Kaiser Permanente

Northern and Southern California | New and Current Enrollee

Completion of Covered Services

POLICY AND PROCEDURE

POLICY AND PROCEDURE for Facilitating Completion of Covered Services to New and Current Enrollees

I. Definitions

For the purposes of this *Policy and Procedure* these terms shall be defined as follows:

A. **"Qualified New Enrollee"** means a commercial group enrollee; an individual Plan enrollee; Federal Employees Health Benefits Program ("FEHBP") enrollee; or enrollee in a Medi-Cal, Major Risk Medical Insurance Program ("MRMIP"), or other government-sponsored program and Medicare Advantage plan for whom all of the following are true:

Group Coverage:

1. The individual has enrolled in Kaiser Foundation Health Plan, Inc. ("Health Plan"), group coverage; and
2. The individual is receiving services from a Non-Plan Provider on the effective date of Health Plan coverage for an acute condition, serious chronic (including but not limited to congenital) condition, terminal illness, pregnancy (including the immediate postpartum period); for performance of an authorized surgery or procedure (including related post-operative services) authorized by Kaiser Permanente and recommended and documented to occur within 180 days of the effective date of Health Plan coverage; is a child under 36 months old as of the effective date of Health Plan coverage; or the individual is receiving inpatient care at a hospital or is institutionalized at a licensed facility.

Individual Coverage:

a. The individual has enrolled in Health Plan's Individual Plan coverage.
b. The individual is receiving services from a Non-Plan Provider on the effective date of Individual Plan coverage for an acute condition, serious chronic (including but not limited to congenital) condition, terminal illness, pregnancy (including the immediate postpartum period), or has an authorized surgery or procedure (including related post-operative services) recommended and documented to occur within 180 days of the effective date of Individual Plan coverage, is a child under 36 months old on the effective date of Individual Plan coverage, or the individual is receiving inpatient care at a hospital or is institutionalized at a licensed facility.

c. **"Qualified Current Enrollee"** means a commercial (group or individual); FEHBP; or Medi-Cal, MRMIP, or other government-sponsored program enrollee for whom all of the following are true:

a. The individual is enrolled in Health Plan coverage; and
b. The individual is receiving services from a terminated Plan Provider, or from a Plan Provider whose terms of participation have been amended to eliminate previously included services or items*, on the effective date of termination or amendment of the Plan Provider's contract, for an acute condition, serious chronic (including but not limited to congenital) condition, terminal illness, or pregnancy (including the immediate postpartum period),*or* has an authorized surgery or procedure (including related post-operative services) recommended and documented to occur within 180 days of the effective date of termination of the Plan Provider's contract, is a child under 36 months old on such

*Refers to durable medical equipment (DME).

effective date; or the individual is receiving inpatient care at a hospital or is institutionalized at a licensed facility.

d. The Centers for Medicare and Medicaid Services ("CMS") requires continuity of care for Medicare Advantage plan members when a provider a member is paneled with and/or receiving care from is terminated from the Medicare Advantage plan's network. CMS does not specify timeframes however does support Medicare Advantage plans following the NCQA 90-day continuity of care timeframes.

e. **"Plan Provider"** means a physician, physician group, general acute care hospital, or other health care practitioner or provider who is employed or contracts to provide services and/or supplies to Health Plan enrollees as part of Health Plan's health care delivery system.

   For Medicare Advantage, plan provider is a provider/group/facility listed in the plan's Medicare Advantage provider directory.

f. **"Non-Plan Provider"** means a provider who is not a Plan Provider, as defined above.

g. **"Region"** means a Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently parts of Northern and Southern California.

Note: Current Medicare Advantage, including Medicare Advantage Group Plan enrollees not eligible for completion of covered services under Health and Safety Code § 1373.96 are eligible for completion of covered services under National Committee for Quality Assurance ("NCQA") standards. See Attachment A for these standards.

Note: Enrollees who are Seniors and Persons with Disabilities who are Medi-Cal only beneficiaries and were notified by the California Department of Health Care Services that they must transition to Medi-Cal managed care may be eligible to receive continued services from an out-of-Plan fee-for-service provider if the requirements in Attachment B are met.

Note: Continuity of care will not be offered or approved for any qualified new enrollees who were self-paying for requested services at the time of their enrollment with Kaiser Permanente.

II. Purpose

A. To describe the process by which Kaiser Permanente shall review requests from Qualified New Enrollees for completion of covered services provided by Non-Plan Providers and from Qualified Current Enrollees for coverage of health care services provided by terminated Plan Providers or by Plan Providers whose terms of participation have been amended to eliminate previously included services.

B. To describe the process for facilitating completion of covered services for Qualified New Enrollees who, at the time of enrollment, are receiving services from a Non-Plan Provider and for Qualified Current Enrollees who are receiving services from a terminated Plan Provider or from a Plan Provider whose terms of participation have been amended to eliminate previously included services.

C. To comply with Health and Safety Code §§ 1373.65, 1373.95, and 1373.96.

*Refers to durable medical equipment (DME).

III. Policy

A. Kaiser Permanente shall facilitate completion of covered services for Qualified New Enrollees who, at the time of enrollment, are receiving services from a Non-Plan Provider, or for Qualified Current Enrollees who, at the time of Plan Provider contract termination, are receiving services from a terminated Plan Provider or from a Plan Provider whose terms of participation have been amended to eliminate previously included services or items*.

B. Kaiser Permanente shall review a request from Qualified New Enrollees or Qualified Current Enrollees to complete services with their Non-Plan Provider or with their terminated Plan Provider or Plan Provider whose terms of participation have been amended to eliminate previously included services or items*, respectively, in accordance with this *Policy and Procedure*.

C. If Kaiser Permanente approves a request for coverage of Non-Plan Provider services or amended/terminated Plan Provider services or items* in accordance with this *Policy and Procedure*, such services shall be for a period that is determined in accordance with Health and Safety Code § 1373.96. The time periods for qualifying conditions are as follows:

1. An acute condition, for the duration of the condition.
2. A serious chronic (including but not limited to congenital) condition, for a period of time necessary to complete a course of treatment and provide for a safe transfer of the enrollee, not to exceed 12 months from the contract amendment/termination date or the effective date of the new enrollee's coverage.
3. A pregnancy, for the duration of the pregnancy and through the immediate postpartum period.
4. Pregnant enrollees who have a mental health condition that occurs, or can impact the enrollee, during pregnancy, during the postpartum period, or during interpregnancy, and that includes, but is not limited to, postpartum depression, not to exceed 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later.
5. A terminal illness, for the duration of the illness.
6. Care of a child, between birth and 36 months, not to exceed the earlier of:
    a. Twelve (12) months from the contract termination date or the effective date of the new enrollee's coverage, or
    b. The child's third birthday.
7. Performance of a surgery or other procedure (including related post-operative services), authorized by Health Plan as part of a documented course of treatment, and recommended and documented to occur by a Qualified Current Enrollee's terminated Plan Provider or Plan Provider whose terms of participation have been amended to eliminate previously included services, or a Qualified New Enrollee's Non-Plan Provider within 180 days of the contract amendment or termination date or the effective date of the Qualified New Enrollee's coverage, respectively.
8. When the enrollee is receiving inpatient care at a hospital or is institutionalized at a licensed facility for the duration of the inpatient care.

D. If Kaiser Permanente approves a request for coverage of Non-Plan Provider services or terminated Plan Provider services in accordance with this *Policy and Procedure*, Kaiser Permanente will require the Non-Plan Provider or the terminated Plan Provider to accept specified contractual terms and conditions in accordance with Health and Safety Code § 1373.96. The terms and conditions may include, but are not limited to, payment rates, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Kaiser Permanente will not provide coverage for

*Refers to durable medical equipment (DME).

the services of the Non-Plan Provider or the terminated Plan Provider if the provider does not agree to comply with the specified contractual terms and conditions. In the following circumstances, completion of covered services will not be offered by the Plan as the provider will not be available to provide continued services to qualified enrollees:

- Provider death
- Provider on long-term medical or maternity leave
- Provider relocated outside of the Plan's licensed service area
- Provider retired
- Provider terminated due to quality/performance issues

E. Unless otherwise agreed, the continued services rendered by the terminated or Non-Plan Provider shall be compensated at rates and methods of payments similar to those used by the Plan or provider group for currently contracting providers of similar services that are located in the same or similar geographic area and whose rates are not capitated.

F. The amount of, and requirements for, any copayments, deductibles, or other cost-sharing components incurred by enrollees during the completion of covered services with a terminated or Non-Plan Provider, are the same as would be paid by the enrollee receiving care from a Plan Provider.

G. Health Plan is not required to continue the services of any provider whose contract is terminated or not renewed due to medical disciplinary cause or reasons referenced in Health and Safety Code § 1373.96(h).

*Refers to durable medical equipment (DME).

IV. Procedure

A. **Notice to New Enrollees.** Health Plan shall include notice of this *Policy and Procedure* and information on how to request completion of Non-Plan Provider covered services as part of the enrollment materials. If an enrollee is enrolled in individual coverage that is leaving the market or a portion of the market causing the enrollee's coverage to be terminated, that plan or insurer is required to provide information about the availability of completion of covered services in its termination notice to the affected enrollee.

B. **Notice to Current Enrollees.** Health Plan shall provide current enrollees with prior written notice of this *Policy and Procedure* and information on how to request completion of covered services as follows:

1. At least 60 days' notice to current enrollees assigned to:
    a. A Plan Provider primary care practitioner group, upon termination of the Plan Provider practitioner group's contract.
    b. An individual primary care practitioner whose employment or contract with a Plan Provider practitioner group terminates. If the Plan does not receive at least 60 days' notice of an individual provider's termination, the Plan will notify affected enrollees as soon as reasonably possible.
2. At least 30 days' notice to each enrollee who has an upcoming procedure authorized or scheduled at the Terminating Hospital within the next six months, as well as those who had accessed the Terminating Hospital at least once during the past year for non-emergent services, subject to any waivers granted by the Department.

    For Medi-Cal HMO enrollees, this notice requirement shall be in addition to any other timely notice requirements imposed by the Department of Health Care Services (DHCS).

3. At least 30 days' notice to current enrollees receiving covered services from a specialty Plan Provider (either individual or practitioner group) upon termination of the specialty care Plan Provider's employment or contract with Health Plan or with a Plan Provider practitioner group.
4. For Medicare Advantage no-cause contract terminations:

- For Primary Care Providers and Behavioral Health providers MA plans must give 45 calendar days' notice via phone call and letter to impacted enrollees when either a primary care or behavioral health provider terminates their contract for no cause during the contract year
- Impacted enrollees include those currently assigned to the provider and those who have been patients of the provider within the past three years
- Written notice and one attempted telephonic notice are required, so long as the enrollee has not opted out of phone calls for plan business.

