Section (Primary Department) **Health Care Management**	**SUBJECT (Document Title)** **Continuity of Care/Transition Assistance - CA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
03/30/2023		05/31/2023	05/31/2023
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☒ **Medicaid/CHIP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **Medicare/SNP**	☐ Colorado	☐ Louisiana	☐ New York – Empire	☐ Virginia
☐ **MMP/Duals**	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Medicaid (Anthem) is responsible for providing Access to Care, Continuity of Care (COC) and coordination of services for medically necessary medical and mental health services and durable medical equipment.

Members who are, or will be, receiving excluded services will be disenrolled from Anthem in order to be eligible for the services. Anthem is responsible for ensuring continuation and coordination of services until the member is disenrolled from the plan, unless stated otherwise.

This policy describes the continuity of care (COC) procedures and processes to be followed by Anthem for members who are transitioning from Medi-Cal Fee-For-Service (FFS) or another health plan to enroll as an Anthem member.

DEFINITIONS:

Assessment: A new assessment is considered completed 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.

Basic Case Management: a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health need and provided by a collaborative effort between the Medical Management staff, the primary care provider and other professionals who have an active role in managing members' health care condition and needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised Physician Assistant (PA), Nurse practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of carved out and linked services are considered basic case management services.

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<u>Care Coordination:</u> services, which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are, included as part of a functioning Medical Home.

<u>Continued Access to Care/Continuity of Care:</u> All members have the right to continue receiving Medi-Cal services covered under the MCPs contract, including mental health when transitioning to an MCP even in circumstances in which the member does not continue receiving services from their pre-existing provider. Anthem must arrange for continuity of care for covered services without delay to the member with a network provider, or if there is no network provider to provide the covered service with and OON provider. The process of authorizing continuation of health care services with a terminating/ non-participating provider under specified conditions, and for up to 12 months from member enrollment with a plan of care to transition the member in-network. If a member changes managed care plans (MCP) by choice following the initial enrollment, or if the member loses and then later regains MCP eligibility during the 12 -month COC period, the 12 month continuity of care period for a pre-existing provider may start over one time. For example, if a member enrolls in an MCP on January 1, 2023, but then later changes to another health plan by choice on April 1, 2023, then the 12 month COC may start over **one time** and the member may see the provider until April of the following year.

If the member changes MCPs or loses and then regains MCP eligibility a second time (or more), the continuity of care period does not start over meaning that the member does not have the right to a new twelve months of continuity of care. If the member returns to Medi-Cal FFS and later re-enrolls in an MCP, the continuity of care period does not start over

<u>Durable Medical Equipment (DME)</u>: Equipment that is medically necessary as defined by 22 CCR section 51160 that a provider prescribes for a member that the member uses in the home, in the community, or in a facility that is used as a home.

<u>Medical Exemption Request (MER):</u> A MER is a request for temporary exemption from MCP enrollment into an MCP only until a member’s condition has stabilized to a level that would enable the member to transfer to a network provider of the same specialty without deleterious medical effects. Medical Exemption Requests (MER). Anthem is required to consider MERS that have been denied as automatic continuity of care requests to allow members to complete courses of treatment with OON providers.

<u>Pre-existing relationship</u>: means the member has seen a Primary Care Provider; Specialist; or select ancillary provider (including PT/OT/ST/BHT/RT) for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment with Anthem

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PROCEDURE:

I. Continuity of Care Requirements

Anthem will provide COC in the following situations:

- Members transitioning from Medi-Cal FFS or from another health plan to enroll as an Anthem member

Members who meet the COC requirements may request COC for up to 12 months after the enrollment date with Anthem if a pre-existing relationship exists with that provider.

II. COC Provider Protections in HSC section 1373.96:

- Additional protections for members include being able to continue seeing a terminated or nonparticipating provider, at a member, authorized representative, or provider's request, to complete covered services for specific conditions outline below.
- COC protections extend to Primary Care Providers; Specialists and select ancillary providers including physical therapy (PT); occupational therapy (OT); respiratory therapy (RT); behavioral health treatment (BHT); and speech therapy (ST) providers. COC protections do not extend to all other ancillary providers such as radiology; laboratory; dialysis centers; Non-Emergency Medical Transportation (NEMT); Non-Medical Transportation (NMT); other ancillary services, with the exception of a prior treatment authorization; and non-enrolled Medi-Cal Providers, Anthem is not required to authorize ongoing treatment with a provider when the provider's termination is based on reasons relating to medical disciplinary cause or reason, as defined by California Business and Professions Code Section 805(a)(6), or fraud or other criminal activity.

