KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Continuity of Care for New Members	**Policy #**	3.40-P
Policy Owner	Utilization Management	**Original Effective Date**	1/1996
Revision Effective Date	11/2025	**Approval Date**	12/17/2025
Line of Business	☒ Medi-Cal ☐ Medicare ☐ Corporate		

I. PURPOSE

To define the process by which KHS will authorize and make arrangements for ongoing services Continuity of Care (COC) for members transitioning from a Managed Care Health Plan (MCP) with its contract expiring or terminating to a new MCP on or after January 1, 2023, in compliance with the most current regulatory requirements and most recent Medi-Cal Managed Care Plan Transition Policy Guide Version.

II. POLICY

A. Kern Health Systems (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 Health Plan (MCP) with its contract expiring or terminating to a new MCP on or after January 1, 2023.

B. KHS informs members of their continuity of care protections including information about these protections in member informing materials such as information packets, Member Handbooks, Member Newsletters and on the KHS website. This information contains the steps and information for how a member, authorized representative, and provider may initiate a continuity of care request with KHS.

C. Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal MCP have the right to request continuity of care in accordance with state law and the KHS contract, regardless of if the member has a condition listed in HSC section 1373.96. All KHS Members with pre-existing provider relationships who make a continuity of care request to KHS must be given the option to continue treatment for up to twelve (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 managed care plan. Continuity of care applies to primary care

providers, specialists, and select ancillary providers, including physical therapy; occupational therapy: respiratory therapy; behavioral health therapy; and speech therapy providers.

D. Continuity of durable medical equipment (DME) and medical supplies will be honored without a request by the member, authorized representative, or provider.

    1. KHS will allow transitioning members undergoing durable medical equipment (DME) services to keep their existing DME rentals and medical supplies from their existing provider, under the previous prior authorization for a minimum of ninety (90) days following KHS enrollment and until the KHS is able to reassess, the new equipment or supplies are in possession of the member, and ready for use.
    2. If the DME or medical supplies have not been delivered, KHS will allow the delivery and for the member to keep the equipment or supplies for a minimum of ninety (90) days.
    3. If KHS does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization. After ninety (90) days, KHS may reassess the member's authorization at any time and require the member to switch to a network DME provider.

E. Continuity of Non-Emergency Medical Transportation and Non-Medical Transportation, KHS must allow members to keep the modality of transportation under the previous prior authorization with a network provider until the KHS is able to reassess the member's continued transportation needs.

F. Providing Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) to the out-of-network provider at no cost to the members.

G. KHS informs Members of their right to obtain NEMT or NMT services to access out-of-network services.

H. KHS will comply in performing COC for a member's mandatory transition from Medi-Cal FFS to KHS, or from an MCP with its contract expiring or terminating to a new MCP on or after January 1, 2023, as follows:
    1. Active prior treatment authorizations for services remain in effect for ninety (90) days and must be honored by the MCP without a request by the member, authorized representative, or provider.
    2. KHS will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an Out of Network (OON) provider.
    3. After ninety (90) days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by KHS, whichever is shorter.
    4. If KHS does not complete a new assessment, the active treatment authorization remains in effect and after ninety (90) days, KHS may reassess the member's prior treatment authorization at any time.

I. A new assessment is considered complete if the member has been seen in-person and/or via synchronous telehealth by a network provide and this 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.

J. If the reassessment pertains to Enhanced Care Management (ECM) authorizations after ninety (90) days, KHS will reassess against ECM discontinuation criteria, not ECM Population of Focus eligibility criteria.

K. In the event an FFS qualifying member is transitioning into KHS and requires out-of-network transplant services, KHS will provide the member an explanation of disenrollment process of filing a Medical Exemption Request (MER) for temporary exemption from enrollment.

L. For COC pertaining to terminated provider are described in KHS Policy 3.39-P.

M. KHS will provide information to members about their continuity of care rights as well as to providers (both in and out-of-network). KHS will, at a minimum, include information about continuity of care in provider training and new member orientation materials.

