provider, at a member, authorized representative, or provider's request. And will accommodate Continuity of Care (COC) for members transitioning from a Managed Care Plan (MCP) with its contract expiring or terminating to a new MCP on or after January 1, 2023.

KHS will comply in performing COC for a member's mandatory transition from Medi-Cal Fee For Service (FFS) to KHS, or from an MCP with its contract expiring or terminating to a new MCP on or after January 1, 2023, in accordance with Department of Health Care Services (DHCS) requirements.

III. DEFINITIONS

TERMS	DEFINITIONS
N/A	

IV. PROCEDURES

A. When the member's coverage of services is scheduled to end while the member still requires care, KHS shall offer, educate, and assist the member or the member's designated representative in accessing alternatives for continuing care.

Members whose benefits will end and require ongoing support and services are identified through various channels within the KHS Health Services Departments to include:

1. Prior authorization requests,
2. Acute and skilled nursing facility discharge planning,
3. Case management,
4. Special program member aging out reports,
5. Provider notifications,
6. Health Plan enrollment and disenrollment notifications and eligibility reports.
7. Member voluntary or involuntary disenrollments from Program i.e., Enhanced Care Management.

Member requests that could not be granted due to benefit limitations are identified during requests for extensions of a previously approved services. When this occurs, the Care Manager (CM) is notified.

The CM staff will evaluate the requested services against the number of services prior approved and available to the member. The Care Manager will consult the requesting practitioner, if necessary, to determine the remaining services that are available to the member.

Medical Management staff will refer the request for additional services exceeding benefit limitations to a Medical Director or treating providers for review to determine if additional services can be approved in accordance with KHS essential benefits and the medical necessity guidelines. Examples are:

1. Members receiving CCS, BHT, EPSDT.

The institutional concurrent review nurses will perform discharge planning and Care Transition Service functions for:

1. Member transitions from a change in acute or skilled level of care by referring as appropriate to Community Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Long Term Care, Enhanced Care Management (ECM), Substance Use Disorder (SUD) providers.

Behavioral Health Care Managers will work with the County Behavioral Health Plan to assist with lower level of care transfers for members in need of Non-Specialty Mental Health Services (NSMHS) due to mild to moderate symptoms and impairments. Additionally, Behavioral Health staff will assist with higher level of care transfers to SMHS from NSMHS when members no longer meet criteria for NSMHS benefits due to moderate to severe or higher symptoms and impairments.

California Children's Services (CCS), EPSDT, BHT program-eligible patients must be less than 21 years of age. KHS will assist CCS, EPSDT, BHT that are aging out or transitioning out of the services. Aging out happens when the member turns 21. KHS will ensure an organized process of preparing adolescents and families prior to the member turning 21to move from a pediatric to an adult model of health care for medically necessary services and care.

The Medical Management staff will request assistance from the Social Services staff to evaluate resources available through community-based agencies. KHS maintains a directory of available community, State, and national resources to provide to members in need of additional services when the benefit has been exhausted. The directory is reviewed and updated at least annually.

1. Agency type,
2. Geographical locations,
3. Cultural and linguistic capabilities.

B. Outreach

The CM will make at least two (2) telephonic outreach attempts to contact the identified member in addition to working with the member's provider or facility or Program CMs to discuss supportive coordination of ongoing services, transitions of care, or continuity of care to another provider or continue care with the existing provider. Opportunity is given to the member to discuss personal preferences and considerations the member or member's care giver may have.

All attempts and discussion will be documented in the member's case profile record.

KHS will follow all required written member notifications processes as appropriate and include documentation of alternative resources such as available care, services, and supports that are in the community. Notifications to include notices of action (NOAs) will comply with regulatory requirements pertaining to Members Rights and Responsibilities and referral and service notices i.e.,

1. Benefit Exhaustion
2. Carved Out Services
3. Denial Notifications
4. Referral Modifications.

C. Medi-Cal Special Programs Requiring Benefit Transitions

CCS: KHS will assist CCS eligible members that are aging out or transitioning out of CCS Services. Aging out happens when the member turns 21. KHS will ensure an organized process of preparing adolescents and families to move from a pediatric to an adult model of health care based on DHCS & CCS member transition to adult services protocols.