III. Qualifying Conditions: The medical conditions that may qualify a member for continued Access to Care /Continuity of Care, past the normal 12 month period, may include, but are not limited to:

- **An acute condition.** An acute condition 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. Completion of covered services shall be provided for the duration of the acute condition.
- **A serious chronic condition.** A 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. Completion of covered

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services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the health care service plan in consultation with the enrollee and the terminated provider or nonparticipating provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.

- **Pregnancy.** HSC section 1373.96 requires Anthem to, at the request of a member, authorized representative, or provider, provide for the completion of covered Services relating to pregnancy, during pregnancy, and immediately after the delivery (the post-partum period, which is 12 months), and care of a newborn child between birth and age 36 months, by a terminated or non-participating health plan provider. For the duration of the pregnancy and immediate postpartum period of 12 months. For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care Provider, completion of Covered Services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- **Terminal illness**. HSC section 1373.96 requires Anthem to, at the request of a member, authorized representative, or provider, provide for the completion of covered services of a member with a terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services must be provided for the duration of a terminal illness, even if it exceeds 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member.
  Care of a newborn child between the ages of birth and 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee. **Surgery or other procedure authorized by Anthem Medicaid and is scheduled to occur within 180 days** of the contract's termination or within 180 days of the effective date of coverage for a newly covered enrollee

IV. Processing Continuity of Care Requests:

Anthem members are notified of their right to request continued Access to Care at the time of enrollment (through their Evidence of Coverage), whenever their provider terminates (through their member notification letter), or during a time of transition into Anthem from a Fee-for-Service (FFS) Medi-Cal program. Members, member advocates, caregivers, providers, or terminating providers may contact Anthem to

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request continued Access to Care on behalf of the members. Customer Care Center representatives may refer new enrollees requesting continued Access to Care directly to the Medical Management Department

A. Acceptance of Requests: Anthem must accept COC requests from the Member, providers or authorized representative. Requests must be accepted over the telephone, according to the requestor's preference, and must not require the requestor to complete and submit a paper or online form if the requester prefers to make the request by telephone.

B. Retroactive Requests: Anthem must retroactively approve a COC request and reimburse providers for services that were already provided if the request meets the following COC requirements:

- Provider must be willing to accept Anthem contract rates or Medi-Cal FFS rates
- Requested services occurred after the member's enrollment with Anthem
- Have dates of service within 30 calendar days of the first service for which the provider requests retroactive reimbursement (i.e. the first date of service is not more than 30 calendar days from the date of the reimbursement request.

C. Requirements for Case Completion/Notification: The COC process begins when Anthem receives the COC request. The request will begin to be processed within 5 working days from the COC request and completed based on the below:

- 30 calendar days for non-urgent requests;
- 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the Member)

Anthem will allow continued access for up to 12 months from date of enrollment to an out of network provider when they have been seen within the previous 12 months if the following requirements are met:

- The provider meets Anthem's applicable professional standards and has no disqualifying quality-of-care issues. Under these circumstances, a quality-of-care issue means Anthem can document its concerns with the provider's quality of care to the

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extent that the provider would not be eligible to provide services to any other Anthem members.
- The provider is a California State Plan approve provider. (Refer to list of suspended or ineligible providers)
- The provider supplies the MCP with all relevant treatment information, for the purposes of determining COC, medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
- The provider is willing to accept Anthem's contract rates or Medi-Cal FFS rates per H&S code section 1373.9(d)(2).
- Anthem is not required to authorize ongoing treatment with a provider when the provider's termination is based on reasons relating to medical disciplinary cause or reason, as defined by California Business and Professions Code Section 805(a)(6), or fraud or other criminal activity.

If Anthem is not able to come to an agreement with the terminated provider or non-participating provider, or if the member, authorized representative, or provider does not submit a request for the completion of covered services by said provider, Anthem is not required to continue the provider's services. In addition to the reimbursement rate, the terminating/non-participating provider must agree to the following:
- Continue to accept reimbursement of the Anthem-negotiated rate as payment in full.
- Adhere to Anthem's policies and procedures, including but not limited to, those regarding referrals, pre-authorization and treatment plan approval from Anthem. Provider questions about reimbursement rates outside the continued Access to Care program are referred to Network Support.

All Out-of-Network providers will be provided information on how they can obtain the Anthem clinical protocols and evidence-based practice guidelines.