N. KHS is not required to provide continuity of care for services not covered by Medi-Cal.

O. KHS will accept continuity of care requests from the member, authorized representative, or provider over the telephone, according to the requestor's preference, and does not require the requestor to complete and submit a paper or online form if the requestor prefers to make the request by telephone.

P. KHS will notify the member of COC processing as well as the COC decision by using the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, and then notice by mail?

Q. For non-urgent requests, within seven calendar days of receipt of the continuity of care request

R. For urgent requests, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three days of receipt of the continuity of care request.

S. COC does not apply to members who had an option to remain with their previous health plan.

T. COC for drugs and medications is addressed in KHS Policy and Procedure #13.01-P: Drug Treatment and Non-Formulary Treatment Request.

U. When applicable, KHS will inform members of their right to seek out-of-network family planning services.

III. DEFINITIONS

TERMS	DEFINITIONS
Acute condition	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.
Existing Relationship	The member has seen a primary care provider (PCP) or specialist at least once during the twelve (12) months prior to the date of his or her initial enrollment unless otherwise specified in this policy.
Individual Provider	A person who is licensed as defined in Section 805 of the Business and Professions Code or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.
Medical Exemption Request (MER)	A request to the Department of Health Care Services (DHCS) for temporary exemption from Managed Care Plan (MCP) enrollment until the Medi-Cal beneficiary's condition has stabilized to enable a transfer to an MCP provider of the same specialty without deleterious medical effects.
New Member	A new member is an enrollee who has transitioned from FFS Medi-Cal or another qualifying government program and is assigned a mandatory aid code.
Provider	Any professional person, organization, health facility (including a hospital), or other person or institution licensed by the state to deliver or furnish health care services.
Provider group	Includes a medical group, independent practice association, or any other similar organization.
Quality of Care Issue	A quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS beneficiaries.
Maternal mental health condition	A mental health condition that can impact a woman during their pregnancy or during the postpartum period, or that arises during pregnancy or in the postpartum period, up to one year after delivery.
Serious chronic condition	Medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: A. Persists without full cure or worsens over an extended period of time. B. Requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.

Terminated Provider	A practitioner, provider group, or hospital whose contract to provide services for KHS is terminated or not renewed by any of the contracting parties.

IV. PROCEDURES

A. Qualifying For Continuity of Care

1. KHS will determine if a relationship exists through use of data provided by DHCS to the KHS, such as Medi-Cal FFS utilization data. A member or his or her provider may also provide information to the KHS that demonstrates a pre-existing relationship with the provider.

2. KHS is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider).

3. An existing relationship means the member has seen an out-of-network primary care provider (PCP) or specialist at least once during the twelve (12) months prior to the date of his or her initial enrollment with KHS for a non-emergency visit, unless otherwise specified in the All Plan Letter (APL18-008).

4. The provider is willing to accept the higher of KHS's contract rates or Medi-Cal FFS rates.

5. The provider meets KHS's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality-of-care issue means KHS can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other KHS Members).

6. The provider is a California State Plan approved provider.

7. The provider supplies KHS with all relevant treatment information, for the purpose 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.

8. If a member changes health plans, the twelve (12) month continuity of care period may start over one time. If the member changes health plans a second time (or more), the continuity of care period does not start over, as the member does not have the right to a new twelve (12) months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls with KHS, the continuity of care period does not start over. If a member changes health plans, this continuity of care policy does not extend to providers that the member accessed through their previous health plan.

9. KHS will retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets all continuity of care requirements, including the provider being willing to accept KHS's contract rates or Medi-Cal FFS rates, and the services that are subject to the retroactive request meet the following requirements:

a. Occurred after the member's enrollment into KHS,
b. The dates of service are within thirty (30) calendar days of the first service for which the provider requests retroactive reimbursement.

10. As necessary to support a member's pre-existing relationship with a provider KHS will utilize data provided by DHCS or by an MCP with its contract expiring or terminating, such as Medi-Cal FFS utilization data or claims data from an MCP. Additionally, KHS will use treatment authorization request (TAR) data or prior authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for durable medical equipment and medical supplies.

