	Continuity of Care	UM-003
Department	Health Services	
Functional Area	Utilization Management	
Line of Business	☒ Medi-Cal ☒ D-SNP	

DELEGATION OF FUNCTION		
☒ Health Net	☐ Community Care IPA	☐ Not Delegated
☒ Community Health Group	☐ Primary Healthcare Medical Group	
☐ Imperial County Physicians MG	☐ Premier Patient Care	

DATES			
Policy Effective Date	06/12/2023	**Reviewed/Revised Date**	12/11/2025
Next Annual Review Due	12/11/2026	**Regulator Approval**	12/15/2023

APPROVALS			
Internal		**Regulator**	
Name	Gordon Arakawa, MD	☐ DHCS ☐ NA ☒ DMHC	
Title	Chief Medical Officer		

ATTACHMENTS

NA

AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Title 42 Code of Federal Regulations ("CFR") 418.3
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1367(d), 1373.95, 1373.96
  - Title 22 California Code of Regulations Rules ("CCR") 51340, 51340.1, 53887, 53923.5
  - Title 28 CCR Rules 1300.67.1 (a) – (e); 1300.67.1.3 (b)
  - DMHC: Technical Assistance Guide ("TAG") "Continuity of Care" (last published 06/27/2014); All Plan Letter ("APL") 19-013
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 5.2.12 ; APLs 15-019, 16-002, 17-007, 20-017, 21-003; 22-032, 22-032, 24-014, 24-010, 22-016
  - Knox-Keene Health Care Service Act and Regulations, Section 1373.95
- **Accreditation**
  - NCQA: Network Management (NET) 4, Element B: Continued Access to Practitioners
  - NCQA: Quality Management and Improvement (QI) 3, Element D: Transition to Other Care

HISTORY

Revision Date	Description of Revision
06/12/2023	Policy creation
05/13/2024	Policy revision to include additional 1373.95 provisions
06/30/2025	Annual Review – Updates for APLs and/or applicable regulations
12/11/2025	Updates to procedure section

I. OVERVIEW

A. Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") is responsible for ensuring there are CONTINUITY OF CARE ("CoC") processes in place that are in strict adherence to the guidelines and processes stated herein. CHPIV delegates its CoC processes to CHPIV's Subcontractor, Health Net, who performs the function on behalf of CHPIV.

II. POLICY

A. CHPIV will ensure continued access for up to 12 months to an OUT-OF-NETWORK PROVIDER with whom the MEMBER has an ONGOING RELATIONSHIP, as long as CHPIV has no Quality of Care issues with the PROVIDER and the PROVIDER will accept either CHPIV's or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I Code section 14182(b)(13) – (14).
   1. CHPIV will ensure all MEMBERS receive continued access for foster youth and former foster youth transitioning from Medi-Cal Fee-for-Service (FFS) to Medi-Cal Managed Care. CHPIV will ensure uninterrupted access to existing providers for up to 12 months from the transition date, regardless of whether the provider is in-network, without requiring a continuity of care request from the MEMBER, in accordance with APL 24-014.
   2. CHPIV will ensure automatic continuity of care for all MEMBERS transitioning from Medi-Cal Fee-for Service (FFS) who are residing in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). The MEMBERS shall remain in their current ICF/DD facility without being required to submit a continuity of care request. CHPIV will ensure to make reasonable efforts to avoid disruption of services or residential placement in accordance with DHCS CoC guidelines.

B. CHPIV will ensure the MEMBER's right to continue receiving Medi-Cal services covered under the CHPIV's Contract when transitioning to CHPIV even in circumstances in which the Member does not continue receiving services from their pre-existing Provider. CHPIV will ensure CoC 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 an OON Provider.

C. For new enrollees residing in Subacute Care Facilities, CHPIV will ensure to honor the MEMBERS request for continuity of care if the criteria outlined in APL 22-016 apply. CHPIV shall notify the member and facility staff of the members' rights to request continuity of care and shall assist with the request process. CHPIV shall ensure timely processing of the request consistent with all applicable CoC regulations in accordance with APL 24-010.

