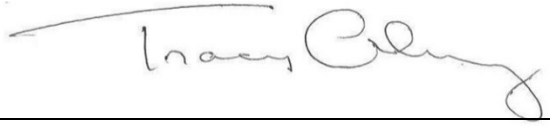
blue california
Promise Health Plan

Policy Title: Continuity of Care for Medi-Cal Members		**POLICY #:** 10.2.40	
		Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date:** 1/01/14	**Effective Date:** 11/22	**Revision Date:** 6/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer 			**Date:** 06/11/2024
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions 			**Date:** 06/11/2024

A. PURPOSE

I. To define the policy and procedure and provide guidance on how Blue Shield Promise Health Plan (Blue Shield Promise) has established a Continuity and Coordination of Care (CoC) program for:

a. Qualified newly enrolled Blue Shield Promise members.

b. Established Blue Shield Promise members when their benefits or insurance coverage is scheduled to end, and they will require continued care.

c. Established Blue Shield Promise members when an in-network provider is terminated for administrative reasons and the member is undergoing treatment for an acute or serious chronic medical condition, terminal illness, pregnancy, or newborn care.

d. Established Medi-Cal Fee for Service (FFS) members who were transferred to Blue Shield Promise and are no longer permitted to remain in the Medi-Cal FFS plan.

i. The following populations will transition from FFS to Medi-Cal managed care no sooner than January 1, 2022:

1. Trafficking and Crime Victims Assistance Program, except share of cost (non-dual and dual)
2. Individuals participating in accelerated enrollment (non-dual and dual)
3. Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual)
4. Beneficiaries with other health coverage (non-dual)

5. Beneficiaries living in rural ZIP codes (non-dual)

ii. American Indian/Alaska Native beneficiaries have the option to opt in or opt out of managed care enrollment in non-county organized health system (COHS) counties only. In COHS counties, American Indian/Alaska Native beneficiaries do not have the option to opt out of mandatory managed care enrollment.

iii. In addition, DHCS will transition Omnibus Budget Reconciliations Act (OBRA) and share of cost (SOC) beneficiaries (except institutional long-term care SOC beneficiaries) that are currently enrolled in the Medi-Cal managed care delivery system into Medi-Cal FFS.

iv. Skilled Nursing Facility (SNF) Long Term Care (LTC) Benefit Standardization provisions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including the mandatory transition of beneficiaries to managed care.

e. Medi-Cal FFS members who are mandatorily transitioning from Medi-Cal FFS to enroll as a member in a managed care plan (MCP) on or after January 1, 2023 may request continuity of care (CoC) for up to 12 months after the enrollment date with Blue Shield Promise, if a pre-existing relationship exists with that provider, regardless of the member having a condition listed in HSC section 1373.96.

II. Blue Shield Promise members undergoing treatment through a pre-existing provider relationship during the previous 12 months prior to enrollment into Blue Shield Promise, to continue receiving care at the time of enrollment with a non-participating provider for up to 12 months, in accordance with APL 23-022 and Health & Safety Code §1373.96.

III. Blue Shield Promise transitioning members in the following Special Populations will focus their attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care. Blue Shield Promise will transfer supportive information important for members' care coordination and management. Blue Shield Promise will work with the Previous MCP to transfer and share supportive information important for members' care coordination and management that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

IV. Blue Shield Promise will identify Special Population by using DHCS or Previous MCP data, including information provided in the standard monthly Plan Data Feed to implement CoC protections, program enrollment, specific pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. Upon receiving data for Special Populations, Blue Shield Promise will proactively begin the CoC for Providers process.

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

Populations.

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

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

d. List of Special Populations:

    i. Adults and children are determined eligible to receive Enhanced Care Management services.

    ii. Adults and children determined eligible to receive Community Supports

    iii. Adults and children receiving Complex Care Management

    iv. Enrolled in 1915(c) waiver programs.

    v. Receiving in-home supportive services (IHSS)

    vi. Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Mode

    vii. Children and youth receiving foster care, and former foster youth through age 25.

    viii. In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C

    ix. Taking immunosuppressive medications, immunomodulators, and biologics

    x. Receiving treatment for end-stage renal disease (ESRD)

    xi. Living with an intellectual or developmental disability (I/DD) diagnosis

    xii. Living with a dementia diagnosis

    xiii. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)

    xiv. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)

    xv. Receiving specialty mental health services (adults, youth, and children)

    xvi. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality

    xvii. Receiving hospice care

xviii. Receiving home health

xix. Residing in Skilled Nursing Facilities (SNF)

xx. Receiving hospital inpatient care

xxi. Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023

xxii. Newly prescribed DME (within three months prior to January 1, 2024)

xxiii. Members receiving Community-Based Adult Services

B. DEFINITIONS

1. "Acute Conditions" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

2. "Authorized Surgery/ Procedure" means surgery or another procedure which has been recommended and documented by the provider and scheduled to take place within 180 days of the enrollee's effective date or provider termination date and authorized for continued care by Blue Shield Promise.

3. "Behavioral Health Treatment Services" are services such as applied behavioral analysis and other evidenced based intervention services that develop, to the maximum extent practicable, the functioning of beneficiaries including those with or without autism spectrum disorder (ASD).

4. "Continuity of Care" is defined as the lack of interruption in needed care as it pertains to APL 23-022 and Health & Safety Code §1373.96.