B. Continuity of Care Process

1. Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to KHS for continuity of care. When this occurs, KHS will begin to process the request within five working days following the receipt of the request.

2. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless KHS makes this option available to the member. Following identification of a pre-existing relationship, KHS determines if the provider is an in-network provider.

3. If the provider is not an in-network provider, KHS 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 continuity of care relationship for the member.

4. KHS will complete a COC in three calendar days if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when KHS starts the process to determine if the member has a pre-existing relationship with the provider.

C. Other COC Request Completion Timeline

1. Each continuity of care request must be completed within the following timelines:
    a. Thirty calendar days from the date KHS receives the request.
    b. Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs.

2. A continuity of care request is considered completed when:
    a. The member, in the manner outlined above, that the request has been approved KHS and the

out-of-network Medi-Cal FFS provider is unable to agree to a rate.
b. KHS has documented quality of care issues with the Medi-Cal FFS provider; or
c. KHS makes a good faith effort to contact the provider, and the provider is non-responsive for thirty (30) calendar days.

3. KHS will send the COC notice by mail to the member within seven calendar days of the continuity of care decision to include:
    a. A statement of the MCP's decision.
    b. A clear and concise explanation of the reason for denial.
    c. The member's right to file a grievance or appeal.

D. Other Process Requirements

1. If the provider is not a network provider, the KHS 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 continuity of care for the member. KHS must work with the approved OON provider and communicate its requirements on letters of agreement, including referral and authorization processes, to ensure that the OON provider does not refer the member to another OON provider without authorization from KHS.

2. If KHS and the out-of-network Medi-Cal FFS provider are unable to reach an agreement because they cannot agree to a rate or KHS has documented quality of care issues with the provider, KHS will offer the member an in-network alternative. If the member does not make a choice, the member will be referred to or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

3. If a provider meets all of the necessary requirements including entering into a letter of agreement or contract with KHS, KHS will allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with KHS for a shorter timeframe. In this case, KHS will allow the member to have access to that provider for a shorter period of time.

4. KHS will authorize the COC of transitioning members all necessary scheduled specialist appointments with OON providers when continuity of care has been established, and the appointments occur during the twelve (12) month continuity of care period. If KHS is unable to arrange a specialist appointment with a network provider on or before the member's scheduled appointment with the OON provider, KHS will make a good faith effort to allow the member to keep their appointment with the OON provider.

5. At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, KHS will work with the provider to establish a care plan for the member.

6. Upon approval of a continuity of care request, KHS will notify the member of the following within seven

calendar days:

a. The request approval.
b. The duration of the continuity of care arrangement.
c. The process that will occur to transition the member's care at the end of the continuity of care period.
d. The member's right to choose a different provider from KHS's provider network.

7. KHS will notify the member thirty (30) calendar days before the end of the continuity of care period using the member's preferred method of communication about the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

E. Extended Continuity of Care

1. KHS may choose to work with a member's out-of-network provider past the twelve (12) month continuity of care period; however, KHS is not required to do so to fulfill the obligations under this APL or KHS's contract.

F. Member and Provider Outreach

1. KHS will inform members of their continuity of care protections and will include information about these protections in member information packets and handbooks. This information will include how the member and provider initiate a continuity of care request with KHS. KHS will translate these documents into threshold languages and make them available in alternative formats, upon request. KHS will provide training to call center and other staff who come into regular contact with members about continuity of care protections.

G. Out of Network Provider Referral

1. An approved out-of-network provider must work with KHS and its contracted network and will not refer the member to another out-of-network provider without authorization from KHS. Authorization for an out-of-network provider to provide the second opinion at no cost to the Member, in such cases, KHS will make the referral, if medically necessary, and if KHS does not have an appropriate provider within its network.

2. Providing clinical protocols and evidence-based practice guidelines governing prior authorization, utilization management and retrospective review to all out-of-network Providers providing services to its members.

