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 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:

1. The individual has enrolled in Health Plan's Individual Plan coverage.
2. 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.

B. **"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:

1. The individual is enrolled in Health Plan coverage; and
2. 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 effective date; or the individual is receiving inpatient care at a hospital or is institutionalized at a licensed facility.

*Refers to durable medical equipment (DME).

Note: Current Medicare Advantage enrollees not eligible for completion of covered services under Health and Safety Code § 1373.96 may be 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.

C. **"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.

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

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.

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.

*Refers to durable medical equipment (DME).

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.

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 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 (or 30 days' notice for Medicare enrollees) 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 (or 30 days' notice for Medicare enrollees) of an individual provider's termination, the Plan will notify affected enrollees as soon as reasonably possible.

2. At least 60 days' notice (or 30 days' notice for Medicare enrollees) to current enrollees living within a 15- mile radius of a Plan Provider hospital, upon termination of that hospital's contract.

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.

C. **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.

D. **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**.

E. **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.

F. **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.

G. 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.

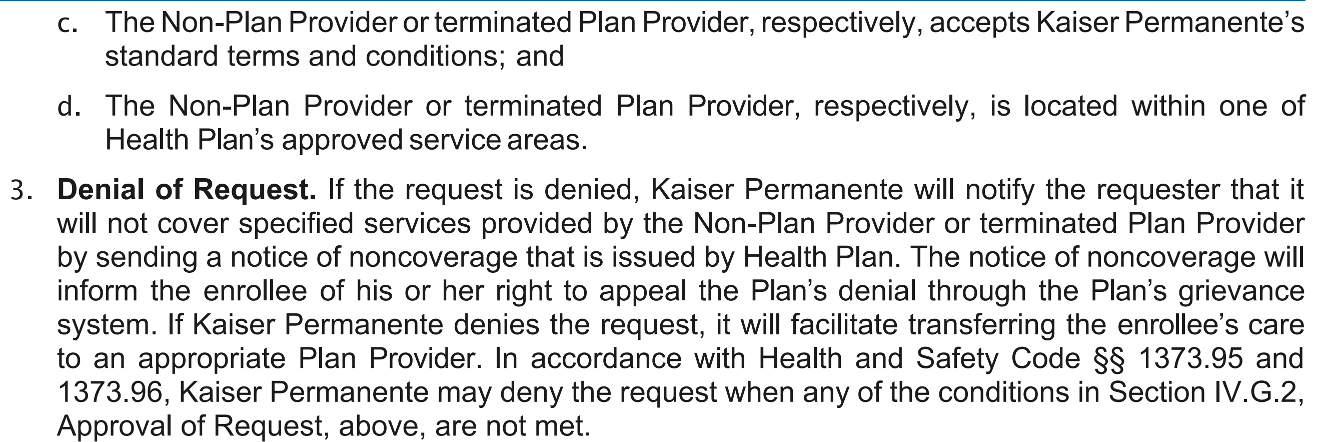
   If the request involves an acute care condition, then Kaiser Permanente will both make the determination and notify the requester within five (5) business days of the receipt of all of the information necessary to make a decision.

   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.

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).

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) or for members transitioning from other MCPs with contracts expiring or terminating into Kaiser Permanente's 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 March 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, and to Enrollees transitioning to Kaiser Permanente from MCPs with contracts expiring or terminating on or after January 1, 2023.

4.1.3 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.

4.1.4 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.

4.1.5 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.

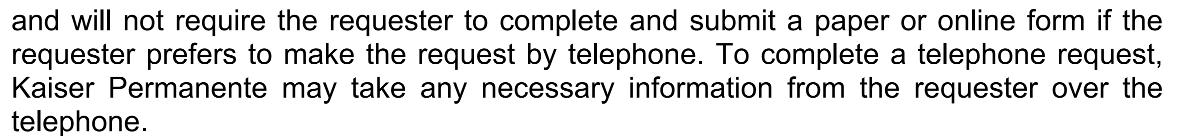
4.1.6 Continuity of Care does not extend to all other ancillary providers such as radiology; laboratory; dialysis centers; NEMT; NMT; other ancillary services; or to non-enrolled Medi-Cal providers.

4.1.7 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 member'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 22-032.

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

6.8.3 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 22-032.

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 22-032.

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 22-032.

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 22-032.

9.3.3 This requirement is applicable to any existing Medi-Cal Provider relationship that is allowed under the general requirements of APL 22-032.

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 22-032, 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.

9.5.6 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.

9.9 **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 22-032: Continuity of care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal enrollees who transition into a new Medi-Cal Managed Care Health Plan 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 Health and Safety Code sections 1367(d) and 1373.96

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

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

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

Kaiser Permanente Member Service Contact Center

Hours: 7 days, 24 hours.

Closed holidays.

English and more than 150 languages using interpreter services	**1-800-464-4000**
Spanish	**1-800-788-0616**
Chinese dialects	**1-800-757-7585**
TTY	**711**