C. For all other mid-year specialty no-cause contract terminations including all other specialties and facilities listed in the MA provider directory including but not limited to hospitals, SNFs, Urgent Care Centers, ASCs, MA plans must give at least a 30 calendar days written notice to enrollees seen on a regular basis (assigned to, currently receiving care, or received care in past 3 months).

D. **Process for Facilitating the Batch Transfer of Enrollees**. In the event that Health Plan terminates a Plan Provider practitioner group or an individual practitioner whose employment or contract with such a group terminates, Health Plan will facilitate the transfer of assigned enrollees to a new Plan Provider

practitioner group by directing the enrollee to contact the Member Service Contact Center or local Member Services/Outreach Department for assistance in obtaining a new Plan Provider primary care practitioner. This information, as well as how to request completion of covered services from a terminated Plan Provider practitioner group, is contained in the notice sent to affected enrollees about the termination of the Plan Provider practitioner group's contract. In the event that the enrollee does not choose a new Plan Provider primary care practitioner, Health Plan may assign the enrollee to a Permanente Medical Group ("PMG") primary care practitioner or to a contracted primary care practitioner.

1. If Health Plan assigns an enrollee to a new Plan Provider primary care practitioner or Plan Provider hospital, it will do so to Plan Providers who are within a 30-minute or 15-mile radius (or 30-minute or 10-mile radius for Medi-Cal enrollees for primary care practitioner) of the enrollee's residence or workplace or alternatively, within a reasonable distance as determined by the standard pattern of practice within the geographic location where the enrollee receives his or her health care.
2. Prior to assigning enrollees to an alternative Plan Provider group or hospital, Health Plan will verify that the receiving Plan Provider group has the capacity to accept and maintain the block of enrollees within the ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees.
3. Health Plan will verify that the receiving Plan Provider group has the administrative and financial capacity to accept and maintain the block of enrollees that are transferred to them.
4. Health Plan enrollees may change personal PMG primary care practitioners or contracted primary care practitioners upon request.
5. The local Kaiser Permanente hospital administration will facilitate the transfer of enrollees from a terminated Plan Provider hospital by notifying enrollees who reside within a 15-mile radius of the hospital of the contract termination as well as Medi-Cal enrollees who have received services at the terminating hospital within the last twelve (12) months or are scheduled to receive services at the terminating hospital within the next six (6) months. Kaiser Permanente hospital administration will advise the enrollees of where they should receive nonemergency hospital services. This information, as well as how to request completion of covered services from a terminated Plan Provider hospital, is contained in the notice sent to affected enrollees about the termination of the Plan Provider hospital's contract.
6. Health Plan will verify that the receiving Plan Provider hospital will have the capacity to serve the entire dependent enrollee population based on normal utilization. Health Plan will verify that the receiving Plan Provider hospital will provide the same range of services as the terminated Plan Provider hospital or, if this is not the case, Health Plan will ensure that the same range of services are available from a network of Plan Provider hospitals located within appropriate geographical standards.
7. Health Plan will verify that there is a complete network of Plan Provider primary care practitioners and specialists with admitting staff privileges with at least one Plan Provider hospital equipped to provide the range of health care services Health Plan has contracted to provide.
8. If, after sending the notice to enrollees, an agreement is reached with a terminated Plan Provider group or Plan Provider hospital to not terminate the contract, to renew the contract, or to enter into a new contract, Health Plan shall offer affected enrollees the option to return to the previously terminated Plan Provider by sending notice to the enrollee's residence within thirty (30) days of the agreement with the terminated Plan Provider group or Plan Provider hospital.

9. The Regional Provider Delivery Systems Department shall submit a block transfer filing to the Department of Managed Health Care ("DMHC") for review at least 75 days prior to the effective date of termination of a contract with a Plan Provider group to whom enrollees are assigned or a Plan Provider hospital in the event that the transfer will affect 2,000 or more Health Plan enrollees. If Health Plan is unable to comply with this time frame because of exigent circumstances, Regional Health Plan Licensing will apply to the DMHC for a waiver and will submit its filing as soon as reasonably possible.

10. When there is a clinic or primary care practitioner contract termination that will result in more than 500 Medi-Cal beneficiaries being required to change their primary care practitioner, Health Plan will submit to the Department of Health Care Services ("DHCS") for its review and approval, the beneficiary notice and description of how Kaiser Permanente intends to continue to provide covered services to affected enrollees.

11. Health Plan may not send the notice to affected enrollees until the DMHC has reviewed and approved the notice's contents or approved templates. If the DMHC does not respond within seven days of the date of its receipt of Health Plan's filing, the notice shall be deemed approved and Health Plan will send out the notice to affected enrollees.

12. At such time that the notice is approved by the DMHC, the local Kaiser Permanente facility administration staff will facilitate the actual block transfer of affected enrollees.

E. **Policy and Procedure Upon Request.** Health Plan will provide a copy of this *Policy and Procedure* to enrollees upon request. This *Policy and Procedure* is also available to enrollees online at **kp.org**.

F. **Request for Completion of Covered Services.** To receive completion of covered services from a Non-Plan Provider or a terminated Plan Provider, enrollees must contact the Member Service Contact Center at **1-800-464-4000** or **711** for TTY users to request such completion, within thirty (30) days (or as soon as reasonably possible) from the effective date of Health Plan coverage for a new enrollee or thirty (30) days (or as soon as reasonably possible) from the effective date of termination of a terminated Plan Provider's contract or employment.

G. **Review of Request for Continued Services.** A request for completion of covered services will be reviewed as follows:

1. Health Plan will review an enrollee's request and determine whether the services being requested are covered services under the terms of the enrollee's Health Plan coverage. If Health Plan determines that the requested services are covered services, Health Plan will forward the request to a designated Permanente Medical Group physician ("Designated PMG physician").

2. The Designated PMG physician will review the enrollee's request and will determine whether the enrollee's condition meets the statutory criteria for the qualifying conditions and whether the services would otherwise be covered. The Designated PMG physician will also give reasonable consideration to the potential clinical effect that a change of provider would have on the enrollee's treatment for the condition. In connection with serious chronic conditions, the Designated PMG physician will consult with the enrollee and the enrollee's Non-Plan Provider or terminated Plan Provider, respectively, prior to determining a reasonable transition period.

H. **Kaiser Permanente's Notice of Determination**

1. **Time Frame.** If the request does not involve a request for urgent care or is not related to an acute care condition, Kaiser Permanente will notify the requester of its determination within fifteen (15) days of receiving all of the information necessary to make a decision.

If a request involves an urgent care request, then Kaiser Permanente will both make the determination and notify the requester within 72 hours of the receipt of the request. If the requester fails to provide sufficient information, Kaiser Permanente will notify the requester within 24 hours and provide the requester with at least 48 hours to respond. Kaiser Permanente will then notify the requester of the decision within 48 hours after the earlier of (1) Kaiser Permanente's receipt of the specified information or (2) the end of the time allotted to the requester to respond.

If the request involves an acute care condition, then Kaiser Permanente will both make the determination and notify the requester within five (5) business days of the receipt of all of the information necessary to make a decision.

For purposes of this Section IV.G.1, "urgent care request" means any request for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations as set forth above either (1) could seriously jeopardize the life or health of the requester or the ability of the requester to regain maximum function, or (2) in the opinion of a physician with knowledge of the requester's medical condition, would subject the requester to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

2. **Approval of Request.** Kaiser Permanente will notify the requester that it will cover specified services provided by the Non-Plan Provider or terminated Plan Provider if:
   a. Health Plan determines the services being requested are covered services; and
   b. The Designated PMG physician determines the enrollee's condition meets the statutory criteria for completion of covered services; and
   c. The Non-Plan Provider or terminated Plan Provider, respectively, accepts Kaiser Permanente's standard terms and conditions; and
   d. The Non-Plan Provider or terminated Plan Provider, respectively, is located within one of Health Plan's approved service areas; and
   e. The Non-Plan Provider or terminated Plan Provider provides services in the same service area and Kaiser Permanente region that the enrollee resides in.
3. **Denial of Request.** If the request is denied, Kaiser Permanente will notify the requester that it will not cover specified services provided by the Non-Plan Provider or terminated Plan Provider by sending a notice of noncoverage that is issued by Health Plan. The notice of noncoverage will inform the enrollee of his or her right to appeal the Plan's denial through the Plan's grievance system. If Kaiser Permanente denies the request, it will facilitate transferring the enrollee's care to an appropriate Plan Provider. In accordance with Health and Safety Code §§ 1373.95 and 1373.96, Kaiser Permanente may deny the request when any of the conditions in Section IV.G.2, Approval of Request, above, are not met.

ATTACHMENT A

Medicare requirements

I. Purpose

To describe the process for facilitating completion of covered services for current Medicare Advantage enrollees who are receiving services from a terminated primary care or specialty care Plan Provider (to comply with NCQA (QI 9) requirements).

Medicare Advantage Continuity of Care beginning January 1, 2024:
42.CFR.422.112 Access to Services (b)(8)(B)

Beginning January 1, 2024, a minimum 90-day transition period beginning with the first day of enrollment in a Kaiser Permanente Medicare Advantage ("MA") plan for any active course(s) of treatment when a Medicare beneficiary has enrolled in an MA plan after starting a course of treatment, even if the service is furnished by an out-of-network provider. This includes enrollees new to a plan and enrollees new to Medicare. The MA organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days or the course of treatment, whichever is shorter. When a Medicare beneficiary enrolls in a Kaiser Permanente Medicare Advantage ("KPSA") plan, the transition period applies to the shorter of 90 days or the course of treatment for care the new enrollee is currently in with a provider when they join Kaiser Permanente, regardless of what kind of coverage the new enrollee had before joining their KPSA plan and regardless of where that provider is located. The provider does not need to be in the Kaiser Permanente network or service area. The Centers for Medicare and Medicaid Services ("CMS") does not allow the new plan (Kaiser Permanente) to subject this to prior authorization, even if the service is provided by an out-of-network provider. Kaiser Permanente doctors and providers are also not allowed to deny the enrollee the care from the previous provider for the CMS defined duration timeframe (90 days or the course of treatment, whichever is shorter).

CFR § 422.111 (e)(1) and (2) Disclosure requirements.

Beginning January 1, 2024, for contract terminations that involve a primary care or behavioral health provider, Medicare Advantage plan enrollees must receive at least 45 calendar days before the termination effective date of a written notice and one attempt at telephonic notice (if enrollee has not formally opted out from receiving plan calls and retain the records of both) to enrollees who are currently assigned to that primary care provider and to those enrollees who have been patients of that primary care or behavioral health provider within the past three years.

For contract terminations that involve specialty types other than primary care or behavioral health the plan must provide a written notice (and retain the records) at least 30 calendar days in advance of the termination effective date to all enrollees who are assigned to, currently receiving care from, or have received care within the past three months from a provider or facility being terminated. Kaiser Permanente uses the Centers for Medicare and Medicaid Services ("CMS") model notice for written notices of provider terminations.