5. "Member with existing relationship" where a member has seen an out of network primary care provider (PCP), specialist, or select ancillary provider at least once during the 12 months prior to the date of his or her initial enrollment into Blue Shield Promise for a non-emergency visit.

6. "Newborn/Infants" are newborn to 36 months of age general pediatric or specialist care until the earlier of 12 months from the effective/provider termination date or the date the child is 36 months of age.

7. "Non-participating provider (non-contracted provider)" is a provider who is not contracted with Blue Shield Promise, or a provider group contracted with Blue Shield Promise.

8. "Pregnancy" is the three trimesters of pregnancy and the immediate post-partum

period, including maternal mental health. The postpartum period begins immediately after childbirth and extends for approximately six weeks.

9. "Risk of Harm" is defined as an imminent and serious threat to the health of the beneficiary.

10. "Serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

11. "Specialist" is a physician or other health professional who has advanced education and training in a clinical area of practice and is accredited, certified, or recognized by a board of physicians or like peer group, or an organization offering qualifying examinations (board-certified) as having special expertise in that clinical area of practice.

12. "Select Ancillary Providers" includes physical therapy, occupational therapy, respiratory therapy, behavioral health treatment, and speech therapy providers.

13. "Terminal Illness" is an incurable or irreversible condition that has a probability of causing death within one year or less. Terminal illness is covered for the duration of the terminal illness.

C. POLICY

I. Blue Shield Promise recognizes that a strong provider-patient relationship, particularly for members with serious medical and behavioral health conditions, may enhance the healing process. Maintaining CoC as members change providers and health plans is an important aspect of this relationship. The Blue Shield Promise CoC program complies with National Committee for Quality Assurance (NCQA) standards, and Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) regulatory requirements in accordance with the CoC requirements set forth in Health & Safety Code §1373.96.

II. Members will be informed of their CoC protections and information about these protections is included in member information packets, handbooks, and on the Blue Shield Promise website. This information includes how a member, authorized representative, and provider may initiate a CoC request with Blue Shield Promise. Blue Shield Promise translates these documents into threshold languages and makes them available in alternative formats upon request. Blue Shield Promise provides training to call center and other staff who come into regular contact with Members about CoC protections.

III. **Program Goals** The goals of the Blue Shield Promise CoC program are to:

a. Promote continuous and appropriate care for members transitioning into Blue Shield Promise by ensuring Member's IPA/Medical Group and both UM and CM participate in the process, as necessary.
b. Strengthen continuity between medical and behavioral health care. Blue Shield Promise facilitates timely communication, sharing of necessary information and coordination of care between and among member's mental health providers and between medical and mental health providers.
c. Provide a timely review of new enrollee requests to continue services with an existing health care provider who does not belong to Blue Shield's provider network.
d. Ensure a smooth transition of care to the new enrollee's Blue Shield Promise contracted provider(s) at appropriate levels of care. If a Case Management need is identified, UM will ensure appropriate Clinical staff are involved.
e. Ensure that existing members who are in a course of treatment with a provider who is terminating as a Blue Shield Promise contracted provider, including general acute care hospital and skilled nursing facilities, continue to receive timely and appropriate authorization and treatment to ensure no disruption in services for the member.

D. PROCEDURES

I. Blue Shield Promise will accept CoC requests via telephone call, electronically, or in writing, according to the requester's preference.

II. Blue Shield Promise will provide acknowledgment of the CoC request advising the member that the CoC request has been received, the date of receipt, and the estimated timeframe for resolution within the timeframes below:

a. For non-urgent requests, within seven calendar days of receipt of the CoC request

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

c. For CoC acknowledgements, Blue Shield Promise must notify the member by using the member's known preference of communication or by notifying the member using one of these methods in the following order: telephone call, text message, email, and then notice by mail.

III. **Out of Network Providers.**

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

i. Blue Shield Promise will notify the member and the member's Care

Manager that the member may continue with his or her provider.

b. Blue Shield Promise will work with the approved OON provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the OON provider does not refer the member to another OON provider without authorization from Blue Shield Promise. In such cases, Blue Shield Promise will make the referral, if medically necessary, if Blue Shield Promise does not have an appropriate provider within its network, to ensure no disruption in services for the member.
    i. If the member's provider is OON and Blue Shield Promise establishes a CoC for Providers agreement, Blue Shield Promise will notify the member and the member's Care Manager of the length of time that they can stay with their provider.
    ii. If the provider is OON and cannot establish a CoC for Providers agreement, Blue Shield Promise will notify the member and the member's Care Manager that the member must change to a network provider and assign the member a new network provider.
c. Blue Shield Promise will direct the eligible provider not to refer the member to other OON providers without prior approval from Blue Shield Promise.
d. After establishing a CoC for Providers agreement with the eligible provider, Blue Shield Promise will reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and the DHCS Policy Guide, and as agreed upon with the provider.