H. Continuity of Care (CoC) for Members Transitioning From an MCP With Its Contract Expiring or Terminating to a New MCP on or After January 1, 2024.

1. This section applies to members who must change MCPs on January 1, 2024, including:
    a. Members who actively choose an MCP.

b. Members who are assigned to an MCP. (Note: All transitioning members will have the opportunity to choose a new MCP; if they do not choose a new MCP by the established deadline, DHCS will assign them to an MCP).

I. Continuity of Care for PCP

1. KHS will put forth the best efforts to ensure there is no disruption to the trusted relationships between all transitioning members and their PCPs. To support this in congruence with the established DHCS goal KHS as a receiving MCP will aspire to retain at least ninety percent (90) % of transitioning members' PCPs either as network providers or through COC for Providers agreements.

2. KHS is unable to enter a contract with a newly assigned member's PCP, and the member requests to continue with their trusted PCP, KHS will offer the PCP a COC for Providers Agreement with the expectation the agreement provisions are met such as no quality issues, accepting PCP a Medi-Cal capitation arrangement or FFS reimbursement commensurate with KHS reimbursement and prior MCP payments to the PCP.

3. The expectation is that the PCP shall agree as these members are already included in the PCP's panel, neither a closed panel status nor a status that the PCP is not accepting new members should impact the assignment of these members to the PCP.

4. PCP changes from the previously assigned PCP prior to the Transitions will be honored and arranged by KHS upon request by the member.

J. CoC Transitioning Members to PCP Reporting

1. From November 2023, through December 2024. KHS will comply with reporting to the DHS and post-transition reporting PCP data retention elements at the frequencies and format as determined by the Department of Health Care Services 2024 Medi-Cal Managed Care Plan Transition Policy Guide Version 6, February 23, 2024 and the preceding 2024 Medi-Cal Managed Care Plan Transition Policy Guide Version 7, dated March 25, 2024 –revise date of reporting for select data elements in the section on Transition Monitoring and Oversight Reporting Requirements, and corrected hyperlink errors on page 96 of the guide.

Figure 1 represents the data element reporting cadence provided on the most recent Transition Policy Guide.

Figure 1. Data Element Reporting Cadence

Month(s)	Data Elements	Cadence
November 22, 2023	Baseline for select data element	One-time reporting

November 2, 2023-December 31, 2023	Select data elements	Bi-weekly reporting
January 1, 2024-February 29, 2024	All data elements	Bi-weekly reporting
March 2024-June 30, 2024	Select data elements	Monthly reporting
July 1, 2024-December 31, 2024	Select data elements	Quarterly reporting

2. MCPs will report data to DHCS on Wednesdays with up to a three-business day lag from the end of the reporting period. For example,
    a. Data for the first two weeks of January 2024 (January 1-14, 2024) will be reported to DHCS on Wednesday, January 17, 2024
    b. Data for February 12-25, 2024, will be reported to DHCS on Wednesday, February 28, 2024
    c. Data for the month of March 2024 will be reported to DHCS on Wednesday, April 3, 2024
    d. Data for the month of April 2024 will be reported to DHCS on Friday, May 6, 2024
        i. Via Survey Monkey
        ii. Figure 1. Data Element Reporting Cadence
        iii. Figure 2. Table Layout Key
        iv. Figure 3. PCP Retention – All Members

K. CoC Data Elements for all Providers -All Members Reporting

1. This data includes requests made by or on behalf of all members to include transitioning members who meet Special Population criteria.
    a. Via Survey Monkey
    b. Figure 1. Data Element Reporting Cadence
    c. Figure 2. Table Layout Key
    d. Figure 4. CoC for Providers – All Members
    e. Figure 5. CoC for Providers – Special Populations
    f. Figure 6. CoC for Services – All Members
    g. Figure 7. CoC for Services – Special Populations
    h. Figure 8. CoC Coordination and Management Information

L. Enhanced Care Management and Community Supports Data Elements

1. Via Survey Monkey

a. Figure 1. Data Element Reporting Cadence
b. Figure 2. Table Layout Key
c. Figure 9. COC for Enhanced Care Management (ECM) Covered Services and Providers
d. Figure 10. COC for Community Supports Covered Services and Providers

M. Non-Specialty Mental Health Services – Continuity of Care for Approved Provider Types:

1. KHS is required to cover outpatient mental health services, as outlined in APL 17-018, 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. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS medical necessity criteria for members under twenty-one (21) years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.