D. CHPIV will ensure that 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 for MEMBERS transitioning to CHPIV. CHPIV will ensure arrangement of services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider.

E. CHPIV will ensure that all MEMBERS are allowed to request CONTINUITY OF CARE in accordance with 42 CFR section 438.62 and APL 22-032.
F. CHPIV will ensure that additional CONTINUITY OF CARE Protections are provided for MEMBERS with specific conditions as defined in H&S Code section 1373.96.
G. CHPIV will ensure proper evaluation of denied Medical Exemption Requests (MER) as automatic CONTINUITY OF CARE requests.

H. CHPIV ensures there is a comprehensive process for block transfers of MEMBERs from a NETWORK PROVIDER GROUP or HOSPITAL to a new PROVIDER GROUP or HOSPITAL.

I. CHPIV will ensure to maintain documented processes to facilitate continuity of care hen a MEMBERS provider terminates from the network or when the MEMBER transitions between health plans. CHPIV shall provide timely written notice to the MEMBER regarding their continuity of care rights and assist MEMBERS with submitting continuity of care requests in accordance with H&S Code Section 1373.95.

J. CHPIV will ensure a review for the completion of Covered Services at the request of a MEMBER in accordance with H&S Code section 1373.95. All MEMBERSs with PRE-EXISTING RELATIONSHIP with the PROVIDER who make a CONTINUITY OF CARE request must be given the option to continue treatment for up to 12 months with an OUT-OF-NETWORK PROVIDER, if the following criteria are met:
    1. The MEMBER has seen the OUT-OF-NETWORK PROVIDER at least once within the 12 months before Enrollment with CHPIV;
    2. The OUT-OF-NETWORK PROVIDER accepts CHPIV's rate offered in accordance with H&S Code section 1373.96(d)(2) or €(2); and
    3. The OUT-OF-NETWORK PROVIDER meets CHPIV's applicable professional standards and has no disqualifying Quality of Care issues.

K. CHPIV ensures facilitation of the completion of covered services in accordance with H&S Code section 1373.96 for the following conditions:
    1. An acute condition. Completion of covered services shall be provided for the duration of the acute condition.
    2. A serious chronic condition. Completion of covered services shall 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 CHPIV in consultation with the MEMBER and the terminated provider or nonparticipating provider and consistent with good professional practice.
    3. A pregnancy. Completion of covered services shall be provided for the duration of the pregnancy.
    4. Care of a newborn child between birth and age 36 months.
    5. Surgery or other procedure that is authorized by CHPIV.

L. CHPIV ensures an Enrollee Transfer Notice is sent to MEMBERs describing its policy and informing MEMBERs of their right of completion of covered services

M. CHPIV ensures that reasonable consideration is given to the potential clinical effect on the MEMBER's treatment caused by a change of PROVIDER.

N. CHPIV will ensure a process for accepting requests from the MEMBER, authorized representative, or PROVIDER over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

O. CHPIV will ensure a process for accepting and approving retroactive CoC requests and for reimbursing PROVIDERS for services that were already provided if the request meets all CoC requirements.

P. CHPIV ensures the development and implementation of procedures that further describe the following:

1. Date of CoC process initiation.
2. Validation of has a PRE-EXISTING RELATIONSHIP with the PROVIDER by requesting all relevant treatment information from the OUT-OF-NETWORK (OON) PROVIDER,
3. Timelines for making CoC determinations:
    a. 30 calendar days for non-urgent requests;
    b. 15 calendar days if the MEMBER's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
    c. As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is an identified risk of harm to the MEMBER).
4. Acknowledgment of the CoC request within the required timeframes, advising the MEMBER that the CoC request was received, the date of receipt, and the estimated timeframe for resolution.
5. Decision notification 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:
    a. For non-urgent requests, within seven calendar days of the decision.
    b. For urgent requests, within the shortest applicable timeframe that is appropriate for the MEMBER's condition, but no longer than three calendar days of the decision.
6. Content of MEMBER notification:
    a. Denial notifications:
        i. A statement of the MCP's decision.
        ii. A clear and concise explanation of the reason for denial.
        iii. The MEMBER's right to file a grievance or appeal. For additional information on grievances and appeals, refer to APL 21-011 or subsequent iterations of this APL.
    b. Approval notifications:
        i. A statement of the MCP's decision.
        ii. The duration of the CONTINUITY OF CARE arrangement.
        iii. The process that will occur to transition the MEMBER's care at the end of the CONTINUITY OF CARE period.
        iv. The MEMBER's right to choose a different Network PROVIDER.
7. Process for notifying MEMBERSs within 30 calendar days before the end of the CONTINUITY OF CARE period, using the MEMBER's preferred method of communication, about the process that will occur to transition the MEMBER's care to a IN-NETWORK PROVIDER at the end of the CONTINUITY OF CARE 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.
8.