IV. **Qualified newly enrolled Blue Shield Promise members (ages: under 21, adult ages 21-49, and adult ages 50+) for Medi-Cal regardless of immigration status have continuity of safety net, primary care providers to the extent feasible and applicable.** New Blue Shield Promise Medi-Cal members have a pre-existing provider relationship during the previous 12 months prior to enrollment who is not in Blue Shield Promise's Medi-Cal network. The member, authorized representative, or provider is entitled to apply for CoC over the telephone, or according to the requestor's preference, and does not require the requestor to complete and submit a paper or online form if the requestor prefers to make the request by telephone to continue receiving services to complete the treatment plan for up to 12 months after the enrollment date. Blue Shield Promise focuses attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care.

a. Established Blue Shield Promise member when their benefits or insurance coverage is scheduled to end, and they will require continued care. An active course of treatment typically involves regular visits with the provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Treatment Record Review (TRR) providers only apply to behavioral health.

b. Discontinuing an active course of treatment resulting from the exhaustion or termination of a benefit or health coverage could cause a recurrence or worsening of the member's condition under treatment and interfere with anticipated outcomes. Blue Shield Promise will act to ensure CoC, despite discontinuation of benefits or disenrollment from continued coverage for any member receiving an active course of treatment for an acute episode, or long term or chronic illness.

V. **Continued Coverage of Care with Terminated Network Providers** Blue Shield Promise will, at the request of the enrollee, provide the completion of covered services by a terminated or out of network provider, in accordance with the CoC requirements set forth in Health & Safety Code §1373.96.
   a. The Previous MCP must complete all data sharing requirements outlined in the "Summary of MCP Provided Data Files" table within the DHCS Transition Plan.
   b. The Previous MCPs must use the CoC data template:
      i. Data Elements for All Members to prepare member level data files for transitioning members in accordance with requirements outlined in Sections VIII.B.1-VIII.B.4 of the DHCS 2024 MCP Transition Plan.
   c. The Previous MCPs must use the CoC Data template:
      i. Special Populations Specifications to identify relevant members and prepare Transitioning Member Special Populations Data files using the CoC Data Template
      ii. Special Population Member File and CoC Data Template
      iii. Special Populations Accompanying Data workbooks for transmittal to Receiving MCPs
   d. The Previous MCPs must use the CoC Data template:
      i. Special Population Member file to prepare a file identifying members that meet the criteria outlined in CoC Data Template
      ii. Special Populations Specifications for transmittal to Receiving MCPs.
   e. The Previous MCPs must use the CoC data template:
      i. Special Populations Accompanying Data to prepare Special Populations accompanying data for certain Special Population groups for transmittal to Receiving MCPs
   f. The Previous MCPs must share Transitioning Member Identifying Data files with Blue Shield Promise and DHCS in accordance with the required data elements and format outlined in the 2024 MCP Transition Plan.
   g. The Previous MCPs must share Transitioning Member Utilization Data files directly with Blue Shield Promise and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D of the DHCS 2024 MCP Transition Plan.
   h. The Previous MCPs must share Transitioning Member Utilization Data files with Blue Shield Promise and DHCS in accordance with the required data elements and format outlined in the transitioning member claims/encounter information as indicated in the DHCS 2024 MCP Transition Plan.
   i. The Previous MCPs must share Transitioning Member Authorization Data files with Receiving MCPs and DHCS in accordance with the required data elements

and format outlined in the transitioning member authorization information as indicated in the DHCS 2024 MCP Transition Plan.

j. Blue Shield Promise will identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either approve/schedule a Network provider or an OON provider to transport the member.
k. The Previous MCPs must share Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data files with Blue Shield Promise and DHCS in accordance with the required data elements and format outlined in the DHCS 2024 MCP Transition Plan.
l. The Previous MCPs must share Transitioning Member Special Populations Information Data files with Blue Shield Promise in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D pf the DHCS 2024 MCP Transition Plan. Previous MCPs must also share a copy of this data with DHCS to facilitate DHCS' oversight of the transition.
m. The Previous MCP must inform Blue Shield Promise of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends.
n. The completion of covered services will be provided by the terminated provider to an enrollee who at the time of the contract's termination was receiving services from that provider for one of the conditions eligible for completion of covered services.
o. The completion of covered services will be provided by a non-participating provider to a newly covered enrollee who at the time his or her coverage became effective was receiving services from that provider for one of the conditions eligible for completion of covered services.
p. Transition of care will be implemented to members affected by a termination of provider/facility but are still in need of care.
q. Members who are in active course of treatment and who request CoC due to termination of provider will be granted.

VI. **Medi-Cal Members currently enrolled in State Medi-Cal Transitioning to Blue Shield Promise**

a. In an instance where a member would like their OON provider to provide a service and they have a pre-existing relationship with the OON provider, the member may make a CoC request if they are mandatorily transitioning from Medi-Cal FFS to Blue Shield Promise on or after January 1, 2023, or if the conditions in HSC section 1373.96 are met. Blue Shield Promise will make a good faith effort to enter into an agreement if all CoC requirements is met.
b. Medi-Cal members that were enrolled in Medi-Cal FFS with DHCS transitioned to Blue Shield Promise that have a pre-existing provider relationship during the previous 12 months prior to enrollment who is not in Blue Shield Promise's Medi-Cal network. The member is entitled to apply for CoC to continue receiving services to complete the treatment plan for up to 12 months after the enrollment date.

    i. CoC protection extends to Primary Care Providers, Specialists, and select

ancillary providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), and speech therapy providers; subject to the CoC requirements.

ii. CoC protection does not extend to all ancillary providers such as radiology, laboratory, dialysis centers, non-emergency medical transportation (NEMT), non-medical transportation (NMT), other ancillary services, and non-enrolled Medi-Cal Providers.

c. Medi-Cal members in Skilled Nursing Facilities (SNF)
Effective January 1, 2023 through June 30, 2023, Blue Shield Promise will automatically provide members residing in a SNF with 12 months of CoC for the SNF placement if the following conditions are met:

i. There is evidence of the member's SNF residency and a pre-existing relationship with the SNF.