D. Validating Pre-Existing Relationship:

Anthem must determine if the member has a pre-existing relationship with the provider. This may be determined by using FFS utilization data or claims data from an MCPA member, authorized representative or provider may also provide information to Anthem that demonstrates a pre-existing relationship with a provider. A member's self-attestation of a pre-existing relationship is not sufficient to provide proof of a relationship with a

provider, instead, actual documentation must be provided, A pre-existing relationship means the member has seen an out-of-network primary care provider , a specialist or select ancillary provider (including PT/OT/ST/RT or BHT for a non-emergency visit at least once during the 12 months prior to the date of his or her initial enrollment with Anthem

Following identification of a pre-existing relationship, Anthem will determine if the provider is a network provider. If the provider is a network provider, then Anthem will allow the member to continue seeing the provider. If the provider is not a network provider, Anthem will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish continuity of care for the member.

E. Member Notifications:

1) **Assessment and Determination/Notification:**
   If the UM/CM Nurse cannot approve the request, the request is referred to a Peer Clinical Reviewer (PCR) or Medical Director for determination.

   The UM/CM Nurse may determine that the member is not eligible for continued Access to Care for non-clinical reasons. Non-clinical reasons may include:
   - Treating physician is a contracted provider, no request is needed.
   - Member, Provider or authorized representative withdraws the request.
   - Other Health Insurance is primary.
   - Date of service is prior to the member's effective date with Anthem Medicaid.
   - Course of treatment has been completed.
   - Services rendered are covered under a global fee.
   - Requested services are not a covered benefit with Anthem Medicaid.

2) **Member Acknowledgement Notifications:** Anthem will provide acknowledgement of the COC request within the timeframes specified below using 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:

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- Non-Urgent requests within 7 calendar days
- Urgent Requests within 3 calendar days, but as soon as possible given the members condition.

The acknowledgement will include the following:

- Notification to the member that the COC request has been received The date of receipt of the request
- The estimated timeframe for resolution

3) **Member Denial Notification:** For COC requests that are denied, Anthem will include the following information in the notice:
   - A statement of Anthem's decision
   - A clear and concise explanation of the reason for the denial
   - The member's right to file a grievance or appeal.
     If Anthem and the OON provider are unable to reach an agreement because they cannot agree to a rate, or Anthem has documented quality of care issues with the provider, Anthem will offer the member a network provider alternative. If the member does not make a choice, the member must be referred to a network provider. If the member disagrees with the COC determination, the member maintains the right to file a grievance.

4) **Member Approval Notification:**
   For COC requests that are approved, Anthem will include the following information in the notice:
   - A statement of Anthem's decision
   - The duration of the COC arrangement
   - The process that will occur to transition the member's care at the end of the COC period
   - The member's right to choose a different in network provider

   Anthem will attempt to notify the member of the continuity of care decision via the member's preferred method of communication or by telephone.

   If the provider meets all necessary requirements, including entering into an LOA or contract with Anthem, Anthem 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 Anthem for a shorter timeframe. In this case, Anthem will allow the member to have access to that provider for the shorter period of time.

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

The MCP must notify the member within 30 calendar days before the end of the COC period, using the member's preferred method of communication. The notification will include the process that will occur to transition the member's care to a network provider at the end of the COC period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

5) **Provider Notification:** If continued Access to Care will be provided, Anthem notifies the terminating/non-participating provider of the following:
    - Specific services authorized to be provided by the terminating/non-participating provider.
    - Frequency and duration of authorized services.
    - Provider reimbursement rate.
    - Billing instructions for the provider.
    - Toll free telephone number and address for the UM/CM department.
    - Toll free telephone number for Customer Care to verify benefits.
    - Requirements on not referring to other OON providers if Anthem has in network providers available.
    - Anthem 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 Anthem. If there is no in-network provider, Anthem will

facilitate the referral, if medically necessary, if Anthem does not have an appropriate provider within its network.

F. Scheduled Specialist Appointments:
At the member, provider or authorized representatives request, Anthem 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. If COC has not been established, but Anthem is unable to arrange a specialist appointment with a network provider on or before the member's scheduled appointment with the OON provider, we 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 Anthem, it does not establish the requisite pre-existing provider relationship for the member to submit a COC request.

G. Continuity of Medi-Cal Covered Services and Prior Treatment Authorizations:

- Following a member's transition from Medi-Cal FFs to Anthem or from another MCP, active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the member, authorized representative or provider. Anthem will use the Treatment Authorization Request (TAR) data or Prior Authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies.
- Anthem will arrange for services authorized under the active prior treatment authorization with a network provider, or if no network provider is available, with an OON provider. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by Anthem, whichever is shorter. If Anthem does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, Anthem may reassess the member's prior treatment authorization at any time.
- **Durable Medical Equipment Rentals and Medical Supplies**: Anthem will allow transitioning members to keep their existing DME rentals and medical supplies from their existing provider, under the previous Prior Authorization for a minimum of 90 days following enrollment with an MCP and until the new MCP is able

to reassess the new equipment or supplies are in possession of the member and ready to use.

