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 condition, terminal illness, or pregnancy (including the immediate postpartum period); for performance of an authorized surgery or procedure authorized by Kaiser Permanente and recommended and documented to occur within 180 days of the effective date of Health Plan coverage; or for care of a child under 36 months old as of the effective date of Health Plan coverage; and
3. The individual did not have the option to stay with his or her current health plan or provider; and
4. The individual was not offered an out-of-network option.

Individual Plan Coverage:
1. The individual has enrolled in Health Plan’s Individual Plan coverage because their previous individual health care service plan or insurance coverage was withdrawn from the market or a portion of the market; and
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 condition, terminal illness, pregnancy (including the immediate postpartum period), or has an authorized surgery or procedure recommended and documented to occur within 180 days of the effective date of Individual Plan coverage, or is a child under 36 months old on the effective date of Individual Plan coverage.

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 on the effective date of termination of the Plan Provider’s contract, for an acute condition, serious chronic condition, terminal illness, or pregnancy (including the immediate postpartum period), or has an authorized surgery or procedure recommended and documented to occur within 180 days of the effective date of termination of the Plan Provider’s contract, or is a child under 36 months old on such effective date.

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

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1 This Completion of Covered Services Policy and Procedure is issued in accordance with guidelines provided by California’s Department of Health Care Services (“DHCS”) in its All Plan Letter (“APL”) 18-008 (issued March 02, 2018), which supersedes APL 15-019 (issued August 26, 2015), which superseded APL 14-021 (issued December 29, 2014), which superseded APL 13-023 (issued December 24, 2013); and with APL 16-001 (issued January 08, 2016), which supersedes APL 06-007.
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.

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.

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 the terminated Plan Provider.

B. Kaiser Permanente shall review a request from Qualified New Enrollees or Qualified Current Enrollees to complete services with their Non-Plan Provider or terminated Plan Provider, respectively, in accordance with this Policy and Procedure.

C. 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, 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 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 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 members who have a mental health condition that occurs, or can impact the member, during pregnancy or during the postpartum period 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, 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 a Qualified New Enrollee’s Non-Plan Provider within 180 days of the contract termination date or the effective date of the Qualified New Enrollee’s coverage, respectively.

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).
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 all 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](http://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 1800-464-4000 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

I. Purpose & Applicability

To describe the process for facilitating completion of covered services (also known as continuity of care ("COC")) from Non-Plan Providers for Medi-Cal beneficiaries enrolled in or transitioning into Kaiser Permanente’s Medi-Cal Managed Care Plan ("MCP").

II. Policy

A. Except as otherwise described below in Section II.C., for Medi-Cal beneficiaries mandatorily transitioning from Medi-Cal fee-for-service ("FFS") into Kaiser Permanente’s MCP, Kaiser Permanente shall provide continued access to their previous out-of-network primary care providers or specialists (a "Non-Plan Provider"), for a period of up to 12 months, as long as the following requirements are met:

1. The transitioning enrollee has an existing relationship with the Non-Plan Provider as evidenced by that enrollee having seen the Non-Plan Provider for at least one (1) non-emergency visit during the 12 months prior to the date of his or her initial enrollment in Kaiser Permanente (self-attestation is not sufficient); and

2. The Non-Plan Provider meets Kaiser Permanente’s applicable professional standards and has no disqualifying quality-of-care issues (documented to the extent the Non-Plan Provider would not be eligible to provide services to other Kaiser Permanente enrollees); and

3. The Non-Plan Provider will accept the higher of Kaiser Permanente’s contract rates or Medi-Cal FFS rates; and

4. The Non-Plan Provider is California State Plan approved; and

5. The Non-Plan Provider supplies Kaiser Permanente with all relevant treatment information required for determining medical necessity as well as a current treatment plan (subject to federal and state privacy laws and regulations).

B. Continuity of care under this Policy does not apply to services that are not covered by the Medi-Cal program or by Medi-Cal managed care plans, durable medical equipment ("DME"), transportation, other ancillary services, and carved-out services, except as explicitly stated herein.

C. Additional continuity of care rights, exceptions, and modifications to this Policy apply under certain circumstances, as described in further detail below:

1. Non-Specialty Mental Health Services. Section II. A applies to enrollees who were receiving specialty mental health services ("SMHS") from a County Mental Health Program ("MHP"), in instances where an enrollee’s mental health condition has stabilized and the enrollee no longer qualifies for SMHS.² The 12-month COC period may start over one (1) time, to the extent the enrollee later requires SMHS from a MHP and the enrollee’s mental health condition is again stabilized and the enrollee no longer qualifies for SMHS.