2. KHS 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 to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from KHS. 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").

3. KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to twelve (12) months of continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in KHS's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to KHS for non-specialty mental health services, the twelve (12) month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to KHS or changes MCPs (i.e., the member does not have the right to a new twelve (12) months of continuity of care).

N. Covered California to Medi-Cal Transition

1. This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

2. To ensure that continuity of care and coordination of care requirements are met, KHS will ask these

members if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member enrolls in Medi-Cal, KHS will contact the member by telephone, letter, or other resources no later than fifteen (15) days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. KHS will make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

3. KHS will honor any active prior treatment authorizations for up to sixty (60) days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

4. KHS will, at the member's or provider's request, offer up to twelve (12) months of continuity of care with out-of-network providers, in accordance with the requirements in DHCS APL 23-022.

O. Pediatric Palliative Care Waiver Transitions

1. DHCS' Pediatric Palliative Care (PPC) Waiver Program ended on December 31, 2018. Most services previously covered under the waiver are covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). For those individuals currently enrolled in KHS or transitioning from Medi-Cal FFS, KHS will provide continuity of care to out-of-network providers who provided Medi-Cal-covered PPC Waiver Program services to the member for services that are also covered by Medi-Cal under EPSDT. KHS is not required to provide continuity of care for services that were exclusive to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT. KHS will allow, at the request of the member, the provider, or the member's authorized representative, up to twelve (12) months continuity of care with the out-of-network provider in accordance with the requirements in APL 18-008.

P. Seniors And Persons with Disabilities FFS Treatment Authorization Request Continuity Upon Enrollment

1. For a newly enrolled Seniors and Persons with Disabilities (SPDs), KHS will honor any active FFS Treatment Authorization Requests (TARs) for up to sixty (60) days or until a new assessment is completed by KHS. A new assessment is considered completed by KHS if the member has been seen by a KHS-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The FFS TAR must be honored as outlined above without a request by the member or the provider.

2. If the member was seeing a regular Medi-Cal (FFS) doctor before enrolling in a health plan, the beneficiary may be able to continue to see that doctor for twelve (12) months while they are enrolled in the health plan, as long as the doctor agrees to work with the health plan, accepts payment from the health plan, and has no quality-of-care issues. If the member wants to see their current regular Medi-

Cal (FFS) doctor, these steps must be followed:

a. The Member must call KHS.
b. The Member must tell the KHS that they want to continue seeing their regular Medi-Cal (FFS) doctor.
c. The Member must tell KHS the name of their regular Medi-Cal (FFS) doctor and ask KHS to contact the doctor on their behalf.
d. The regular Medi-Cal (FFS) doctor may continue to see the beneficiary if the health plan determines that the beneficiary has seen that doctor in the past twelve (12) months, that there are no quality-of-care issues, and the doctor and KHS agree on a payment amount.

Q. Behavioral Health Treatment for Members Under the Age of Twenty-one (21) Upon Transition

1. KHS is responsible for providing Early and Periodic Screening, Diagnostic, and Treatment services for members under the age of twenty-one (21). Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in DHCS APL 23-022 and APL 19-004, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of twenty-one (21), KHS will offer members continued access to out-of-network BHT providers (continuity of care) for up to twelve (12) months if all requirements in this APL are met.

2. For BHT, an existing relationship means a 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 a Regional Center (RC) to KHS or the date of the member's initial enrollment with KHS if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, KHS will assign the member to that provider to continue BHT services.

3. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into KHS, or the date of the member's enrollment into KHS, if the enrollment date occurred after the transition.