II. Policy

A. Kaiser Permanente shall facilitate completion of covered services for current Medicare Advantage enrollees who are receiving services from a terminated Plan Provider.

B. Kaiser Permanente shall review a request from current Medicare Advantage enrollees for completion of covered services with their terminated Plan Provider in accordance with this *Policy and Procedure.*

C. If Kaiser Permanente approves a request for completion of covered services by a terminated Plan Provider in accordance with this *Policy and Procedure,* such services shall be for a period that is determined in accordance with NCQA requirements. The time periods for qualifying conditions are as follows:

   1. Current treatment through the lesser of the current period of active treatment, or up to 90 calendar days for enrollees undergoing active treatment for a chronic or acute medical condition.

   2. Treatment through the postpartum period for a high-risk pregnancy or a second- or third-trimester pregnancy.

D. If Kaiser Permanente approves a request for coverage in accordance with this *Policy and Procedure*, Kaiser Permanente will require the terminated Plan Provider to agree to accept specified contractual terms and conditions in accordance with Health and Safety Code § 1373.96. (See page 3.)

III. Procedure

A. Health Plan shall provide prior written notice to Medicare qualified enrollees using the same procedure as specified in this *Policy and Procedure* for commercial qualified enrollees.

B. Requests for completion of covered services must be submitted to our Member Service Contact Center at **1-800-464-4000** or **711** for TTY users no later than thirty (30) days from the effective date of termination of a terminated Plan Provider's contract.

C. Review of requests for completion of covered services and approval or denial of the requests will follow the same policy and procedure as for commercial qualified enrollees.

ATTACHMENT B

Medi-Cal Continuity of Care Requirements[1]

1.0 Purpose & Policy Statement

To describe the process for facilitating completion of covered services (also known as Continuity of Care, or "COC") for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as members in Kaiser Permanente's Medi-Cal Managed Care Plan (MCP) on or after January 1, 2023. This process applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal.

2.0 Scope / Coverage

2.1 This policy applies to all employees who are employed by any of the following entities (collectively referred to as "Kaiser Permanente"):

2.1.1 Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals (together, KFHP/H);

2.1.2 KFHP/H's subsidiaries;

2.1.3 The Permanente Medical Group (TPMG)

2.1.4 Southern California Permanente Medical Group (SCPMG)

3.0 Definitions

3.1 **All Plan Letter (APL):** A means by which DHCS conveys information or interpretation of changes in policy or procedure at Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis

3.2 **California State Plan Approved Provider:** A provider who is enrolled and participating in the Medi-Cal program

3.3 **DHCS:** California Department of Health Care Services

3.4 **DME:** Durable Medical Equipment

3.5 **D-SNP:** Dual Special Needs Plans are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offer care coordination and wrap-around services

3.6 **MCP:** Medi-Cal Managed Care Plan

3.7 **Medical Exemption Request (MER):** A request for temporary exemption from enrollment into an MCP only until the beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to a Network Provider of the same specialty without deleterious medical effects.

3.8 **MHP:** County Mental Health Plan

3.9 **NEMT:** Non-Emergency Medical Transportation

[1] Attachment B revised November 2023.

3.10 **Network Provider**: Any provider, group of providers, or entity that has a network provider agreement with KFHP and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with KFHP.

3.11 **NMT:** Non-Medical Transportation

3.12 **NSMHS:** Non-Specialty Mental Health Services as outlined in APL 22-005 and APL 22-006

3.13 **Pre-existing relationship:** enrollee has seen the eligible Non-Plan Provider for a non-emergency visit at least once during the 12 months prior to the date of their initial enrollment in Kaiser Permanente.

3.14 **SMHS:** Specialty Mental Health Services

3.15 **SPD:** Seniors and Persons with Disabilities

4.0 Provisions and Procedures

4.1 Covered Services

4.1.1 The Medi-Cal Continuity of Care requirements listed in this *Completion of Covered Services* Policy and Procedure Medi-Cal Attachment B are in addition to those set forth in HSC section 1373.96 and (addressed in the main section of the Policy and Procedure), which provides for the enrollee's completion of Covered Services with a terminated Plan Provider or by a Non-Plan Provider, if a pre-existing relationship exists with that Provider, and if the enrollee has one of the conditions listed in HSC section 1373.96.

4.1.2 Continuity of Care applies to enrollees who are mandatorily transitioning from Medi-Cal Fee-For-Service ("FFS") to Medi-Cal managed care with Kaiser Permanente on or after January 1, 2023.

4.1.3 Effective January 1, 2024, Continuity of Care applies to enrollees ages 26 through 49 who are newly eligible for Medi-Cal, regardless of immigration status, to ensure continuity of care through safety net, primary care providers to the extent feasible and applicable in accordance with this policy and existing continuity of care requirements outlined by DHCS.

4.1.4 Enrollees may request Continuity of Care with a Non-Plan Provider for up to 12 months after the enrollment date with Kaiser Permanente if a pre-existing relationship exists with that provider, regardless of the enrollee having a condition listed in HSC section 1373.96.

4.1.5 Continuity of Care applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal, for their Medi-Cal providers. Continuity of Care with Medicare providers is not addressed in this Attachment B.

4.1.6 Continuity of Care extends to primary care providers, specialists, and select ancillary providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health therapy, and speech therapy providers.

4.1.7 Continuity of Care does not extend to all other ancillary providers such as radiology; laboratory; dialysis centers; NEMT; NMT; other ancillary services; or to non-enrolled Medi-Cal providers.

4.1.8 Continuity of Care applies only to covered Medi-Cal benefits.

4.2 Processing Continuity of Care Requests

4.2.1 Acceptance of Requests

Kaiser Permanente will accept Continuity of Care requests from the enrollee, authorized representative, or provider over the telephone, according to the requester's preference, and will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, Kaiser Permanente may take any necessary information from the requester over the telephone.

4.2.2 Retroactive Requests

4.2.2.1 Kaiser Permanente 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 outlined in this document, including the provider being willing to accept Kaiser Permanente's contract rates or Medi-Cal FFS rates, and the services that are the subject of the retroactive request meet the following requirements:

- Occurred after the enrollee's enrollment into Kaiser Permanente; and
- Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive reimbursement (i.e., the first date of service is not more than 30 calendar days from the date of the reimbursement request).

4.2.3 Completion of Requests

The Continuity of Care process begins when Kaiser Permanente receives the Continuity of Care request.

4.2.3.1 Kaiser Permanente will first determine if the enrollee has a pre-existing relationship with the provider.

4.2.3.2 Kaiser Permanente will request from a Non-Plan Provider 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 regulation.

4.2.3.3 Kaiser Permanente will provide Continuity of Care when the following requirements are met:

4.2.3.3.1 Kaiser Permanente is able to determine that the enrollee has a pre-existing relationship with the provider;

4.2.3.3.2 The provider is willing to accept Kaiser Permanente's contract rates or Medi-Cal FFS rates;

4.2.3.3.3 The provider meets Kaiser Permanente's applicable professional standards and has no disqualifying quality of care issues; and

4.2.3.3.4 The provider is a California State Plan approved provider.

4.2.4 Validating Pre-Existing Relationship

4.2.4.1 Kaiser Permanente will determine if a relationship exists through use of 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 Kaiser Permanente.

4.2.4.2 An enrollee, authorized representative, or provider may also provide information to Kaiser Permanente that demonstrates a pre-existing relationship with the provider.

4.2.4.3 An enrollee's self-attestation of a pre-existing relationship is not sufficient proof of a pre-existing relationship (instead, actual documentation must be provided) unless Kaiser Permanente makes this option available to the enrollee.

4.2.4.4 Following identification of a pre-existing relationship, Kaiser Permanente will determine if the provider is a Network Provider.

4.2.4.4.1 If the provider is a Network Provider, then Kaiser Permanente will allow the enrollee to continue seeing the provider.

4.2.4.4.2 If the provider is not a Network Provider, Kaiser Permanente 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 enrollee.

4.2.5 Timeline

4.2.5.1 Kaiser Permanente will begin to process non-urgent requests within five (5) working days following the receipt of the Continuity of Care request.

4.2.5.2 Each Continuity of Care request will be completed within the following timelines from the date Kaiser Permanente received the request:

4.2.5.2.1 30 calendar days for non-urgent requests;

4.2.5.2.2 15 calendar days if the enrollee's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or

4.2.5.2.3 As soon as possible, but no longer than three (3) calendar days for urgent requests (i.e., where there is identified risk of harm to the enrollee).

4.2.6 Enrollee Notifications

4.2.6.1 Kaiser Permanente will provide acknowledgment of the Continuity of Care request within the timeframes specified below, advising the enrollee that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution.

4.2.6.2 Kaiser Permanente will notify the enrollee by using the enrollee's known preference of communication or by notifying the enrollee using one of these methods in the following order: telephone call, text message, email, and then notice by mail:

4.2.6.2.1 For non-urgent requests, within seven (7) calendar days of the decision.

4.2.6.2.2 For urgent requests, within the shortest applicable timeframe that is appropriate for the enrollee's condition, but no longer than three (3) calendar days of the decision.

4.2.6.3 A Continuity of Care request is considered complete when Kaiser Permanente notifies the enrollee of Kaiser Permanente's decision. Kaiser Permanente will attempt to notify the enrollee of the Continuity of Care decision via the enrollee's preferred method of communication or by telephone.

4.2.6.4 Kaiser Permanente will also send a notice by mail to the enrollee within seven (7) calendar days of the Continuity of Care decision.

4.2.7 Enrollee Notification of Denial

For Continuity of Care requests that are denied, Kaiser Permanente will include the following information in the notice:

- A statement of Kaiser Permanente's decision
- A clear and concise explanation of the reason for denial
- The enrollee's right to file a grievance or appeal

If Kaiser Permanente and the Non-Plan Provider are unable to reach an agreement because they cannot agree to a rate, or because Kaiser Permanente has documented quality of care issues with the provider, Kaiser Permanente will offer the enrollee a Network Provider alternative. If the enrollee does not make a choice, the enrollee will be referred to a Network Provider. If the enrollee disagrees with the Continuity of Care determination, the enrollee maintains the right to file a grievance.

4.2.8 Enrollee Notification of Approval

For Continuity of Care requests that are approved, Kaiser Permanente will include the following information in the notice:

- A statement of Kaiser Permanente's decision
- The duration of the Continuity of Care arrangement
- The process that will occur to transition the enrollee's care at the end of the Continuity of Care period
- The enrollee's right to choose a different Network Provider

4.2.8.1 If a provider meets all of the necessary requirements, including entering into a letter of agreement or contract with Kaiser Permanente, Kaiser Permanente will allow the enrollee to have access to that provider for the length of the Continuity of Care period unless the provider is only willing to work with Kaiser Permanente for a shorter timeframe. In this case, Kaiser Permanente will allow the enrollee to have access to that provider for the shorter period of time.