ii. The facility is enrolled and licensed by CDPH;

iii. The facility is enrolled as a Medi-Cal provider;

iv. The SNF and Blue Shield Promise agree to payment rates that meet state statutory requirements, and

v. The facility meets Blue Shield Promise's standards and does not have disqualifying quality-of-care issues.

d. Following the initial 12-month automatic CoC period, members who require additional CoC or members who enroll after June 30th, 2023, may request SNF CoC in accordance with APL 23-022.

e. Durable Medical Equipment (DME) rentals and Medical Supplies.

i. Blue Shield Promise will allow transitioning Members 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 enrollment and until Blue Shield Promise is able to reassess, the new equipment or supplies are in possession of the Member, and ready for use. (Subject to existing DME Provider meeting the CoC Requirements).

ii. Continuity of DME and medical supplies will be honored without a request by the Member, authorized representative, or Provider.

iii. If DME or medical supplies have been arranged for a transitioning Member, but the equipment or supplies have not been delivered, Blue Shield Promise will allow the delivery and for the Member to keep the equipment or supplies for a minimum of 90 days following enrollment and until Blue Shield Promise is able to reassess.

iv. If Blue Shield Promise does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization. After 90 days, Blue Shield Promise may reassess the Member's authorization at any time and require the Member to switch to a Network DME Provider.

VII. **Medi-Cal Members currently enrolled in another MCP Transitioning to Blue Shield Promise**

a. Blue Shield Promise will ensure that transitioning members are able to access assistance from Blue Shield Promise's call center starting November 1, 2023, prior to their enrollment with the Blue Shield Promise before January 1, 2024. Prospective requests will automatically be loaded into the authorization/claims system by January 1, 2024.
    i. The previous MCP must provide Blue Shield Promise, by November 21, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members.
    ii. The previous MCPs must complete the transfer of supportive data for these members before January 1, 2024, or within 15 calendar days of the member changing to a new Care Manager, whichever is later.
    iii. Blue Shield Promise will proactively contact the previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care.
    iv. Blue Shield Promise must receive confirmation from the previous MCP to ensure that they completed all data transfer sharing activities as described in the CoC Data Sharing Policy, which includes transmitting utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to Blue Shield Promise.

b. Blue Shield Promise will honor active Prior Authorizations when data is received from previous MCP and/or when requested by the member, authorized representative, or provider and Blue Shield Promise obtains documentation of the Prior Authorization within the 6-month CoC period.
    i. Blue Shield Promise will allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.
        i. This applies to DME or medical supplies that have been arranged for but not yet delivered, in which case Blue Shield Promise will allow the delivery and permit the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

c. Blue Shield Promise will receive the members known to be receiving inpatient care by December 22, 2023, from the Previous MCP, and must refresh that information daily through January 9, 2024, including holidays and weekends.
    i. Once the member is known to Blue Shield Promise as being in inpatient hospital care, either through the Previous MCP or via other means, Blue Shield Promise will contact the hospital to provide for completion of and coordination of the member's care.

ii. Blue Shield Promise will also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.

d. Blue Shield Promise will ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

i. If Blue Shield Promise is unable to bring a Transplant Program in Network, Blue Shield Promise will make a good faith effort to:

1) Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in Section V.C of the 2024 MCP Transition Policy Guide and according to the following terms:

(a) Make explicit the existing statutory requirement that Receiving MCPs (including Blue Shield Promise) are to pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)

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

ii. If Blue Shield Promise is unable to enter into a CoC for Providers agreement, Blue Shield Promise will:

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

(b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement. Guidance regarding written explanations will be clarified in the forthcoming Section, Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

iii. Blue Shield Promise will start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024)

VIII. Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition

a. Blue Shield Promise will ensure care is not disrupted for members in the adult expansion population, which is defined by APL 23-031 as follows:

i. New Enrollee Population: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.

ii. Transition Population: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or are unable to establish SIS for full scope MediCal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.

b. PCP assignment procedures are outlined in the Medi-Cal Enrollment P&P 10.12.1 Medi-Cal Primary Care Physician (PCP) Member Assignment.

IX. Conditions and Timeframes

a. Validation of requirements

i. Upon receiving the CoC Provider request, Blue Shield Promise will confirm whether the request meets the following requirements:

1. The provider is providing a service that is eligible for CoC for Providers;
2. The member has a pre-existing relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding the membership transition;
3. The Provider is willing to accept Blue Shield Promise's contract rates or Medi-Cal FFS rates;
4. The provider meets Blue Shield Promise's applicable professional standards and has no disqualifying quality of care issues; and
5. The provider is a California Medicaid State Plan approved provider.

ii. Blue Shield Promise must determine if a relationship exists through use of data provided by DHCS, such as Medi-Cal FFS utilization data or claims data from an MCP.