¹ This Attachment B to Kaiser Permanente’s Completion of Covered Services Policy and Procedure is issued in accordance with guidelines provided by California’s Department of Health Care Services (“DHCS”) in its All Plan Letter (“APL”) 18-008 (REVISED) (Second revision issued December 07, 2018), which supersedes APL 15-019, APL 14-021, and APL 13-023.
² Continuity of care for Non-SMHS applies only to psychiatrists and mental health provider types that are permitted, through California’s Medicaid State Plan, to provide outpatient, Non-SMHS. See State Plan Amendment (“SPA”) 14-012, Attachment 3.1-A.
2. **Enrollees Transitioning from Covered California.** Section II.A. applies to enrollees that transition from Covered California to Kaiser Permanente. Kaiser Permanente shall honor any active Prior Treatment Authorizations for up to 60 days, or until a new assessment is completed by a Plan Provider.

3. **Health Homes Program (“HHP”).** Section II.A. applies to Medi-Cal FFS beneficiaries who voluntarily transition to managed care to enroll in the HHP.

4. **Pediatric Palliative Care (“PPC”).** Section II.A. 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.

5. **California Children's Services (“CCS”) Whole Child Model (“WCM”) Program.** Section II.A. applies to enrollees who transition into the WCM, with the following additional WCM-specific requirements for COC:
   a. Specialized or Customized Durable Medical Equipment (“DME”). WCM enrollees with an established relationship with a specialized or customized DME provider, have a right to COC if the specialized or customized DME meets all of the following criteria:
      i. Is uniquely constructed or substantially modified solely for the use of the enrollee; and
      ii. Is made to order or adapted to meet the specific needs of the enrollee; and
      iii. Is 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.
   b. 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 Kaiser Permanente.
   c. 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 agree that the drug is no longer medically necessary, or if it is no longer prescribed by the county CCS program provider.
   d. 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.

6. **Seniors and Persons with Disabilities (“SPDs”).** Section II.A. applies to SPDs. In addition, for newly enrolled SPDs, Kaiser Permanente shall honor any active Medi-Cal FFS Treatment Authorization Request (“TAR”) for up to 60 days or until a new assessment is completed by a Plan Provider.

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1. Kaiser Permanente’s COC Policy regarding services provided under the PPC Waiver Program is issued in accordance with DHCS APL 18-020 (issued December 07, 2018), which supersedes APL 17-015, and with APL 18-008 (REVISED) (Second revision).
2. Kaiser Permanente’s COC Policy regarding services provided under the WCM program is issued in accordance with DHCS APL 18-023 (issued December 23, 2018), which supersedes APL 18-011, and with California Welfare & Institutions Code § 14094.13.
7. Behavioral Health Treatment ("BHT"). Continuity of care rights for BHT apply only to Non-Plan qualified autism services providers, qualified autism services professionals, or qualified autism services paraprofessionals. An existing relationship with a qualified Non-Plan Provider of medically necessary BHT services is evidenced by the enrollee having seen such provider for least one (1) time during the six (6) months prior to either the transition of services or the date of the enrollee’s initial enrollment with Kaiser Permanente, if the enrollment occurred on or after July 01, 2018. COC rights apply to current enrollees and any Medi-Cal beneficiaries that join Kaiser Permanente; a mandatory transition from Medi-Cal FFS or Covered California is not required for these COC rights to apply. Enrollees that transition BHT services from a Regional Center to Kaiser Permanente will automatically be treated as having requested COC with their Non-Plan Provider of BHT services under Section III.A. of this Attachment B; no written or verbal request from such enrollees is required. If the requirements in Section II.A. are not met, Kaiser Permanente shall continue BHT services with a Plan Provider at the same level provided by the Non-Plan Provider, until a comprehensive diagnostic evaluation and assessment has been completed and Kaiser Permanente has approved a new behavioral treatment plan.