4. KHS will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

R. Enhanced Care Management – Medi-Cal FFS to Managed Care Transition

1. KHS will provide continuity of care with an out-of-network provider, in accordance with the requirements of DHCS APL 23-022, for Medi-Cal FFS beneficiaries who voluntarily transition to KHS to enroll in the Enhanced Care Management (ECM). Because ECM services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for ECM services. Reference ECM policy 18.20-P

S. Existing Continuity of Care Provisions Under California State Law

1. In addition to the protections set forth above, KHS Members also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with Welfare and Institutions Code Section (§) 14185(b), KHS will allow members to continue use of any (single-source) drugs that are

part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the member immediately prior to the date of enrollment, whether or not the drug is covered by KHS, until the prescribed therapy is no longer prescribed by the KHS-contracting provider.

2. Additional requirements pertaining to continuity of care are set forth in Health and Safety (HSC) Code § 1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, maternal mental health, terminal illness, the care of a newborn child between birth and age thirty-six (36) months, and performance of a surgery or other procedure that is authorized by KHS as a 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 contract's termination date or within One hundred and eighty (180) days of the effective date of coverage for a newly covered member. This APL does not alter KHS's obligation to fully comply with the requirements of HSC §1373.96. In addition to the requirements set forth in this APL, KHS will allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a member a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. KHS will allow for the completion of these services for certain timeframes which are specific to each condition and defined under HSC § 1373.96.

T. Pregnant And Post-Partum Beneficiaries

1. As noted above, HSC §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age thirty-six (36) months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC §1373.96 for additional information about applicable circumstances and requirements.

2. Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into KHS have the right to request out-of-network provider continuity of care for up to twelve (12) months in accordance with KHS's contract and the general requirements listed in DHCS APL 23-022. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of DHCS APL 23-022 (continuity of care for members transitioning from FFS to managed care).

U. Maternal Mental Health Services

1. As noted above, HSC §1373.96 requires health plans in California to, at the request of a member, provide for the completion of covered services by an out-of-network provider relating to treatment of a mental health condition that impacts a woman during pregnancy and immediately after the delivery (the post-partum period), up to one year after delivery.

2. Pregnant and post-partum Medi-Cal members into KHS have the right to request out-of-network provider continuity of care for up to twelve (12) months in accordance with KHS's contract and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS

provider relationship that is allowed under the general requirements of this APL (continuity of care for members transitioning from FFS to managed care). Please refer to HSC §1373.96 for additional information about any applicable circumstances and requirements.

V. Medical Exemption Requests

1. A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into KHS only until the member's medical condition has stabilized to a level that would enable the member to transfer to a KHS provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from KHS enrollment that only applies to members transitioning from Medi-Cal FFS to KHS. A MER should only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. KHS is required to consider MERs that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with APL 17-007.

W. LTC Facility Continuity of Care (COC)

1. Attempts to maintain continuity of care will be facilitated in recognizing any treatment authorizations made by DHCS for nursing facility services that were in effect when the beneficiary enrolled into KHS. KHS will put forth best efforts to identify members' requiring continuity of care before the transition by identifying the Member's Skilled Nursing Facility (SNF) residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or Provider.

2. The COC requirement is established under W&I Code §14186.3(c)(3). COC for Medi-Cal is for a period up to twelve (12) months.

3. For Nursing Facilities with residents who are assigned to KHS, existing approved up to twelve (12) months.

4. Members will be allowed to stay in the same SNF under continuity of care if all the following applies:
    a. The facility is enrolled and licensed by California Department of Public Health (CDPH),
    b. The facility is enrolled as a provider in Medi-Cal,
    c. The SNF and KHS agree to payment rates that meet state statutory requirements, and,
    d. The facility meets the DHCS and KHS applicable professional standards and has no disqualifying quality-of-care issues.

5. Following their initial twelve (12) month automatic continuity of care period, Members may request an additional twelve (12) months of continuity of care, following the process established by APL 18-008, Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care, and in accordance with the provisions set forth in Health and Safety Code, Section 1367.01.