1. The beneficiary has seen the PCP, specialist, or select ancillary provider at least once during the 12 months prior to the date of his or her initial enrollment into Blue Shield Promise for a non-emergency visit. If the CoC provider is within Blue Shield Promise's network, the member will be allowed to continue care with the in-network provider. If the CoC provider is out-of-network, Blue Shield Promise will make a good faith effort to issue a letter of agreement, if conditions set forth in Section VII Terms and Conditions with Non-Participating Provider are met.
2. If the member has a scheduled specialist appointment with an OON provider who the member has not seen within the previous 12 months and does not have an established relationship, Blue Shield Promise will refer to prior authorization OON referral or customer service to assist with an in-network provider. Blue Shield Promise will make a good faith effort to allow the member to keep the appointment with the OON specialist if conditions set forth in Section VII Terms and Conditions with Non-Participating Provider are met.
3. The requester may contact Blue Shield Promise prior to the date of service up until December 31, 2024. If the services were rendered prior to the CoC request, the requester must contact Blue Shield Promise within 30 calendar days after the date of service.
4. If a beneficiary changes MCPs or loses and then later regains eligibility during the 12-month period, the 12-month continuity of provider period may start over one time. If the beneficiary changes to another MCP or loses and then later regains eligibility a second time (or more), the CoC period does not start over, meaning that the beneficiary does not have the right to a new 12 months of CoC.

5. If the beneficiary returns to Medi-Cal FFS and later re-enrolls in Blue Shield Promise, the CoC period does not start over. If a beneficiary changes to Blue Shield Promise, this CoC policy does not extend to providers that the beneficiary accessed through their previous MCP.
6. The provider is willing to accept Medi-Cal FFS rates or accepts Blue Shield Promise's contract rates.
    a) Blue Shield Promise will offer members an alternative network provider in a timely manner so that member's service is not disrupted in the event Blue Shield Promise and the eligible provider are unable to reach a CoC for Providers agreement.
7. The provider meets applicable professional standards and does not have any disqualifying quality of care issues.
8. If a member does not actively choose an alternative network provider, Blue Shield Promise will refer member to a network provider.
9. If there are no network providers to provide covered service, Blue Shield Promise will arrange for an OON Provider.

b. The provider is a California State Plan approved provider.
    i. Blue Shield Promise will contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into a CoC for Providers agreement for the member's care within the identified timeframe.

c. Validate an existing Behavioral Health Treatment relationship.
    i. Behavioral Health Treatment for Members Under the Age of 21 upon Blue Shield Promise Transition: Blue Shield Promise will ensure that members under 21 receive Early and Periodic Screening, Diagnostic, and Treatment services.
    ii. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.
    iii. Continued access to out-of-network BHT providers for up to 12 months if all policy requirements are met.
    iv. An existing relationship for BHT means a member has seen the out-of-network provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to Blue Shield Promise or the date of the member's initial enrollment in Blue Shield Promise if enrollment occurred on or after July 1, 2018.
    v. If this this request from a transition of BHT Services from a Regional Center (RC) to Blue Shield Promise
    vi. At least 45 days prior to the transition date, DHCS will provide a list of members for whom the responsibility for BHT services will transition from RCs to Blue Shield Promise, as well as member specific utilization and assessment data.

vii. If the beneficiary has an existing BHT service relationship, as defined above, with an in-network provider, Blue Shield Promise must assign the beneficiary to that provider to continue BHT services.
viii. DHCS utilizing data that is supplied to the Plan will be used to identify each beneficiary BHT provider and proactively contact the provider or providers to begin the CoC process, regardless of whether a beneficiary's parent or guardian files a request for CoC.
ix. If the data file indicates that multiple providers of the same type meet the criteria for CoC Blue Shield Promise should attempt to contact the beneficiary's parent or guardian to determine his or her preference.
x. If Blue Shield Promise does not have access to beneficiary data that identifies an existing BHT provider, Blue Shield Promise must contact the beneficiary's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist it in offering CoC.
xi. If the RC is unwilling to release specific provider rate information to Blue Shield Promise, then Blue Shield Promise may negotiate rates with the CoC provider without being bound by the usual requirement that Blue Shield Promise offer at least a minimum FFS – equivalent rate.
xii. If Blue Shield Promise is unable to complete a CoC agreement, Blue Shield Promise must ensure that all ongoing services continue at the same level with an MCP in-network provider until BSCPHP has conducted an evaluation and/or assessment, as appropriate, and established a treatment plan.
xiii. Blue Shield Promise may refer to the CoC section of APL 23-010 for additional requirements and information regarding CoC for transitioning members receiving BHT.
xiv. Retroactive requests for BHT service CoC reimbursement are limited to services that were provided after a member's transition date into Blue Shield Promise, or the date of the member's enrollment into Blue Shield Promise, if the enrollment date occurred after the transition.
xv. Blue Shield Promise will continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.
xvi. Blue Shield Promise will provide CoC with an OON Specialty Mental Health Services (SMHS) provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the mental health plan, and instead become eligible to receive non-specialty mental health services (NSMHS) from Blue Shield Promise. In this situation, the CoC requirement only applies to psychiatrists and/or mental health provider types that are permitted to provide NSMHS.
xvii. Blue Shield Promise allows, at the request of the member, authorized representative, or provider, up to 12 months of CoC with an OON mental health plan provider in accordance with the CoC requirements. After the

CoC period ends, the member must choose a mental health provider in Blue Shield Promise's network for NSMHS.

xviii. Former Low Income Health Plan (LIHP) beneficiaries transitioned into Medi-Cal managed care can request continued access to out-of-network LIHP providers for up to 12 months.

xix. Pregnant and Post-partum Medi-Cal beneficiaries Blue Shield Promise will provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period) and care of a newborn child between birth and age 36 months, by a terminated or non-participating health plan provider. These requirements will apply for pregnant and post-partum beneficiaries and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.

xx. Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into Blue Shield Promise on or after January 1, 2023, have the right to request out-of-network provider CoC for up to twelve (12) months in accordance with plan contracts and the foregoing requirements.