4.2.8.2 When the Continuity of Care agreement has been established, Kaiser Permanente will work with the provider to establish a plan of care for the enrollee. At any time, enrollees may change their provider to a Network

Provider regardless of whether or not a Continuity of Care relationship has been established.

4.2.8.3 Kaiser Permanente will notify the enrollee 30 calendar days before the end of the Continuity of Care period, using the enrollee's preferred method of communication, about the process that will occur to transition the enrollee's care to a Network Provider at the end of the Continuity of Care period. This process includes engaging with the enrollee and provider before the end of the Continuity of Care period to ensure continuity of services through the transition to a new provider.

4.2.9 Provider Referral Outside of the Kaiser Permanente Network

Kaiser Permanente will work with the approved Non-Plan Provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the Non-Plan Provider does not refer the enrollee to another Non-Plan Provider without authorization from Kaiser Permanente. In cases where such medically necessary care is not available in the Kaiser Permanente network for the enrollee's region, Kaiser Permanente will make the referral.

4.2.10 12-Month Continuity of Care Period Restart

4.2.10.1 If an enrollee voluntarily changes MCPs to Kaiser Permanente following initial enrollment in another MCP, or if an enrollee loses and later regains Kaiser Permanente eligibility during the 12-month Continuity of Care period, the 12-month Continuity of Care period for a pre-existing provider may start over one time.

4.2.10.2 If an enrollee loses and later regains Kaiser Permanente eligibility a second time (or more), the Continuity of Care period does not start over and the enrollee does not have the right to a new 12 months of Continuity of Care.

4.2.10.3 If the enrollee returns to Medi-Cal FFS, if applicable, and later re-enrolls in Kaiser Permanente, the Continuity of Care period does not start over.

4.2.11 Scheduled Specialist Appointments

4.2.11.1 At the enrollee, authorized representative, or provider's request, Kaiser Permanente will allow transitioning enrollees to keep authorized and scheduled specialist appointments with Non-Plan Providers when Continuity of Care has been established and the appointments occur during the 12-month Continuity of Care period.

4.2.11.2 If an enrollee, authorized representative, or provider contacts Kaiser Permanente to request to keep an authorized and scheduled specialist appointment with a Non-Plan Provider that the enrollee has not seen in the previous 12 months and there is no established relationship with the Non-Plan Provider, Kaiser Permanente may arrange for the enrollee to keep the appointment or schedule an appointment with a Network Provider on or before the enrollee's scheduled appointment with the Non-Plan Provider.

4.2.11.3 If Kaiser Permanente is unable to arrange a specialist appointment with a Network Provider on or before the enrollee's scheduled appointment with the Non-Plan Provider, Kaiser Permanente is encouraged to make a good faith effort to allow the enrollee to keep their appointment with the Non-Plan Provider.

4.2.11.4 An appointment with the Non-Plan Provider occurring after the enrollee's transition to Kaiser Permanente does not establish the requisite pre-existing Provider relationship for enrollee Continuity of Care.

5.0 Additional Continuity of Care Protections in HSC section 1373.96

5.1 HSC section 1373.96 offers additional protections for enrollees to continue seeing a terminated/expired Plan Provider or Non-Plan Provider, at an enrollee, authorized representative, or provider's request, to complete covered services for specific conditions outlined below. HSC section 1373.96 specifies timeframes for each condition, some of which differ from the policy in APL 23-022.

5.2 If Kaiser Permanente is not able to come to an agreement with the terminated/expired Plan Provider or Non-Plan Provider, or if the enrollee, authorized representative, or provider does not submit a request for the completion of covered services by such provider, Kaiser Permanente is not required to continue the provider's services.

6.0 Continuity of Medi-Cal Covered Services and Prior Treatment Authorizations

6.1 All enrollees have the right to continue receiving Medi-Cal services covered under Kaiser Permanente's Medi-Cal managed care plan contract with DHCS when transitioning to Kaiser Permanente, even in circumstances in which the enrollee does not continue receiving services from their pre-existing provider.

6.2 Kaiser Permanente will arrange for Continuity of Care for covered services without delay to the enrollee with a Network Provider, or if there is no Network Provider to provide the covered service, with a Non-Plan Provider.

6.3 When an enrollee would like to continue receiving a covered service from a Non-Plan Provider with whom they have a pre-existing relationship, they may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal FFS to Kaiser Permanente, transitioning from Kaiser Permanente with its contracts expiring or terminating to a new MCP on or after January 1, 2023, or if the conditions in HSC section 1373.96 are met.

6.4 Kaiser Permanente will make a good faith effort to enter an agreement if all Continuity of Care requirements are met.

6.5 Following an enrollee's mandatory transition from Medi-Cal FFS to Kaiser Permanente, or an enrollee's transition to Kaiser Permanente from MCPs with contracts expiring or terminating on or after January 1, 2023, the enrollee's active prior treatment authorizations for services remain in effect for 90 days and will be honored without a request by the enrollee, authorized representative, or provider.

6.5.1 Kaiser Permanente 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 a Non-Plan Provider.

6.5.2 After 90 days, the active treatment authorization remains in effect for the duration of

the treatment authorization or until completion of a new assessment by Kaiser Permanente, whichever is shorter.

6.5.3 If Kaiser Permanente does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, Kaiser Permanente may reassess the enrollee's prior treatment authorization at any time.

6.5.4 A new assessment is considered complete by Kaiser Permanente if the enrollee has been seen in-person and/or via synchronous Telehealth by a Network Provider and this provider has reviewed the enrollee's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

6.5.5 If Kaiser Permanente is reassessing Enhanced Care Management (ECM) authorizations after 90 days, Kaiser Permanente will reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria.

6.6 Additionally, in an instance where a service has been rendered with a Non-Plan Provider, and that provider satisfies the Continuity of Care requirements, the enrollee, authorized representative, or provider may request Continuity of Care to retroactively cover the service.

6.7 Durable Medical Equipment Rentals and Medical Supplies

6.7.1 Kaiser Permanente will allow transitioning enrollees to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing Provider under the previous prior authorization for a minimum of 90 days following the enrollee's enrollment with Kaiser Permanente, and until the following are complete:

6.7.1.1 Kaiser Permanente is able to reassess the enrollee's authorization;

6.7.1.2 The new equipment or supplies are in possession of the enrollee, and

6.7.1.3 The new equipment or supplies are ready for use.

6.7.2 Continuity of DME and medical supplies will be honored without a request by the enrollee, authorized representative, or provider.

6.7.3 If DME or medical supplies have been arranged for a transitioning enrollee but the equipment or supplies have not been delivered, Kaiser Permanente will allow the delivery and for the enrollee to keep the equipment or supplies for a minimum of 90 days following the enrollee's enrollment with Kaiser Permanente, and until Kaiser Permanente is able to reassess.

6.7.4 If Kaiser Permanente does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization.

6.7.5 After 90 days, Kaiser Permanente may reassess the enrollee's authorization at any time and require the enrollee to switch to a Network DME Provider.

6.8 Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)

6.8.1 For NEMT and NMT, Kaiser Permanente will allow enrollees to keep the modality of transportation under the previous prior authorization with a Network Provider until the new MCP is able to reassess the enrollee's continued transportation needs. Continuity of Care does not extend to NEMT or NMT providers.

6.8.2 Kaiser Permanente will use Treatment Authorization Request (TAR) data or prior

6.8.3 authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies.

6.8.4 Kaiser Permanente will pay claims for prior authorizations or existing authorizations when data is incomplete.

7.0 Enrollee and Provider Outreach and Education

7.1 Kaiser Permanente will inform enrollees of their Continuity of Care protections and include information about these protections in enrollee information packets, handbooks, and on Kaiser Permanente's website.

7.2 This information will include how an enrollee, authorized representative, and provider may initiate a Continuity of Care request with Kaiser Permanente.

7.3 Kaiser Permanente will translate these documents into threshold languages and make them available in alternative formats, upon request.

7.4 Kaiser Permanente will provide training to call center and other staff who come into regular contact with enrollees about Continuity of Care protections.

8.0 Reporting

8.1 Kaiser Permanente will continue to report on existing metrics related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents.

8.2 Kaiser Permanente will adhere to any additional reporting on Continuity of Care at any time and in a manner determined by DHCS.

9.0 Specific Contexts

There are other transitions for specific enrollee populations that Kaiser Permanente will allow Continuity of Care for, which have distinct processing requirements and timelines.

9.1 Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity of Care for Approved Provider Types:

9.1.1 Kaiser Permanente will cover Non-Specialty Mental Health Services (NSMHS), as outlined in APL 22-005 and APL 22-006, or any subsequent iterations of these APLs. County Mental Health Plans (MHPs) are required to provide Specialty Mental Health Services (SMHS) for enrollees who meet the criteria for SMHS.

9.1.2 Kaiser Permanente will provide Continuity of Care with a Non-Plan SMHS Provider in instances where a enrollee's mental health condition has stabilized such that the enrollee no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive NSMHS from Kaiser Permanente.

9.1.2.1 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 NSMHS (referred to in the State Plan as "Psychology").

9.1.3 Kaiser Permanente will allow, at the request of the enrollee, authorized representative, or provider, up to 12 months Continuity of Care with the Non-Plan MHP Provider in accordance with APL 23-022.

9.1.4 After the Continuity of Care period ends, the enrollee must choose a mental health provider in Kaiser Permanente's Network for NSMHS. If the enrollee later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to Kaiser Permanente for NSMHS, the 12-month Continuity of Care period may start over one time.

9.1.5 If the enrollee requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the enrollee returns to Kaiser Permanente or changes MCPs (i.e., the enrollee does not have the right to a new 12 months of Continuity of Care).

9.2 Covered California to Medi-Cal Transition

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 an enrollee's eligibility circumstances that may occur at any time throughout the year. The following requirements are limited to these transitioning enrollees.

9.2.1 To ensure that care coordination requirements are met, Kaiser Permanente will ask these enrollees if there are upcoming health care appointments or treatments scheduled and assist them.

9.2.1.1 If the enrollee requests Continuity of Care, Kaiser Permanente will help initiate the process at that time according to the requirements in APL 23-022.

9.2.1.2 Kaiser Permanente will contact the new enrollee by telephone, letter, or other preferred method of communication, no later than 15 calendar days after enrollment.

9.2.2 Kaiser Permanente will make a good faith effort to learn from and obtain information from the enrollee so that it is able to honor active prior treatment authorizations with a Network Provider and/or establish Continuity of Care.

9.2.2.1 Kaiser Permanente will honor any active prior treatment authorizations for 90 days for services that are covered under its Kaiser Permanente Contract. Kaiser Permanente 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 a Non-Plan Provider.