III. PROCEDURE

A. Delegation of Functions
   1. Delegated functions covered under this policy are described in the applicable delegate's own policies and procedures governing the performance of those functions. Delegates are required to maintain compliant and current policies consistent with applicable regulatory and contractual requirements. CHPIV's oversight activities verify adherence to those standards.

B. Delegation Oversight
   1. CHPIV maintains full accountability for all delegated activities and provides oversight to ensure compliance with federal, state, and contractual requirements.
   2. Oversight activities are conducted in accordance with CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure, and include:
      a. Ongoing monitoring
      b. Performance reviews
      c. Data analysis
      d. Utilization of benchmarks, if available
      e. Annual desktop and on-site audits

IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

TERM	DEFINITION
Member	A beneficiary enrolled in a CHPIV program.
Active Course of Treatment	Means an ongoing treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves 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.
Acute Condition	Means 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. Examples include a heart attack, pneumonia, or appendicitis.
Block Transfer	Means a transfer or redirection of two thousand (2,000) or more members by CHPIV from a Terminated Provider Group or Terminated Hospital to one or more contracting providers that takes place as a result of the termination or non-renewal of a Provider Contract.
Continuity of Care ("COC")	Means the process by which the member and the Provider are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.
Chronic	Means a condition that is long-term and ongoing and is not acute. Examples include diabetes, asthma, allergies, and hypertension.
Medically Necessary/Medical Necessity	Means all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22

TERM	DEFINITION
	CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132 (v). For individuals under 21 years of age, EPSDT service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable". Additional services must be provided if determined to be medically necessary for an individual child.
Non-Participating Provider or Out-of-Network Provider	Means a health care professional or facility that does not have a service contract with the Plan and/or its delegate HNCS that is responsible for providing health care services for the Member who has requested completion of services with that professional or facility at the in-network benefit level.
Ongoing Relationship or Pre-Existing Relationship	Means the member has seen the requested out-of-network provider (PCP or Specialist) at least once during the 12 months prior to the date of the member's initial enrollment in the managed care plan for a non-emergency visit. The Plan and/or its delegate HNCS determines if a relationship exists using data provided by DHCS to the Plan and/or its delegate HNCS, such as Medi-Cal FFS utilization data. The member or their provider may also provide information to the Plan and/or its delegate HNCS that demonstrates a pre-existing relationship with a provider. A member may not attest to a pre-existing relationship (instead of actual documentation being provided).
Participating Provider or In-Network Provider	Means a health care professional or facility that is contracted with the Plan and/or its delegate HNCS, who or that provides covered services to Plan members.
Prior Authorization	Means the formal process that requires a Provider to obtain advanced approval from the Plan and/or its delegate HNCS to provide specific services or procedures. Prior authorization is required for most services or care; however, prior authorization is not required for emergency or out-of-area urgent care services.
Provider	Means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Pregnancy	Means a pregnancy with a three trimester duration and immediate postpartum period.

TERM	DEFINITION
Seniors and Persons with Disabilities (SPDs)	Means a member who falls under a specific SPD aid code as defined by DHCS.
Serious Chronic Condition	Means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: Persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Terminal Illness	Means a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
Terminated Provider	Means a Provider whose contract to provide covered services to members is terminated or not renewed by the Plan and/or its delegate HNCS.