CBAS: KHS will monitor CBAS Center participant discharge responsibilities when the member's benefit ends (no longer meets benefit criteria) in order member to safely transition to another arrangement. To ensure the following measures have been implemented:

1. Conducting ongoing discharge planning based on the assessment of the participant by the Center's multidisciplinary team in accordance with Title 22, California Code of Regulations (CCR), §54213, §78345, and §78437, and as prescribed in the Center's policy and procedures for discharge.
2. Developing participant discharge plans that meet the requirements of Title 22, CCR, §78345, and contain the following per the California Bridge to Reform 1115 Demonstration waiver Special Terms and Conditions, to include:
    a. The date CBAS services are to end.
    b. The name of the member's physician(s)
    c. The name and contact number of the member's case manager (KHS)
    d. Specific information about the participant's current medical condition, treatments, and medication regimen,
    e. Any referrals, medically necessary services, or community resources the member may require after discharge,
    f. The signature of the beneficiary or representative and the date signed on the discharge Plan of Care.

D. EPSDT & BHT

KHS will assist members turning 21 receiving EPSDT and BHT services in accordance with California Welfare and Institutions Code (CA W&I) Section 14059 (a) for individuals 21 years of age or older a service is "medically necessary" or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Benefits for these members will be provided in accordance with benefits for adults over 21 and meet medical necessity

criteria. The KHS Case managers will work with providers to identify ongoing services meeting benefit and medical necessity criteria to provide a safe and supportive care continuum.

E. Long Term Care (LTC)

In the event of a LTC denial based on the member not meeting admission or no longer meeting the Title 22 Medi-Cal guidelines used to determine the medical necessity for continued placement in a long-term care facility; for care that can be delivered at a lower acuity level, an alternative setting will be approved/ recommended such as in lieu of providing nursing facility services, the KHS nurse will assist with referring and coordinating member access to alternate support systems and services such as:

1. Home Health for nursing and social services,
2. CBAS,
3. Long-Term Supports and Services (LTSS), and
4. Multipurpose Senior Services Program (MSSP)
5. Community based Service provider agencies and wrap around services.

V. ATTACHMENTS

Attachment A:	N/A

VI. REFERENCES

Reference Type	Specific Reference
Other KHS Policies	P&P 3.16 P California Children's Services
Other KHS Policies	P&P 19.21 I Community Based Adult Services Program
Other KHS Policies	P&P 3.91 Long Term Care
Regulatory	CA W&I Section 14059 (a
Regulatory	NCQA QI 3D
Regulatory	Title 22, California Code of Regulations (CCR), §54213, §78345, and §78437

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Review	5/2025	Annual Policy Review	UM
Effective	9/2023	To describe requirements when transitioning members due to changes in eligibility or availability of services.	UM

VIII. APPROVALS

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

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

Chief Executive Leadership Approval *		
Title	**Signature**	**Date Approved**
Chief Executive Officer		
Chief Medical Officer		
Chief Operating Officer		
Chief Financial Officer		
Chief Compliance and Fraud Prevention Officer		
Chief Health Equity Officer		
Chief Legal and Human Resources Officer		
Deputy Chief Information Officer		
*Signatures are kept on file for reference but will not be on the published copy		

KERN HEALTH SYSTEMS

Policy and Procedure Review

KHS Policy & Procedure: 30.62-P Care Transitions of Benefits and Services

Last approved version: N/A

Reason for creation: To describe requirements when transitioning members due to changes in eligibility or availability of services.

Director Approval		
Title	**Signature**	**Date Approved**
Christine Pence Senior Director of Health Services		
Dr. Maninder Khalsa Medical Director of Utilization Management		
Dr. Sukhpreet Sidhu Medical Director of Population Health Management		
Amanda Gonzalez Director of Utilization Management		
Melinda Santiago Director of Behavioral Health		
Michelle Curioso Director of Population Health Management		

Date posted to public drive: _____

Date posted to website (“P” policies only) : _____