9.2.2.2 After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by Kaiser Permanente, whichever is shorter.

9.2.2.3 A new assessment is considered complete by Kaiser Permanente if the enrollee has been seen in-person and/or via synchronous telehealth by a Network Provider and this provider has reviewed the enrollee's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

9.2.2.4 Prior treatment authorizations will be honored without a request by the enrollee, authorized representative, or Provider.

9.2.3 Kaiser Permanente will, at the enrollee, authorized representative, or provider's request, offer up to 12 months of Continuity of Care, in accordance with the requirements in APL 23-022.

9.3 Pregnant and Post-Partum Enrollees and Newborn

9.3.1 HSC section 1373.96 requires Kaiser Permanente to, at the request of an enrollee, authorized representative, or provider, provide for the completion of covered services relating to pregnancy, during pregnancy, and immediately after the delivery (the post-partum period, which is 12 months), and care of a newborn child between birth and age 36 months, by a terminated/expired Plan Provider or Non-Plan Provider. These requirements apply for pregnant and post-partum enrollees and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.

9.3.2 Pregnant and post-partum enrollees who are assigned a mandatory aid code, who are transitioning from Medi-Cal FFS to Kaiser Permanente or from Kaiser Permanente with contracts expiring or terminating to a new MCP on or after January 1, 2023, have the right to request Continuity of Care in accordance with the Kaiser Permanente Contract and the requirements listed in APL 23-022.

9.3.3 This requirement is applicable to any existing Medi-Cal Provider relationship that is allowed under the general requirements of APL 23-022.

9.4 Terminally Ill Enrollees

9.4.1 HSC section 1373.96 requires Kaiser Permanente to, at the request of an enrollee, authorized representative, or provider, provide for the completion of covered services of an enrollee with a terminal illness.

9.4.2 A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

9.4.3 Completion of covered services will be provided for the duration of a terminal illness, even if it exceeds 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.

9.5 Medical Exemption Requests

9.5.1 A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into Kaiser Permanente only until the enrollee's medical condition has stabilized to a level that would enable the enrollee to transfer to a Network Provider of the same specialty without deleterious medical effects.

9.5.2 A MER is a temporary exemption from Kaiser Permanente enrollment that only applies to enrollees transitioning from Medi-Cal FFS to Kaiser Permanente. A MER should only be used to preserve Continuity of Care with a Medi-Cal FFS Provider under the circumstances described in this section.

9.5.3 Kaiser Permanente is required to consider MERs that have been denied as automatic Continuity of Care requests to allow enrollees to complete courses of treatment with Non-Plan Providers in accordance with APL 17-007 and APL 23-022, and subsequent iterations.

9.5.4 Kaiser Permanente will process the Continuity of Care request, including the validation of a pre-existing relationship with the Provider, and make a good faith effort to come to an agreement with the Non-Plan Provider for the duration of the treatment.

9.5.5 If Kaiser Permanente reaches an agreement with the Provider, Kaiser Permanente will allow the enrollee Continuity of Care for up to 12 months after the enrollment date with Kaiser Permanente.

9.6 **Health Homes Program ("HHP").** Medi-Cal Continuity of Care applies to Medi-Cal FFS beneficiaries who voluntarily transition to managed care to enroll in the HHP.

9.7 **Pediatric Palliative Care ("PPC").** Medi-Cal Continuity of Care applies to Enrollees who formerly received PPC Waiver Program services, so long as such services are also covered by Medi-Cal under the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") benefit (also known as Medi-Cal For Kids & Teens), in accordance with DHCS APL 18-020 (Palliative Care).

9.8 **California Children's Services ("CCS") Whole Child Model ("WCM") Program.** Medi-Cal Continuity of Care applies to existing CCS providers for enrollees who transition into the WCM, in accordance with DHCS APL 21-005 (California Children's Services Whole Child Model Program). The following are additional WCM-specific COC requirements:

9.8.1 Specialized or Customized Durable Medical Equipment ("DME"). If a WCM enrollee has an established relationship with a specialized or customized DME provider, Kaiser Permanente shall provide access to that provider for up to 12 months, if the specialized or customized DME meets all of the following criteria:

9.8.1.1 Uniquely constructed or substantially modified solely for the use of the enrollee; and

9.8.1.2 Made to order or adapted to meet the specific needs of the enrollee; and

9.8.1.3 Uniquely constructed, adapted, or modified such that it precludes use of the DME by another individual and cannot be grouped with other items meant for the same use for pricing purposes.

9.8.2 Continuity of Care Case Management. WCM enrollees may request COC for case management and care coordination from the enrollee's existing public health nurse ("PHN"), if elected by the enrollee within 90 days of transition of CCS services to KP.

9.8.3 Authorized Prescription Drugs. WCM enrollees are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition, until Kaiser Permanente and the prescribing physician complete an assessment, create a treatment plan, and agree that the drug is no longer medically necessary; or if it is no longer prescribed by the county CCS program provider. In such cases, Kaiser Permanente shall send a Notice of Action to the CCS-eligible enrollee informing them of the service change, as well as their appeal rights, in accordance with DHCS APL 21-011 (Grievance and Appeals Requirements, Notice and "Your Rights" Templates).

9.8.4 Extension of Continuity of Care Period. Kaiser Permanente may, at its discretion, extend COC beyond the initial 12-month period. Kaiser Permanente shall provide CCS-eligible enrollees with written notification 60 days prior to the end of the COC period informing enrollee of their right to request a COC extension, the criteria to be used to evaluate the request, and the appeal process.

9.8.5 CCS-eligible enrollees may receive services outside of their delegated entities if there is a WCM network certification deficiency within Kaiser Permanente.

9.8.6 CCS-eligible enrollee to continue receiving services from their previous delegated entity, including their assigned PCP, for those required to select or be reassigned to a new delegated entity.

9.9 **Managed Long Term Services and Supports ("MLTSS") Benefits.** Medi-Cal Continuity of Care with Community Based Adult Services ("CBAS") facilities and Long Term Care ("LTC") facilities (including skilled, intermediate, and subacute care facilities) shall be provided within the seven (7) Coordinated Care Initiative ("CCI") counties, in accordance with DHCS APL 15-004 (Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties For Beneficiaries not Enrolled in Cal MediConnect). In addition, enrollees residing in LTC facilities on the date of their enrollment with Kaiser Permanente may remain in such facilities for the duration of the CCI, so long as the Policy conditions continue to be met.

10.0 Continuity of Care for SPD beneficiaries

10.1 For newly enrolled SPD beneficiaries who request continuity of care, Kaiser Permanente will provide continued access for up to 12 months to a Non-Plan Provider with whom the beneficiary has an ongoing relationship, as long as Kaiser Permanente has no quality of care issues with the Non-Plan Provider and the Non-Plan Provider will accept either Kaiser Permanente rates or Medi-Cal FFS Rates.

10.2 Kaiser Permanente will use Medi-Cal FFS utilization data from DHCS to confirm that the SPD beneficiary has an ongoing relationship with the Non-Plan Provider.

11.0 References / Appendices

11.1 State and Federal Statutes and Regulations, DHCS Contract, and All Plan Letters.

11.1.1 DHCS APL 23-022: Continuity of care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service on or after January 1, 2023

11.1.2 DHCS APL 21-003: Medi-Cal Network Provider and Subcontractor Terminations

11.1.3 DHCS APL 22-005: No Wrong Door for Mental Health Services Policy

11.1.4 DHCS APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services

11.1.5 DHCS APL 22-018 (REVISED): Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

11.1.6 DHCS APL 18-020: Palliative Care

11.1.7 DHCS APL 21-005: California Children's Services Whole Child Model Program; and California Welfare & Institutions Code § 14094.13 (CCS WCM)

11.1.8 DHCS APL 15-004: Medi-Cal MCP Requirements For Nursing Facility Services In CCI Counties For Beneficiaries Not Enrolled In Cal MediConnect

11.1.9 DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports

11.1.10 DHCS 2023 CalAIM Dual Eligible Special Needs Plans Policy Guide, Section V

11.1.11 DHCS 2023 California's State Medicaid Agency Contract (SMAC) for all D-SNPs, Exhibit A, Attachment 1, Section 9

11.1.12 DHCS KP Whole Child Model Implementation Deliverable List (7/19/2023), WCM 1 and WCM 15

11.1.13 DHCS Adult Expansion Deliverable List (REVISED 6/26/2023), AE 1

11.1.14 Cal. Health and Safety Code sections 1367(d) and 1373.96

11.1.15 Title 28 of the California Code of Regulations (CCR) section 1300.67.1

11.1.16 Title 42 Code of Federal Regulations (CFR) section 438.62

11.1.17 MCP Contract, Exhibit A, Attachment 9, Section 16A

ATTACHMENT B (a)

2024 Medi-Cal Transition Continuity of Care Requirements

1.0 Policy Statement

The California Department of Health Care Services (DHCS) is transforming Medi-Cal to ensure that Californians have access to the care they need to live healthier lives. Beginning in 2024, Medi-Cal managed care plans (MCP) will be subject to new requirements to rigorously advance health equity, quality, access, accountability, and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some Medi-Cal MCPs are changing on January 1, 2024, as a result of four changes in how DHCS contracts with Medi-Cal MCPs, described below. Collectively, these changes comprise the January 1, 2024, MCP Transition. This process applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal.

- **New commercial MCP contracts**: On December 30, 2022, DHCS announced an agreement with five commercial MCPs to serve Medi-Cal members in 21 counties.
- **County-level Medi-Cal managed care model change**: In 2021, DHCS conditionally approved 17 counties to change their Medi-Cal managed care model, subject to federal approval and operational readiness. Counties are shifting to one of three local plan models – Two Plan, County Operated Health System (COHS), or the new Single Plan model.
- **Contract with Kaiser Permanente**: In 2024, Kaiser Permanente expands its Medi-Cal MCP contract to 32 counties and will begin serving new populations, per federal approval and new agreement with DHCS.
- **Changes in subcontracted MCP participation**: DHCS will require HealthNet in Los Angeles County to assign its subcontractor Molina 50% of its total membership in Los Angeles County. In addition, some subcontracted MCPs will serve different counties starting January 1, 2024.

2.0 Purpose

To describe the process for facilitating completion of covered services (also known as Continuity of Care or “COC” or “CoC”) for members transitioning from other MCPs due to contract changes into Kaiser Permanente’s MCP effective January 1, 2024.

3.0 Scope/Coverage

This policy applies to all individuals who are employed by the following entities (collectively referred to as “Kaiser Permanente”):

3.1 Kaiser Foundation Health Plan, Inc. (KFHP or “Health Plan”).

3.2 Kaiser Foundation Hospitals (KFH).

3.3 KFHP/H subsidiaries.

3.4 The Permanente Medical Group, Inc. (TPMG)

3.5 Southern California Permanente Medical Group (SCPMG)

4.0 Definitions

4.1 2024 MCP Transition: Refers to changes to the MCPs operating in specific counties slated to take effect on January 1, 2024, because of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser Permanente direct contract.