6. Members newly enrolled in KHS and residing in a SNF after June 30, 2023, will not receive automatic continuity of care and must instead request continuity of care, following the process established by APL 18-008. Members residing in a SNF will be notified by KHS of their right to request COC.

7. For any COC not granted members will be provided a written notice of action of an adverse benefit determination in accordance with APL 21-011, Grievance and Appeals Requirements, Notice and "Your Rights" Templates.

8. KHS will be responsible for all other approved TARs for services in a SNF exclusive of the SNF per diem rate for a period of ninety (90) days after enrollment into KHS.

9. KHS will reassess the member and authorize and connect the member to medically necessary services with consideration of maintaining provider service relationships willing to accept Medi-Cal rates and meets DHCS and KHS quality standards and credentialing requirements.

10. KHS shall pay providers, including institutional providers, in accordance with the prompt payment provisions including the ability to accept and pay electronic claims.

11. When KHS has authorized services in a facility and there is change in the beneficiary's condition under which the facility determines that the facility may no longer meet the needs the beneficiary, the beneficiary's health has improved sufficiently so the resident no longer needs the services provided by the facility, or the health or safety of individuals in the facility is endangered by the beneficiary, KHS shall arrange and coordinate a discharge of the beneficiary and continue to pay the facility the applicable rate until the beneficiary is successfully discharged and transitioned into an appropriate setting.

12. For prior authorization requests for Members who are transitioning from an acute care hospital KHS will handle them as an expedited, requiring a response time no greater than seventy-two (72) hours, including weekends. This process is supported by the KHS Discharge Planning Policy. KHS shall process TAR request using the timeframes consistent with its policies and procedures, pursuant to the requirements in Health and Safety Code, Section 1367.01.

X. Reporting And Monitoring

1. KHS will follow the most recent Managed Care Transition Policy Guide. KHS may be required to report on metrics related to any continuity of care provisions outlined in the most recent DHCS APL and, state law and regulations, or other state guidance documents at any time and in a manner determined by DHCS.

2. KHS will conduct periodic audits, at a minimum of quarterly reviews, to review COC Notice of Action letter applicable use.

Y. Delegation Oversight

1. KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including, and Policy Letters. These requirements must be communicated by KHS to all delegated entities and subcontractors.

Z. Reporting

1. KHS and contracted delegates maintain monthly or other reports of COC activities and submit the required

reports as contractually stipulated to the DHCS. KHS monitors and reports COC activities such as Appeals and Grievances related to COC to the Utilization Management Committee and analyzes COC data to identify any GAPs or areas of non-compliance to include appropriate corrective actions to mitigate further adverse trends.

V. ATTACHMENTS

Attachment A: Continuity of Care Approval Letter
Attachment B: Continuity of Care Notice of Action Denial Letter

VI. REFERENCES

Reference Type	Specific Reference
Regulatory	Process to review request must be included in policy (HSC §1373.95(a)(2)(D)).
Regulatory	HSC §1373.96 (e)(1) and (2)
Regulatory	HSC §1376.96 (f)
Regulatory	HSC §1373.95© Per M. Punja of DMHC 6/29/04.
Regulatory	HSC §1363.96(j). Language result of AB1596(2004).
Regulatory	HSC §1373.96(c)(1)
Regulatory	HSC §1373.96(k)(1)
Regulatory	HSC §1345(if) and 1373.96(k)(3). Clarification of "hospital" requested by DMHC comment 061A (04/16/04).
Regulatory	HSC §1373.96(c)(2)
Regulatory	HSC §1373.65(g)
Regulatory	HSC §1373.96(c)(4)
DHCS Contract (Specify Section)	Definition requested by DMHC Comment 061A (04/16/04). Per M. Punja we cannot use the definition included in the Insurance Code. Although there is no definition included in the HSC, DMHC expectation is that terminated providers include those whose contract is terminated or not renewed by either party.
Regulatory	HSC §1373.96(c)
All Plan Letter(s) (APL)	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 Medi-Cal Members Who Transition Into A New Medi-Cal Managed Care Health Plan On Or After January 1, 2023
Regulatory	2024 Managed Care Transition Policy Guide February 2023 updated V.6
Regulatory	10 2024 Medi-Cal Managed Care Plan Transition Policy Guide Version 7: Dated March 25, 2024