8. Managed Long Term Services and Supports ("MLTSS") Benefits. Notwithstanding the provider types listed in the Policy above, COC with Community Based Adult Services ("CBAS") facilities and Long Term Care facilities (including skilled, intermediate, and subacute care facilities) shall be provided within the seven (7) Coordinated Care Initiative counties. In addition, enrollees residing in Long Term Care facilities on the date of their enrollment with Kaiser Permanente may remain in such facilities for the duration of the Coordinated Care Initiative, so long as the Policy conditions stated in Section II.A. continue to be met.

9. Medical Exemption Request ("MER"). A MER is made by a Medi-Cal FFS beneficiary to delay mandatory enrollment into an MCP and instead remain in FFS, due to an existing medical condition. Kaiser Permanente shall automatically treat any enrollee whose MER has been denied by DHCS and included on DHCS’s Exemption Transition Data report as having requested COC with their Non-Plan Medi-Cal FFS Provider under Section III.A.

10. Prescription Drugs. Kaiser Permanente shall cover single-source drugs that are part of a prescribed therapy in effect immediately prior to an enrollee’s enrollment with the Health Plan, whether or not the drug is covered by Kaiser Permanente, until the therapy is no longer prescribed by a Plan Provider.

D. The continuity of care rights under Health & Safety Code § 1373.96 set forth in the main terms of the Policy and Procedure also apply to Kaiser Permanente enrollees. COC shall be provided for the length of time required under Health & Safety Code § 1373.96 or this Attachment B, whichever is longer.

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5 Kaiser Permanente’s COC Policy regarding BHT providers is issued in accordance with DHCS APL 18-006 (issued March 02, 2018), which supersedes APL 15-025 and APL 14-011, and with APL 18-008 (REVISED) (Second revision).
6 See Health & Safety Code § 1374.73(c).
7 Kaiser Permanente’s COC Policy regarding MLTSS benefits is issued in accordance with DHCS APL 14-010 (issued September 10, 2014), and with APL 15-004 (issued February 12, 2015).
8 Kaiser Permanente’s COC Policy regarding MERs is issued in accordance with DHCS APL 17-007 (issued May 11, 2017), which supersedes APL 15-001 and APL 13-013, and with APL 18-008 (REVISED) (Second revision).
III. Procedure

A. Requests for continuity of care with Non-Plan Providers are initiated by the transitioning enrollee, their authorized representative on file, or their provider, and must be submitted to Kaiser Permanente’s Member Service Contact Center at 1-800-464-4000 or 711 for TTY users. Requests may be made by telephone; written requests are not required. Please also refer to the exception for BHT services described in Section II.C.7. of this Attachment B.

B. Except as otherwise provided in this Attachment B, review of requests and approval or denial of the requests will follow a similar procedure as for commercial qualified enrollees, as described in the main text of the Policy and Procedure.

C. Requests for COC with Non-Plan Providers must be processed within five (5) business days of receipt of the request or of Exemption Transition Data from DHCS.

D. COC requests will be completed within 30 calendar days of the date on which the request was received, except as follows:
   1. When the enrollee’s medical condition is such that it requires more immediate attention (such as upcoming appointments or other pressing care needs), the review will be completed within 15 calendar days; or
   2. When there is risk of harm to the enrollee, the review will be completed within three (3) days. “Risk of harm” means having an imminent and serious threat to the enrollee’s health.

E. Enrollee notification. Within seven (7) days of Kaiser Permanente’s approval of a request under this Policy, Kaiser Permanente shall inform the enrollee of the approval, the duration of approved care, the transition that will occur at the end of the duration, and the enrollee’s right to choose a Plan Provider.
   At least 30 calendar days before the end of the COC period, Kaiser Permanente shall notify the enrollee regarding the process to transition to a Plan Provider.

F. Retroactive requests. Kaiser Permanente shall accept and approve retroactive COC requests (i.e., for services that were already provided) that meet both the requirements of Section II and the following requirements:
   1. The services that are the subject of the request occur after the enrollee’s enrollment with Kaiser Permanente; and
   2. Date(s) of service are after December 29, 2014; and
      a. For Behavioral Health Treatment, date(s) of service must be after July 01, 2018.
   3. Date(s) of service are within 30 calendar days of the first service for which the provider requests, or has previously requested, retroactive COC reimbursement; and
   4. The request is submitted within 30 calendar days of the first service to which the request applies.

G. If an enrollee disagrees with the result of their COC request under this Policy, the enrollee maintains the right to pursue a grievance or an appeal via the established Health Plan or Medi-Cal program grievance and appeals processes.
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

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