4.2 Active Course of Treatment: A course of treatment in which a member is actively engaged with a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

4.3 All Plan Letter (APL): A means by which DHCS conveys information or interpretation of changes in policy or procedure at Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis

4.4 Authorized Representative: Any individual appointed in writing by a competent member or potential member to act in place or on behalf of the member or potential member for purposes of assisting or representing the member or potential member with grievances and appeals, state fair hearings, independent medical reviews, or in any other capacity, as specified by the member or potential member.

4.5 Care Manager: For the purposes of this policy, a Care Manager is inclusive of the Complex Care Management (CCM) Care Manager and the Enhanced Care Management (ECM) lead care manager, as well as other care managers.

4.6 Care Management Plan: A written plan that is developed with input from the member and/or their family members, parents, legal guardians, Authorized Representatives, caregivers, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and to make recommendations for clinical and non-clinical service needs.

4.7 California State Plan Approved Provider: A provider who is enrolled and participating in the Medi-Cal program.

4.8 Center of Excellence (COE) Transplant Program: A designation assigned to a Transplant Program by DHCS upon confirmation that the Transplant Program meets DHCS' criteria. MCPs are required to ensure all Major Organ Transplant (MOT) procedures are performed in a Medi-Cal approved COE Transplant Program which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, Parts 405, 482, 488, and 498 and section 1138 of the Social Security Act (SSA).

4.9 Community Supports (CS): Substitute services or settings for those required under the California Medicaid State Plan that the MCP may select and offer to its members pursuant to 42 CFR section 438.3(e)(2) when pre-approved by the Department of Health Care Services (DHCS) as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan

4.10 Complex Care Management (CCM): A service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability, in accordance with all National Committee for Quality Assurance CCM requirements.

4.11 Continuity of Care for Providers Agreement: A single case agreement (for a specific, named member) or letter of agreement (for multiple members) between a Receiving MCP and OON Provider, intended to maintain trusted member/provider relationships until a member can transition to a Network Provider with the Receiving MCP. A Continuity of Care for Providers

agreement enables transitioning members to continue receiving care from their existing providers for a period of time, if certain requirements are met.

4.12 **Covered Services:** Those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 et seq. and 14132 et seq., 22 California Code of Regulations (CCR) section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the MCP Contract, and APLs, that are made the responsibility of the Prime MCP pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

4.13 **DHCS:** California Department of Health Care Services

4.14 **DME:** Durable Medical Equipment: Medically necessary medical equipment as defined by 22 CCR section 51160 that a provider prescribes for a member that the member uses in the home, in the community, or in a facility that is used as a home.

4.15 **D-SNP:** Dual Special Needs Plans are Medicare Advantage (MA) plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offer care coordination and wrap-around services.

4.16 **Enhanced Care Management (ECM):** A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria, through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high-touch, and person-centered.

4.17 **ECM Provider**: Community-based entity with experience and expertise providing intense, in-person care management services to members in one or more of the Populations of Focus for ECM

4.18 **MCP:** Medi-Cal Managed Care Plan

4.19 **Medical Exemption Request (MER):** A request for temporary exemption from enrollment into an MCP only until the beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to a Network Provider of the same specialty without deleterious medical effects.

4.20 **Medi-Cal Matching Plan policy:** A policy in specific counties under which Dual-eligible members that choose to enroll in a Medicare Advantage (MA) plan are automatically enrolled with a matching Medi-Cal MCP with the same parent company, if one is available. This policy does not change or impact a member's MA plan choice.

4.21 **Member:** A person eligible for Medi-Cal and enrolled in an MCP

4.22 **MHP:** County Mental Health Plan

4.23 **NEMT:** Non-Emergency Medical Transportation

4.24 **Network Provider:** Any provider or entity that has a Network Provider Agreement with the Prime MCP, Subcontractor, or downstream Subcontractor and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to members. A Network Provider is not a Subcontractor or downstream Subcontractor by virtue of the Network Provider Agreement

4.25 **Network Provider Agreement:** A written agreement between a Network Provider and the Prime MCP, the MCP's Subcontractor, or the MCP's Downstream Subcontractor.

4.26 **Out-of-Network (OON) Provider**: A provider that is not a Network Provider (i.e., does not have a contract to participate in an MCP network)

4.27 **NMT:** Non-Medical Transportation

4.28 **NSMHS:** Non-Specialty Mental Health Services as outlined in APL 22-005 and APL 22-006

4.29 **Pre-Existing Relationship:** When a member had at least one non-emergency visit with the provider during the 12 months preceding January 1, 2024. This Pre-Existing Relationship does not limit the Continuity of Care protections for members who have a health condition listed in the Knox-Keene Health Care Service Plan Act, California Health and Safety Code (HSC) section 1373.96.

4.30 **Previous MCP**: A Prime MCP or Subcontractor MCP that a member is required to leave effective January 1, 2024, for one of the following reasons: 1) the MCP exits the market 2) the Subcontractor and the MCP terminate their Subcontractor Agreement, or 3) DHCS requires the Prime MCP to transition members to a Subcontractor MCP.

4.31 **Prior Authorization**: A formal process requiring a provider to obtain advance approval of the amount, duration, and scope of non-emergent Covered Services

4.32 **Prime MCP:** An MCP that directly contracts with DHCS to provide Covered Services to members within the county or counties specified in their contract.

4.33 **Receiving MCP**: A Prime MCP or Subcontractor MCP that a member joins by choice or default after being required to leave a Previous MCP effective January 1, 2024. Receiving MCPs may be Continuing MCPs or Entering MCPs in a county.

4.34 **SMHS:** Specialty Mental Health Services

4.35 **SPD:** Seniors and Persons with Disabilities

4.36 **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.

4.37 **Subcontractor:** An individual or entity that has a Subcontractor Agreement with an MCP that relates directly or indirectly to the performance of the MCP's obligations under the MCP Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

4.38 **Subcontractor Agreement:** A written agreement between the Prime MCP and a Subcontractor. The Subcontractor Agreement must include a delegation of the Prime MCP's duties and obligations under the contract.

4.39 **Subcontracted MCP:** An MCP that contracts with the prime MCP to assume full or partial risk of a portion of the prime MCP's membership.

4.40 **Transitioning Member:** A member of a Previous MCP who enrolls in a Receiving MCP on January 1, 2024, due to the Previous MCP exiting the county or another required transition to a new Prime MCP or Subcontractor. The term "transitioning member" excludes those members who opt to change MCP by choice.

4.41 **Transplant Program**: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current member of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS). Bone marrow Transplant Programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.

5.0 Provisions

5.1 Covered Services

The Medi-Cal Continuity of Care requirements listed in this *Completion of Covered Services* Policy and Procedure Medi-Cal Attachment B (a) are in addition to those set forth in the Medi-Cal Attachment B to this policy and those set forth in HSC section 1373.96 (and addressed in the main section of the Policy and Procedure), which provides for the enrollee's completion of Covered Services with a terminated Plan Provider or by a Non-Plan Provider, if a pre-existing relationship exists with that Provider and if the enrollee has one of the conditions listed in HSC section 1373.96

5.2 Covered Services – 2024 MCP Transition Policy Guide

Specific to the 2024 MCP Transition and starting below, are the four CoC-related sections/chapters of the 2024 MCP Transition Policy Guide: 1) Chapter V CoC; 2) Chapter VIII CoC Data Sharing Policy; 3) Chapter VII Community Supports; and 4) Chapter VI Enhanced Care Management and will be used to protect members accessing care in accordance with the 2024 MCP Transition Policy Guide.

5.3 Continuity of Care – Chapter V, 2024 MCP Transition Policy Guide

All transitioning members have CoC protections, but some transitioning members – referred to in this 2024 MCP CoC Policy as Special Populations – will need enhanced protections leading up to and throughout the 2024 MCP Transition. Transitioning members in Special Populations are generally individuals living with complex or chronic conditions (See list of Special Populations, Figure 2, Chapter V, 2024 MCP Transition Policy Guide).

5.3.1 Under this 2024 MCP CoC Policy, DHCS is requiring both Previous and Receiving MCPs to focus attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care.

5.3.2 Kaiser Permanente recognizes the importance of transferring and sharing supportive information for Special Population members to enable the new Care Manager to continue the member's care management services without interruption. Kaiser Permanente will transfer supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

5.3.3 Kaiser Permanente will share and complete the transfer of supportive data for these members identified before January 1, 2024 or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

5.3.4 Kaiser Permanente will work with the Previous MCP to transfer and share supportive information important for members' care coordination and management.

5.4 Continuity of Care for Providers – Chapter V, 2024 MCP Transition Policy Guide

5.4.1 To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting Kaiser Permanente. The requester may contact Kaiser Permanente, the Receiving MCP, prior to the date of service up until December 31, 2024. Upon receiving the request, Kaiser Permanente, as the Receiving MCP, will confirm whether the request meets the following requirements:

- The provider is providing a service that is eligible for Continuity of Care for Providers
- The member has a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding January 1, 2024.

- Provider will accept Medi-Cal FFS rates.
- Provider meets Kaiser Permanente's applicable professional standards and has no disqualifying quality of care issues.
- The Provider is a California Medicaid State Plan approved provider.

5.4.2 Permanente will accept Continuity of Care requests from the enrollee, authorized representative, or provider over the telephone, or in writing, according to the requester's preference, and will not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone.

5.4.3 Kaiser Permanente will process CoC for Providers requests and notify members according to the timelines in the "Expectations of the Receiving MCP" subsection of the 2024 MCP Transition Policy Guide. When processing a CoC for Providers request, the MCP will confirm whether the request meets 2024 MCP Transition Policy Guide requirements.

5.4.4 Kaiser Permanente will take any necessary information from the requester over the telephone to complete the request and will ensure that transitioning members are able to access assistance from Kaiser Permanente's call center starting November 1, 2023, prior to their enrollment with the MCP before January 1, 2024

5.4.5 Kaiser Permanente will confirm whether or not the requirements in Section V.C of the 2024 MCP Transition Policy Guide are met as stated in 5.4.1. If requirements in Section V.C are met, Kaiser Permanente will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into a CoC for Providers agreement for the member's care within the timeframe.

5.5 Timeframes for Processing CoC for Provider Requests – Chapter V, 2024 MCP Transition Policy Guide

5.5.1 Kaiser Permanente will resolve the CoC for Providers request and notify the member and provider of the outcome of the CoC for Providers request within the following timeframes in Figure 5 on page 30 on the 2024 MCP Transition Policy Guide from the date of the request.

Figure 5. Timeframes for CoC for Providers Process*

Request	Description	Timeframe for Processing Request**	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the member[29]	As soon as possible, but no longer than 3 calendar days	Within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

5.5.2 For prospective requests made in advance of January 1, 2024, Kaiser Permanente will complete processing of the request by January 1, 2024 or according to timeframes in Figure 5 (above) in the 2024 MCP Transition Policy Guide, whichever is later.