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Revision	2025-11	UM revised the policy per the Chief Compliance Officer's observation regarding Health Homes and ECM.	UM
Revision	2025-06	Policy revised to align with DHCS OR D.0330.31 (R.0131), AIR 1. Approved by DHCS on 8/29/2025.	C.P UM
Revision	2024-10	Attachments A and B were submitted to DHCS for review on 9/19/2024. Attach. A was approved by DHCS on 10/24/2024. Attach. B received an AIR on 10/28/2024. Attach. B was resubmitted to DHCS on 10/29/2024, as a result Attach. B was resubmitted to DMHC for review (eFile 20244841). DMHC approved Attach. B on 11/4/2024. DHCS Approved Attach B on 11/13/2024.	UM
Revised	2024-08-14	Policy version 2024-06 was submitted to DMHC on 8/14/2024 (eFile 20243567). A comment table was received on 8/19/2024, edits were made to the Attach. A and B as a result, the attachments were submitted to DMHC on 9/18/2024. The DMHC provided a closing letter on 10/2/2024.	UM
Revised	2024-06	Revised for formatting corrections by the Senior Director of Health Services.	UM
Revised	2024-06	Revised for LTC and for DHCS 23-018 Policy Transition Guide V7 – Submitted to DHCS on 6/18/2024	UM
Revised	2024-05	Revised for LTC and DHCS 23-018 Policy Transition Guide V6 – Submitted to DHCS 5/23/2024.	UM

Revised	2023-10	Policy status changed by Director of UM from "I" to "P," minor grammar changes. DHCS Approved File & Use for APL 23-022 on 11/30/2023 and DMHC Approved for APL 23-022 on 12/1/2023. Attachment A, COC Approval Letter: DHCS File and Use 10/5/2023, DMHC approval 11/8/2023. Attachment B, COC Denial Notice: DMHC approval 11/8/2023.	UM
Revised	2023-09	DHCS granted File & Use for APL 22-032.	-
Revied	2023-08	Policy approved for 2024 DHCS Contract Readiness (R.0196)	UM
Revised	2023-03	APL18-008, revision add Continuity of Care Denial Letter.	-
Revised	2023-03	DHCS APL-22-032	-
Revised	2022-11	2024 DHCS Contract deliverable R.0131, approved by DHCS on 2/17/2023.	-
Revised	2020-04	Policy revised by Director of Utilization Management to comply with APL 19-014 and changes to HSC §1373.96.	-
Revised	2019-12	Language added requiring quarterly audit reviews.	-
Revised	2019-08	Additional language to comply with APL18-008.	-
Revised	2018-08	Policy to comply with APL 18-008.	-
Revised	2018-04	Policy revised to comply with DHCS Deliverable BHT 10E.	-
Revised	2018-04	Policy revised by Administrative Director of Health Services to comply with APL 18-008.	Administrative Director of Health Services
Revised	2017-07	Policy revised to comply with APL 17-007 new reporting requirements. Reporting changed from quarterly to monthly beginning July 2017. Instructions and templet provided by DHCS.	-
Revised	2017-01	Policy revised to include new attachments; Initial Contact letter provided by Member Services Department and the MER Workflow Process Deleted thirty (30) days from enrollment deadline. Per M. Punja @ DMHC we can include a deadline only if we include an exception for "good cause." DMHC	-

		position is that since the statute doesn't impose a deadline, the plan cannot limit a member's rights by imposing a deadline. As a compromise with the Plans, an exception for "good cause" was determined to be acceptable. (See DMHC Comments 061A (04/16/04)).	

VIII. APPROVALS

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