xxi. This includes individuals with documented maternal mental health conditions; completion of covered services will not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

xxii. Newly Enrolled Seniors and Persons with Disabilities (SPDs) that have any active FFS Treatment Authorization Requests (TARs). The TARs will be honored, without a request by the beneficiary or the provider, for up to 60 days or until a new assessment is completed by the Blue Shield Promise And when meeting the requirements of CoC defined by current law, the CoC will be arranged for a period of up to 12 months.

xxiii. Covered California to Medi-Cal Managed Care. For members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year, Blue Shield Promise will ask these members if there are upcoming health care appointments or treatments scheduled and assist them.

xxiv. For members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage, if the member requests CoC, Blue Shield Promise will help initiate the process at that time.

xxv. For members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage, Blue Shield Promise will contact the new member by telephone, letter, or other preferred method of communication, no later than 15 calendar days after enrollment.

xxvi. For members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage, Blue Shield Promise will make a good faith effort to learn from and obtain information from the

member so that it is able to honor active prior treatment authorizations with a network provider and/or establish CoC.

xxvii. Blue Shield Promise will honor any active Prior Treatment Authorizations, without a request by the member, authorized representative, or provider, for up to 90 days. If an in-network provider is not available to furnish the covered Medi-Cal services, Blue Shield Promise will arrange for services to be completed by an out-of-network provider. After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until Blue Shield Promise completes a new assessment, whichever is shorter.

xxviii. A new assessment is considered completed if the member has been seen in person and/or via synchronous telehealth by a contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.

xxix. The prior treatment authorizations must be honored without a request by the beneficiary or the provider.

xxx. At the beneficiary's or provider's request, Blue Shield Promise will offer up to 12 months of CoC with out-of-network providers, in accordance with the DHCS policy requirements listed APL 23-022. And then CoC will be up to 12 months as defined by APL 23-010 and Health & Safety Code §1373.96.

d. Request Completion Timeframe
    i. Upon a member or authorized representative for the member on file, request for CoC, the process for CoC will be initiated within five working days following the receipt of the request.
    ii. Blue Shield Promise will complete CoC requests within the following timelines:
        1. Thirty (30) calendar days from the date Blue Shield Promise received the request for non-urgent requests;
        2. Fifteen (15) calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
        3. As soon as possible, but no longer than three (3) calendar days for urgent requests (i.e., there is identified risk of harm to the beneficiary).
e. A CoC request is considered completed when:
    i. The beneficiary is informed of his or her right of continued access; or
    ii. The member is notified of the denial. A clear and concise explanation of the denial decision will be provided, along with information on the members' appeal or grievance rights.
        1. A denial is issued If Blue Shield Promise and out-of-network FFS or prior Managed Care Plan (MCP) provider are unable to agree to a rate or Blue Shield Promise has documented quality of care issues, Blue Shield Promise will offer the member an in-network alternative. The denial letter directs members to engage with Customer Care and a

referral is made to CM to assist with care coordination options. The member retains the right to file a grievance if they disagree with the decision.

f. Member Notification of Decision
    i. Blue Shield Promise will notify the member of the decision via the member's preferred method of communication or by one of these methods in the following order: telephone call, text message, email, and then notice by mail. Blue Shield Promise will also send written notification within the following timeframes:
        1. For non-urgent requests, Blue Shield Promise will provide written provider and member notification within seven calendar days of decision.
        2. For urgent requests, Blue Shield Promise will provide written provider and member notification as expeditiously as possible, but not to exceed three calendar days from the date of decision.

IX. **Completion of eligible covered services, as set forth in Health & Safety Code §1373.96(c) and APL 23-022:**

a. Active prior treatment authorizations for services in effect following a member's transition into Blue Shield Promise will be honored for 90 days and the service(s) will be provided by a contracted provider.
b. If an in-network provider is not available to furnish the covered Medi-Cal services without delay, Blue Shield Promise will arrange for services to be completed by an out-of-network provider. The member or member representative will not need to submit a request.
c. After 90 days. The authorization will remain in effect for the duration of the active prior authorization or until a new assessment is completed by the provider, whichever is shorter.
d. If Blue Shield Promise does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, Blue Shield Promise may reassess the member's prior treatment authorization at that time.
    I. A new assessment is considered complete by Blue Shield Promise if the member has been seen in-person and/or via synchronous telehealth by a network provider and this provider has reviewed the member's current condition and completed a new treatment plan that includes assessment of the services specified in the pre-transition active prior treatment authorization.
e. Acute Condition: a medical condition that involves a sudden onset of symptoms due to illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
    i. Completion of covered services will be provided for the duration of the acute condition.
f. Serious Chronic Condition: a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists

without full cure, worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration.

   i. Completion of covered services will be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Blue Shield Promise, in consultation with the enrollee and the terminated provider or non-participating provider and consistent with good professional practice.
   ii. Completion of covered services will not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

g. Pregnancy: is the three trimesters of pregnancy and the immediate postpartum period, including maternal mental health.
   i. Completion of covered services will be provided for the duration of the pregnancy; including individuals with documented maternal mental health, the completion of covered services will not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
   ii. The postpartum period begins immediately after childbirth and extends for 12 months.
h. Performance of a surgery or other procedure that is authorized by Blue Shield Promise, as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee.
i. Terminal illness: is an incurable or irreversible condition that has a high probability of causing death within one year or less.
   i. Completion of covered services will be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee.
j. The care of a newborn child between birth and age 36 months.
   i. Completion of covered services will not exceed 12 months from contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
k. Specialty mental health services: up to 12 months CoC with the out-of-network Mental Health Plan.
l. Members with an existing relationship: the beneficiary has seen an out of network primary care provider (PCP), specialist, or select ancillary provider at least once during the 12 months prior to the date of their initial enrollment with Blue Shield Promise for a non-emergency visit.
m. Active course of treatment is when a member has regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma, not for an acute phase of the condition).