5.6 Member Notifications – Chapter V, 2024 MCP Transition Policy Guide

5.6.1 Kaiser Permanente will notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of Kaiser Permanente's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email according to the timeframes listed in Figure 5 above and in the 2024 MCP Transition Policy Guide on page 30.

5.6.2 Kaiser Permanente will send a notice by mail to the member within seven calendar days of the decision, or if urgent, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days.

5.7 Provider Agreement – Chapter V, 2024 MCP Transition Policy Guide

5.7.1 When a CoC for Providers agreement is established, Kaiser Permanente will work with the eligible provider to ensure no disruption in services for the member.

5.7.2 In addition, Kaiser Permanente will direct the eligible provider not to refer the member to other OON Providers without prior approval from Kaiser Permanente. If referral

is needed for another OON Provider, the Kaiser Permanente will approve the referral to the OON Provider.

5.7.3 After establishing a CoC for Providers agreement with the eligible provider, Kaiser Permanente will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the 2024 MCP Transition Policy Guide, and as agreed upon with the provider.

5.7.4 As the end of the agreed-upon CoC period approaches, Kaiser Permanente will establish a process to transition the member to a Network Provider to continue meeting the needs of the member.

5.7.5 Sixty calendar days before the end of the CoC for Providers period, Kaiser Permanente will notify the member and the eligible provider about the process for transitioning the member's care.

5.7.6 Kaiser Permanente will identify a Network Provider, engage the provider, the member, previous eligible provider, and the member's new Network Provider, and ensure the member's record is transferred within 60 days to ensure continuity of Covered Services through the Transition to the Network Provider.

5.7.7 If a CoC for Providers agreement is not established and Kaiser Permanente and the eligible provider are unable to reach a CoC for Providers agreement, Kaiser Permanente will offer the member an alternative Network Provider in a timely manner, so the member's service is not disrupted.

5.7.8 If the member does not actively choose an alternative Network Provider, Kaiser Permanente will refer the member to a Network Provider.

5.7.9 If there is no Network Provider to provide the Covered Service.

5.7.10 Kaiser Permanente will arrange for an OON Provider.

5.8 Enhanced CoC for Providers Protections for Special Populations – Chapter V, 2024 MCP Transition Policy Guide

5.8.1 As explained in the 2024 MCP Transitions Policy Guide, DHCS and Previous MCPs will identify members who meet the criteria for Special Populations for the Receiving MCP, in this case, Kaiser Permanente. Upon receiving data for Special Populations, Kaiser Permanente will proactively begin the Continuity of Care for Providers process.

5.8.2 Kaiser Permanente will review all available data to identify eligible providers that provided services to Special Populations (during the 12 months preceding January 1, 2024) by January 1, 2024, or within 30 calendar days of receiving data for Special Populations, whichever is sooner.

5.8.3 DHCS requires Receiving MCPs to proactively contact all eligible providers with whom Special Population members have Pre-Existing Relationships to initiate a Network Provider Agreement or a CoC for Providers agreement if requirements in Section V.C. of the 2024 MCP Transition Guide are met. This outreach effort will minimize disruptions in care and risk of harm for transitioning members in Special Populations. Kaiser Permanente will contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement if requirements in the 2024 MCP Transitions Guide in Section V.C are met (see 5.2.2).

5.8.4 Kaiser Permanente will notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:

5.8.4.1 If the member's provider is in network or is brought in network as a result of Kaiser Permanente's outreach, then Kaiser Permanente must send notification that the member may continue with his or her provider.

5.8.4.2 If the member's provider is OON and Kaiser Permanente establishes a CoC for Providers agreement, then Kaiser Permanente will notify the member of the length of time that they can stay with their provider.

5.8.4.3 If the provider is OON and cannot establish a CoC for Providers agreement, Kaiser Permanente will send notification that the member must change to a Network Provider and assign the member a new Network Provider.

5.8.5 In all cases, Kaiser Permanente will include in required notifications that the member may choose to change providers and comply with the notification requirements in Section V.C. In addition, Kaiser Permanente will meet the required timeline in Figure 6 below and in the of the 2024 MCP Transition Policy Guide.

Figure 6. Timeframes for Processing CoC for Providers for Special Populations

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers
Special Population	30 calendar days from receipt of Special Populations data	7 calendar days

5.9 Enhanced Protections for Members Accessing the Transplant Benefit – Chapter V, 2024 MCP Transition Policy Guide

Members accessing the transplant benefit are especially vulnerable and will benefit from additional protections designed to ensure zero disruption and seamless transition to Receiving MCPs. To achieve this objective, DHCS will require mandatory overlap of the Previous MCP's and Receiving MCP's Center of Excellence (COE) Transplant Programs to the maximum extent possible to permit any member accessing the transplant benefit to continue with the same Transplant Programs.

5.9.1 If Kaiser Permanente is unable to bring a Transplant Program in network, Kaiser Permanente will make a good faith effort to enter a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in Section V.C and according to the following terms:

5.9.1.1.1 Make explicit the existing statutory requirement that Kaiser Permanente will pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code).

5.9.1.1.2 Permit the CoC for Providers agreement to continue for the duration of the member's access to the transplant benefit.

If Kaiser Permanente is unable to enter into a CoC for Providers agreement, Kaiser Permanente will:

5.9.1.1.3 Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON Provider, in accordance with the timeline in Figure 6 (above).

5.9.1.1.4 Explain in writing to DHCS why the provider and Kaiser Permanente could not execute a CoC for Provider agreement. Guidance regarding written explanations will be clarified in the forthcoming Section, Transition Monitoring

5.9.1.1.5 and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide

5.10 Continuity of Care for Covered Services – Chapter V, 2024 MCP Transition Policy Guide

5.10.1 Kaiser Permanente will honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and the MCP obtains documentation of the Prior Authorization within the 6-month CoC for Services period.

5.11 Enhanced CoC Services Protections for Special Populations – Chapter V, 2024 MCP Transition Policy Guide

5.11.1 During the 6-month CoC for Services period, Kaiser Permanente will examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization, and must contact those providers to establish any necessary Prior Authorizations.

5.12 Enhanced CoC for Services Protections for Special Population Members Accessing the Transplant Benefit – Chapter V, 2024 MCP Transition Policy Guide

5.12.1 Kaiser Permanente will start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date beginning July 1, 2024.

5.13 Continuity of Care Coordination and Management Information – Chapter V, 2024 MCP Transition Policy Guide

5.13.1 Kaiser Permanente, as the Previous MCP will transfer and share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

5.13.2 Kaiser Permanente, as the Previous MCP, will provide to the Receiving MCP, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served any transitioning members.

5.13.3 Kaiser Permanente, as the Receiving MCP, will proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.

5.13.4 Kaiser Permanente, as the Previous MCP will share and complete the transfer of supportive data for these members before January 1, 2024 or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

5.14 Members in Inpatient Hospital Care – Chapter V, 2024 MCP Transition Policy Guide

5.14.1 Kaiser Permanente will be prepared to receive the members known to be receiving inpatient care by December 22, 2023 from the Previous MCP, and must refresh that information daily through January 9, 2024, including holidays and weekends.

5.14.2 Kaiser Permanente, upon notice of a member in inpatient hospital care either through the Previous MCP or via other means, will contact the hospital to provide for completion of and coordination of the member's care.

5.14.3 Kaiser Permanente will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.

5.15 Members Accessing the Transplant Benefit – Chapter V, 2024 MCP Transition Policy Guide

5.15.1 Kaiser Permanente will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

5.16 Durable Medical Equipment Rentals and Medical Supplies – Chapter V, 2024 MCP Transition Policy Guide

5.16.1 Kaiser Permanente will allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.

5.16.2 In addition, Kaiser Permanente will arrange Continuity of Care protections for DME or medical supplies that have been arranged for but not yet delivered. Kaiser Permanente will allow the delivery and permit the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

5.17 Non-Emergency Medical Transportation and Non-Medical Transportation – Chapter V, 2024 MCP Transition Policy Guide

To provide a robust Continuity of Care Policy for the 2024 MCP Transition, DHCS is specifying additional protections for all transitioning members related to non-emergency medical transportation (NEMT) and non-medical transportation (NMT).

5.17.1 If a Network Provider is not available to provide the transitioning member's scheduled NEMT/NMT service, Kaiser Permanente will make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider.

5.17.2 Kaiser Permanente will work together with the Previous MCP to support continuation of NEMT/NMT services for transitioning members by:

5.17.2.1 Providing authorization data as described in Section V.G of the 2024 MCP Transitions Policy Guide

5.17.2.2 Transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to the Receiving MCP on November 12, 2023, and refresh weekly starting in December 2023

5.18 Scheduled Specialist Appointments – Chapter V, 2024 MCP Transition Policy Guide

5.18.1 Kaiser Permanente will ensure that transitioning members who seek assistance before January 1, 2024, while not yet enrolled with Kaiser Permanente are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

5.19 CoC Data Sharing – Chapter V, 2024 MCP Transition Policy Guide

5.19.1 Kaiser Permanente will receive confirmation from Previous MCPs to ensure that they completed all data transfer sharing activities as described below in the Continuity of Care Data Sharing Policy.

5.19.1.1 DHCS will require Previous MCPs to transmit utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to MCPs.

5.20 CoC Data Sharing Policy – Chapter VIII 2024 MCP Transition Policy Guide

Policies and Procedures for Managed Care Health Plans will demonstrate policies ensuring successful data sharing among DHCS, Previous MCPs, and Receiving MCPs in accordance with the 2024 MCP Transition Policy Guide, Chapter VIII.

This guidance included here lays out the data that DHCS will provide to Receiving MCPs and defines requirements for Previous MCPs to share necessary data for Receiving MCPs to implement CoC protections.

5.20.1 Successful data transfer sharing is critical to effectuating the CoC Policy for the 2024 MCP Transition. To implement the required CoC protections, Receiving MCPs must receive ingestible, accurate, and timely data from Previous MCPs and DHCS.

5.20.2 Specifically, Kaiser Permanente will utilize information provided in the standard monthly Plan Data Feed to implement CoC protections transitioning members.

5.20.3 Kaiser Permanente will use both the DHCS-provided Special Populations Member File and the Previous MCP-provided Transitioning Member Special Population Information Data file to identify Special Populations members' providers and begin outreach, a key tenet of the CoC policies for Special Populations.

5.20.4 Kaiser Permanente will complete all data sharing requirements outlined in the summary of MCP provided data files in Figure 3. below. This guidance outlines a standardized set of "minimum necessary" data elements for data shared from the Previous MCP to the Receiving MCP, as well as standard file formats, transmission methods, and transmission frequencies.