- Continuity of DME and medical supplies will be honored without a request by the member, authorized representative or provider.
- If DME or medical supplies have been arranged for a transitioning member but the equipment or supplies have not been delivered, Anthem will allow for delivery for the member to keep the equipment or supplies for a minimum of 90 days following enrollment and until the new MCP is able to reassess. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization. After 90 days, the MCP may reassess the Member's authorization at any time and require the Member to switch to a Network DME Provider.

H. Non-Emergency Medical Transportation and Non-Medical Transportation:
For NEMT and NMT, Anthem will allow members to keep the modality of transportation under the previous Prior Authorization with a network provider until a reassessment is performed.

I. Member and Provider Outreach and Education
Anthem will inform Members of their Continuity of Care protections and include information about these protections in Member information packets, handbooks, and on the Anthem's website. This information will include how a Member, authorized representative, and Provider may initiate a Continuity of Care request with Anthem. Anthem will translate these documents into threshold languages and make them available in alternative formats, upon request. Anthem will provide training to call center and other staff who come into regular contact with Members about Continuity of Care protections.

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

K. Terminating Providers:
When an individual's FFS provider, or Primary Medical Group (PMG)/Independent Physician Association (IPA) terminates its contract with Anthem or is terminated by Anthem, members are notified of the impending termination and of their right to request continued Access to

Care. Development of a transition plan addressing continuity of care is required for those members

- For hospital termination, Anthem notifies members 60 days in advance of termination only if that hospital is capitated and members are assigned to a specific hospital. For non-capitated hospital terminations, Anthem notifies members if the hospital actually terminates.

L. Transition Care Plan

- Only patients approved for continued Access to Care can complete their current treatment plan with the terminating provider. Anthem members who do not meet the eligibility requirements for continuing care with their present provider may seek assistance from Anthem in selecting a participating provider. Anthem will provide assistance in transitioning the patient to a participating provider. Continued Access to Care shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider.
- When continued Access to Care is approved, the UM/CM Nurse develops and documents a transition plan for the member. Plan development includes contact with the member and the treating provider, as needed, and the participating provider to whom the member's care will be transferred, as appropriate.
- The transition plan includes at least:
  1) The non-participating provider's treatment plan for the member's active course of treatment, for which continued Access to Care was requested.
  2) The specific treatment goal to be reached prior to transfer to the Anthem contracting provider and the estimated date the transfer can be safely accomplished.

M. Covered California to Medi-Cal Transition

For populations that undergo a mandatory transition from Covered California to Anthem 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:

- Anthem will ask these members if there are upcoming health care appointments or treatments scheduled and assist them.

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- If members request continuity of care, Anthem will help initiate the process at that time.
- Anthem will contact the new members by telephone, letter or other preferred method of communication, no later than 15 calendar days after enrollment.
- Anthem 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 continuity of care.
- Anthem will honor any active prior treatment authorizations for 90 days for services that are covered under its contract. Anthem will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide service with an OON provider. After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment is completed, whichever is shorter.

REFERENCES:

- Anthem Medicaid Policy #CA_PNXX_303 “Provider Termination”
- CA_LTXX_001 Continuity of Care for Newly Enrolled LTSS Members
- California Business and Professions Code Section 805(a) (6)
- California DHCS Central Valley/Bay Area, Sacramento, Tulare County Medi-Cal Contracts, Exhibit A, Attachment 9 and Attachment 22
- California DHCS Healthy Families Transition Amendment Exhibit A.20.1.B. A.20.1.C and A.20.2.B.
- California Health & Safety Code 1373.95& 1373.96(d)(2)
- Department of Health Care Services, All Plan Letter #22-032 “Continuity of care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal members who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023” http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
- LTSS Policy Continuity of Care for Long Term Care Transition
- Member Evidence of Coverage 2023
- National Committee for Quality Assurance (NCQA)
- Provider Operations Manual, 2023
- Suspend/Ineligible List https://filessysdev.medi-cal.ca.gov/pubsdoco/SandILanding.aspx#:~:text=In%20accordance%20with%20W%26I%20Code%2C%20section%2014043.61%2C%20subdivision,to%20identify%20suspended%2C%20excluded%20or%20otherwise%20ineligible%20providers.

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Continuity of Care/Transition Assistance - CA**

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):
Behavioral Health
Network Support
Special Programs - LTSS

EXCEPTIONS:

None