X. **Terms and Conditions with Non-Participating Provider:**

a. At the Member, authorized representative, or Provider's request, Blue Shield Promise will allow transitioning Members to keep authorized and scheduled Specialist appointments with OON Providers when CoC has been established and the appointments occur during the 12-month CoC period.
    i. Transitioning Members include beneficiaries who mandatorily transition from Medi-Cal FFS to enroll as Members into Blue Shield Promise on or after January 1, 2023.

b. If the member has a scheduled specialist appointment with an OON provider who the member has not seen within the previous 12 months and does not have an established relationship, Blue Shield Promise will refer to prior authorization OON referral or customer service to assist with an in-network provider.

c. If Blue Shield Promise is unable to arrange a Specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider, Blue Shield Promise will make a good faith effort to allow the Member to keep their appointment with the OON Provider. However, since the appointment with the OON Provider occurs after the Member's transition to Blue Shield Promise, it does not establish the requisite pre-existing Provider relationship for the Member to submit a CoC request.

d. Blue Shield Promise may require a non-participating provider whose services are continued for a newly covered enrollee to agree in writing to be subject to credentialing, utilization review, peer review, and quality improvement requirements.

e. If the non-participating provider does not agree to comply or does not with these contractual terms and conditions, Blue Shield Promise is not required to continue the provider's services.

f. Unless otherwise agreed upon by the non-participating provider and Blue Shield Promise, the services rendered will be compensated at Medi-Cal fee-for-service rate.

g. Neither Blue Shield Promise nor the provider group is required to continue the services of a non-participating provider if the provider does not accept the payment rates provided for in this section.

h. Blue Shield Promise will request all relevant treatment information, as well as a current treatment plan, from out-of-network providers when determining medical necessity for continued care. Blue Shield Promise will provide Medi-Cal beneficiaries with access to an out-of-network provider for up to 12 months, or the shorter period of time if the provider is only willing to work with Blue Shield Promise for a shorter timeframe, if:
    i. The member, authorized representative, or provider submits a request for the completion of covered services.
    ii. The beneficiary has an ongoing, prior relationship with the provider that can be documented using Medi-Cal fee-for-service utilization data or claims data from managed care plans (MCP) whose contract is expiring or

terminating. Blue Shield Promise will also accept information provided by the member, authorized representative, or provider.

iii. The provider accepts Medi-Cal fee-for-service rates or the same rates and methods of payment as those used by Blue Shield Promise for currently contracting providers providing similar services and who are practicing in the same or a similar geographic area as the terminated provider. AND

iv. The provider has no quality of care issues and meets all credentialing requirements.

XI. **Blue Shield Promise will provide newly enrolled SPD beneficiaries access to an out-of-network provider for up to 12 months if:**

i. The beneficiary has an ongoing, prior relationship with the provider that can be documented using Medi-Cal fee-for-service claims data;

ii. The provider accepts BSCPHP rate or Medi-Cal fee-for-service rates, whichever is higher, in accordance with W and I Code §14182(b)(13)(14); and

iii. The provider has no quality of care issues and meets all credentialing requirements.

a. If a member was residing in an out-of-network skilled nursing facility (SNF) when the beneficiary transitioned to Blue Shield Promise, Blue Shield Promise will offer the member the opportunity to return to the out-of-network SNF after a medically necessary absence.

i. This requirement does not apply if the member is discharged from the SNF into the community or a lower level of care.

1. A member who is a resident of a Nursing Facility (NF) prior to enrollment under CCI will not be required to change NFs during the duration of CCI if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and MCP agree to Medi-Cal rates in accordance with the MCP contract with DHCS.

XII. **Exclusions**:

a. Blue Shield Promise considers Medical Exemption Requests (MERs) that have been denied as automatic CoC requests to allow members to complete courses of treatment with OON providers. See P&P 10.2.24 Medical Exemption Requests (MERs) for Continuity of Care.

b. Blue Shield Promise is not required to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason or fraud or other criminal activity.

c. Blue Shield Promise is not required to cover services or provide benefits that are not otherwise covered under Medi-Cal or the terms and conditions of Blue Shield Promise's contract.

d. This section will not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had an option to continue with his

or her previous health plan or provider and instead voluntarily chose to change health plans.

XIII. **Retroactive Request for CoC**

a. Retro requests that meet all CoC requirements the following:
    i. The services that are the subject of the request must have occurred after the beneficiary's enrollment into Blue Shield Promise, and Blue Shield Promise must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider prior to the beneficiary's enrollment into Blue Shield Promise.
    ii. Have a date of service after March 2, 2018.
    iii. Have dates of service within 30 days of the first service for which retroactive CoC is requested.
    iv. Validation that the relationship exists through use of data provided by DHCS to the documentation must be provided.
    v. An existing relationship may be determined:
        1. Through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data.
        2. A beneficiary or his or her provider may also provide information to the MCP which demonstrates a pre-existing relationship with a provider.