Figure 3. Summary of MCP Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Utilization Data	Claims and encounter information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Authorization Data	Prior authorization information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Special Populations Information Data	Transitioning members who meet Special Populations criteria and relevant accompanying data elements	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Special Populations Member Supportive Information Data[56]	Transitioning member screening and assessment findings, and member Care Management Plans	Receiving MCPs and DHCS	Within 15 days of member changing to a new Care Manager or by January 1, 2024, whichever is later

5.20.5 As the Previous MCP, Kaiser Permanente will use the CoC data template 1) Data Elements for All Members to prepare member level data files for transitioning members in accordance with requirements outlined in Sections VIII.B.1-VIII.B.4

5.20.6 As the Receiving MCP, Kaiser Permanente will use CoC Data template 2a) Special Populations Specifications to identify relevant members and prepare Transitioning Member Special Populations Data files using the Continuity of Care (CoC) Data Template 2b) Special Population Member File and Continuity of Care (CoC) Data template 2c) Special Populations Accompanying Data workbooks for transmittal to Receiving MCPs.

5.20.7 As the Previous MCP, Kaiser Permanente will use the CoC Data template 2b) Special Population Member file to prepare a file identifying members that meet the criteria outlined in Continuity of Care (CoC) Data Template 2a) Special Populations Specifications for transmittal to Receiving MCPs.

5.20.8 As the Previous MCP, Kaiser Permanente will use the CoC data template 2c) Special Populations Accompanying Data to prepare Special Populations accompanying data for certain Special Population groups for transmittal to Receiving MCPs.

5.20.9 As the Previous MCP, Kaiser Permanente will share Transitioning Member Identifying Data files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figures 4 and 5 below.

Figure 4: Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code[57]	Numeric 3-digit, Text
Member Homelessness Indicator[58]	Numeric, 1 digit, Text
Member Residential Address[59]	Alpha-numeric, Text
Member Residential City[60]	Alpha-numeric, Text
Member Residential Zip Code[61]	Alpha-numeric, Text
Member Mailing Address[62]	Alpha-numeric, Text
Member Mailing City[63]	Alpha-numeric, Text
Member Mailing Zip Code[64]	Numeric, 5-digit
Member Phone Number[65]	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact[66]	Alpha-Numeric, Text
Description of Member's Selected Alternative Format[67]	Alpha-Numeric, Text

Figure 5: Transitioning Member Primary Care Provider Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider/Clinic Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider/Clinic National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider/Clinic Phone Number[68]	Numeric, 10-digit
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date[69]	MM/DD/YYYY, Date

5.20.10 As the Previous MCP, Kaiser Permanente will share Transitioning Member Utilization Data files directly with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D.

5.20.11 As the Previous MCP, Kaiser Permanente will share Transitioning Member Utilization Data files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined the transitioning member claims/encounter information in Figure 6 below.

Figure 6. Transitioning Member Claims / Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code and Description	Alpha-Numeric, Text
HCPCS Modifier	Alpha-Numeric, Text
Revenue Code and Description	Alpha-Numeric, Text
Place of Service	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
National Provider Identifier (NPI)	Numeric, 10-digit, Text
Provider First Name	Alpha-Numeric, Text
Provider Last Name	Alpha-Numeric, Text
Provider Phone Number[71]	Numeric, 10-digit
Provider Specialty Type	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1	Alpha-Numeric, Text
Diagnosis Code 2	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

5.20.12 As the Previous MCP, Kaiser Permanente will share Transitioning Member Authorization Data files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in the transitioning member authorization information in Figure 7 below.

Figure 7. Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Referring Provider Name	Alpha-numeric, Text
Referring Provider NPI	Numeric, 10-digit, Text
Referring Provider Phone Number[71]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units (as applicable)	Numeric 7-digit, Text
Level of Service	Alpha-Numeric, Text
Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text
Diagnosis Code	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Prior Authorization Status	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text

5.20.13 As the Previous MCP, Kaiser Permanente will identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedule a Network Provider or an OON Provider to transport the member. See Section V.F.2 for more information on CoC for NEMT/NMT in the 2024 MCP Transitions Policy Guide.

5.20.14 As the Previous MCP, Kaiser Permanente will share Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data files with the Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figures 8 and 9 below.

Figure 8. Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Days of Week of Scheduled Service	Alpha-Numeric, Text
Time of Scheduled Service	Alpha-Numeric, Text
Member Phone Number[73]	Numeric, 10-digit
Pickup Location[74]	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number [75]	Numeric, 10-digit
Mode of Transport[76]	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number[77]	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number[78]	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes	Alpha-Numeric, Text

Figure 9. Transitioning Member PCS Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Standing Orders	Alpha-Numeric, Text
Mode of Transportation[79]	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[80]	Numeric, 10-digit

5.20.15 As the Previous MCP, Kaiser Permanente will share Transitioning Member Special Populations Information Data files with Receiving MCPs in accordance with the required transmission method and frequency outlined in outlined in Sections VIII.C-VIII.D. Previous MCPs must also share a copy of this data to DHCS to facilitate DHCS' oversight of the transition.

5.20.16 As the Previous MCP, Kaiser Permanente will inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends.

5.21 CoC Enhanced Care Management (ECM) – Chapter VI, 2024 MCP Transition Policy Guide

The Policies and Procedures (P&Ps) below for Kaiser Permanente will demonstrate policies ensuring Medi-Cal members with authorizations to receive ECM do not experience disruptions to the ECM authorization, provider relationships, or services in accordance with the 2024 MCP Transitions Policy Guide:

5.21.1 Kaiser Permanente will honor all the Previous MCP's authorizations for ECM.

5.21.2 Kaiser Permanente will maintain all authorizations for no less than the length of time originally authorized by the Previous MCP, regardless of whether members are actively receiving ECM.

5.21.3 Kaiser Permanente will offer a CoC for Provider agreement with the Previous MCPs Provider for up to 12 months if the Previous MCP's ECM Provider does not wish to enter into a network contract with Kaiser Permanente's network or if both parties cannot come to an agreement.

5.21.4 Kaiser Permanente will explain in writing to DHCS if Kaiser Permanente's efforts do not result in an agreement with the Previous MCP's ECM Provider and why they could not execute a contract or CoC for Provider agreement.

5.21.5 Kaiser Permanente will confirm that the member's existing ECM Provider is part of its network, agrees to join its network, or participates under a CoC for Provider agreement, that Kaiser Permanente will proceed and assign the member to their existing ECM Provider to ensure the member's relationship with their ECM Provider is not disrupted.

5.21.6 If Kaiser Permanente does not bring the ECM provider into its network or establish an agreement with the ECM Provider, Kaiser Permanente will transition the member to an in-network ECM Provider for outreach activity and continuation of ECM.

5.22 CoC for Community Supports (CS) – Chapter VII, 2024 MCP Transition Policy Guide

The Policies and Procedures (P&Ps) for Kaiser Permanente will demonstrate policies ensuring Medi-Cal members with authorizations to receive ECM do not experience disruptions to the ECM authorization, provider relationships, or services in accordance with the 2024 MCP Transitions Policy Guide:

5.22.1 Kaiser Permanente will honor all of the Previous MCPs authorizations for Community Supports when both MCPs offer the same Community Supports.

5.22.2 Kaiser Permanente will maintain all authorizations for no less than the length of time originally authorized by the Previous MCP (for Community Supports offered by both plans).

5.22.3 If both MCPs offer the same Community Support, Kaiser Permanente will honor the Community Support authorization made by the Previous MCP in alignment with the DHCS' Community Supports, or In Lieu of Services, Policy Guide.

5.22.4 If Community Supports not offered by both the Receiving and Previous MCPs, and Kaiser Permanente does not continue the Previous MCP's authorization for a Member's Community Support, Kaiser Permanente will assess the Member's needs that are addressed by the Community Support and coordinate care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.

5.22.5 If the Previous MCP's Community Supports Provider does not wish to enter into a contract with Kaiser Permanente's network or if both parties cannot come to an agreement, Kaiser Permanente will offer a CoC for Provider agreement with the Community Supports Provider for up to 12 months.

5.22.6 If Kaiser Permanente's efforts do not result in an agreement with the Community Supports Provider, Kaiser Permanente will explain in writing to DHCS why the Provider and the MCP could not execute a contract or CoC for Provider agreement.

5.22.7 If Kaiser Permanente does not bring the Community Supports Provider into its network or establish an agreement with the Community Supports Provider, Kaiser Permanente will transition the Member to an in-network Community Supports Provider.

6.0 Additional Continuity of Care Protections in HSC section 1373.96

HSC section 1373.96 offers additional protections for enrollees to continue seeing a terminated/expired Plan Provider or Non-Plan Provider, at an enrollee, authorized representative, or provider's request, to complete covered services for specific conditions outlined below. HSC section 1373.96 specifies timeframes for each condition, some of which differ from the policy in APL 22-032.

7.0 Appendices/References

7.1 State and Federal Statutes and Regulations, DHCS Contract, and All Plan Letters.

7.1.1 DHCS APL 23-003: California Advancing and Innovating Medi-Cal Incentive Payment Program (Supersedes APL 21-016)

7.1.2 DHCS APL 23-004: Skilled Nursing Facilities - - Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 22-018)

7.1.3 DHCS APL 23-032: 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 enrollees who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023 (Supersedes APL 22-032)

7.1.4 DHCS APL 21-003: Medi-Cal Network Provider and Subcontractor Terminations

7.1.5 DHCS APL 22-005: No Wrong Door for Mental Health Services Policy

7.1.6 DHCS APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services

7.1.7 DHCS APL 22-018 (REVISED): Skilled Nursing Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

7.1.8 DHCS APL 18-020: Palliative Care

7.1.9 DHCS APL 21-005: California Children's Services Whole Child Model Program; and California Welfare & Institutions Code § 14094.13 (CCS WCM)

7.1.10 DHCS APL 15-004: Medi-Cal MCP Requirements For Nursing Facility Services In CCI Counties For Beneficiaries Not Enrolled In Cal Medi Connect

7.1.11 DHCS APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports

7.1.12 DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide v3 (8/07/2023 release)

7.1.13 DHCS 2023 Cal AIM Dual Eligible Special Needs Plans Policy Guide, Section V

7.1.14 DHCS 2023 California's State Medicaid Agency Contract (SMAC) for all D-SNPs, Exhibit A, Attachment 1, Section 9

7.1.15 DHCS KP Whole Child Model Implementation Deliverable List (7/19/2023), WCM 1 and WCM 15

7.1.16 DHCS Adult Expansion Deliverable List (REVISED 6/26/2023), AE 1

7.1.17 Cal. Health and Safety Code sections 1367(d) and 1373.96

7.1.18 Title 28 of the California Code of Regulations (CCR) section 1300.67.1

7.1.19 Title 42 Code of Federal Regulations (CFR) section 438.62

7.1.20 MCP Contract, Exhibit A, Attachment 9, Section 16A

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