XIV. **Assessing the Non-Participating for Quality-of-Care Issues:**

a. The UM Department will assess the request to:
    i. Determine whether the member's condition is consistent with conditions set forth in §1373.96 (c), conditions eligible for covered services (may be subject to MD review);
    ii. Determine whether the member's condition is consistent with conditions or circumstances are set forth in APL 23-022;
    iii. Determine prior relationship with the requested provider through review of:
        1. Medi-Cal fee-for-service claims data from the State;
        2. Medi-Cal active FFS Treatment Authorization Requests (TARs)

b. If the above are established, and the participating Medi-Cal provider meets criteria and agrees to accept the higher of Blue Shield Promise rates or Medi-Cal FFS rates, Blue Shield Promise will offer a letter of agreement for:
    i. Conditions and Timeframes for Completion of eligible covered services, as set forth in §1373.96.
    ii. Conditions and Timeframes for Completion of eligible covered services, as set forth in APL 23-022.

c. Blue Shield Promise will collaborate with the provider in establishing a treatment plan for the members.
    i. The treatment plan will be utilized through the continuum of the member's treatment and as appropriate when the member is transitioning at the end of the authorized treatment time frame or to an in-network provider.

ii. The member may elect at any time to obtain care from an in-network provider regardless of whether or not a CoC relationship has been established.

d. If the provider refuses the rate, a member is notified verbally and assisted by a Blue Shield Promise UM representative to continue care with an in-network provider who is qualified to evaluate and treat the member's condition.
   i. The member will have the option to select a contracted in-network provider of his or her choice.

e. Blue Shield Promise will document CoC request outcomes in member file. BSCPHP will notify the member of the decision following the customary process of authorization determinations and notifications as they apply to Medi-Cal requirements.
   i. In the case of an adverse determination and the member disagrees with Blue Shield Promise, the member can:
      1. File a grievance or Appeal.
      2. Request a Medical Exemption from DHCS – assuming the request is within the first 90 days of enrollment in Blue Shield Promise.

XV. Notification

a. Notification process will include notifying the member in the member's preferred method of communication within seven (7) calendar days of the CoC decision with the following:
   i. A statement of Blue Shield Promise's decision
      1. If Denied: A clear and concise explanation of the reason for denial.
      2. If Approved: The duration of the CoC arrangement.
   ii. As the end of CoC period approaches, Blue Shield Promise will establish a transition process for the member to an in-network provider.
      1. Thirty (30) calendar days before the end of the CoC for Providers period, Blue Shield Promise will notify the member and the eligible provider about the process for transitioning the member's care.
         a. The member's right to choose a different provider from the Plan's network.
         b. A list of contracted providers in the network will be provided for the member to select from.
         c. Engaging with the member and provider prior to the end of CoC to ensure the continuity of services through the transition to the new provider.
      2. Blue Shield Promise will identify a network provider, engage the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of Covered Services through the Transition to the network provider.

XVI. Delegated Oversight

a. Blue Shield Promise UM Delegation Oversight will ensure the delegates meet the requirements of HSC §1373.96 and APL 23-022.
b. Providers and delegates will be educated on CoC provisions through:

i. Webinars
ii. Dissemination of Blue Shield Promise CoC policy
iii. Provider Manual updates
iv. Individual Group onsite trainings

1. Delegated IPAs are bound to follow the requirement of CoC in accordance with APL 23-022 provisions. Compliance will be monitored through reporting. The IPAs will be required to submit pre-established periodic reports to the Plan of all CoC activities to include:
    A. Time frames for processing
    B. Copies of Organization Determination Notices
    C. Transition activities
    D. Member Outreach and Education

All of Blue Shield Promise authorization requirements must comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §438.900, et seq and reference P&P 10.26.3 Behavioral Health Services.

E. MONITORING

N/A

F. REPORTING

Reports Table						
Report Name	Report Description	Regulator/ Internal	Prepared by	Reviewer/ Approver	Method of Submission	Frequency
DHCS Transition Monitoring and Oversight Reporting	CoC for Providers & Services – All members	DHCS	Sr. Mgr, UM Operational Performance; Sr. Mgr, Behavioral Health UM	Compliance	Online via DHCS SurveyMonkey questionnaire	Quarterly

G. ATTACHMENTS

N/A

H. REFERENCES

1. 42 CFR §438.900
2. AB 577
3. APL 22-018, APL 23-022, APL 23-010, APL 23-031
4. Health & Safety Code, §1373.96
5. 10.26.3 Behavioral Health Services
6. Welfare & Institutions Code §14185 (b)
7. 10.2.55 Skilled Nursing Facility (SNF)
8. 10.2.24 Medical Exemption Requests (MERs) for Continuity of Care
9. 10.02.74 LTC Services – ICF/DD
10. 10.12.1 Medi-Cal PCP Member Assignment

11. 2024 MCP Transition Policy Guide

I. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
6/2024	Updated per DMHC Exhibit E1, APL 23-031	
11/2023	Updated per AIR1 requirements	
10/2023	Updated with APL 23-022 revisions	
9/2023	Updated with MCP Transition Guide Ch V & VIIII	
7/2023	Updated with 2024 Expansion Requirements	
5/2023	Updated with APL 23-010 requirements	
3/2023	Updated with APL 23-022 requirements	
2/2023	Updated Regulatory Requirements DHCS	