DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

TECHNICAL ASSISTANCE GUIDE

CONTINUITY OF CARE

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this June 27, 2014 Technical Assistance Guide renders all other versions obsolete

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Continuity of Care Requirements

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Requirement CC-001: Continuity and Coordination of Care

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Medical Director
- QA Director
- Participating Providers
- Staff responsible for monitoring referrals to physicians and other health professionals
- MH Delegate Mental Health Medical or Clinical Director
- MH Delegate Director of Quality Improvement
- Member/Customer Services Director
- Staff responsible for assisting enrollees in transitioning care

DOCUMENTS TO BE REVIEWED

- Related policies and procedures, including: Continuity, timeliness and coordination of care between and among providers (including mental health providers, specialists, facilities, medical groups, case management staff, etc.); screening for and co-management of co-existing medical and mental health conditions; timely communication of clinical information among providers; transitions of care, including completion of covered services by a terminated provider to enrollee who was receiving services and completion of covered services by a nonparticipating provider to a newly covered enrollee; co-payments, deductibles, or other cost sharing requirements during the period of a completion of covered services with a terminated provider or a nonparticipating provider; protecting confidentiality of enrollee health information; specialty referrals; etc.
- Descriptions of the mental health and medical case management systems and mechanisms (including monitoring and reporting) for co-management
- Medical record documentation standards for primary care providers and evidence of distribution to providers
- PCP & Affiliated Provider's office medical records
- Policies and procedures for conducting audits and the medical record audit tool
- Results of medical record audits and subsequent follow-up with providers
- Enrollee Referral Policies, Procedures, and Processes
- Referral monitoring and tracking records, logs and reports
- Practitioner and provider manuals
- Provider surveys (especially addressing satisfaction with feedback received by PCPs following referrals to specialists and referral timeliness)
- Case management program descriptions regarding continuity of care
- Reports of continuity and coordination of care measures, results, analyses, conclusions and actions to be taken

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- Policy regarding transition of care (including mental health parity cases)
- Definition of active treatment for mental health parity cases
- Notification letter templates to enrollees requesting transitional care
- Reports on number, type and disposition of transitional care cases
- Member/Customer Services computer screens/desk procedures on responding to inquiries about transition of care
- Corrective action plans and documentation of interventions and results
- Disease management program description
- Delegated entity oversight reports
- Plan's website
- Enrollee materials describing the PCP selection and change process
- Sample of case management files to be reviewed onsite
- Documentation showing that the Plan promotes a standard of provider communication that adequately communicates its health care treatment recommendations to the enrollee
- Related policies and procedures for maintaining and coordinating enrollee treatment plans and records

CC-001 - Key Element 1:

1. The Plan offers a panel of primary care providers (PCPs) from which enrollees may select a PCP responsible for coordinating the enrollee's health care and encourages each enrollee to choose a PCP.
CA Health and Safety Code section 1367.26(a)(1); 28 CCR 1300.67.1(a) through (e).

Assessment Questions	
1.1	Does the Plan offer a panel of PCPs?
1.2	Does the Plan update its PCP listing and make it available to enrollees? (e.g., via a provider directory and internet website.)
1.3	Does the Plan have a mechanism for enrollees to select a PCP upon enrollment?
1.4	Does the Plan have a mechanism for enrollees who fail to select a PCP to be assigned a PCP?
1.5	Does the Plan have a mechanism for enrollees to change their PCP?

CC-001 - Key Element 2:

2. The Plan ensures that it meets the needs of enrollees with regards to continuity of care including the referral system (including instructions, monitoring, and follow-up); the maintenance and ready availability of medical records; and the availability of health education to enrollees.
28 CCR 1300.67.1(d); 28 CCR 1300.80(b)(4) and (b)(5)(E).

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Assessment Questions	
2.1	Does the Plan have established medical record documentation standards?
2.2	Does the Plan disseminate those standards to providers? (e.g., via provider manual)
2.3	Does the Plan have an effective medical record audit tool that addresses continuity and coordination of care between and among providers?
2.4	Does the Plan regularly conduct medical record audits?
2.5	Does the Plan implement corrective action and complete follow-up review to address any deficiencies?
2.6	Do the Plan's medical record policies provide for the ready availability of medical records? (To facilitate continuity of care.)
2.7	Has the Plan established standards and processes that promote a standard of provider communication that adequately communicates its health care treatment recommendations to the enrollee?
2.8	Does the Plan provide adequate oversight of procedures to confirm that the health care treatment goals have been established and communicated to the enrollee or parent?
2.9	Does the Plan have standards for timely evaluation, screening, and diagnosis of patients with ASD?

CC-001 - Key Element 3:

3. If the Plan contracts with a specialized health care service plan for the purpose of providing mental health services, the Plan has established standards and processes for the appropriate sharing of information (e.g., adequate, timely feedback and consultation) and coordination of care between and among medical and mental health providers, general and specialty practitioners and institutions, referring and consulting providers, etc.
28 CCR 1300.74.72(g)(3) through (5).

Assessment Questions	
3.1	Does the Plan regularly conduct medical record audits? Has the Plan established standards and processes to facilitate timely communication, sharing of necessary information and coordination of care between and among an enrollee's mental health providers and between medical and mental health providers?
3.2	Do these **processes include communication** among providers between **levels of care**? (e.g., inpatient care, partial hospitalization, outpatient care, day and residential treatment)
3.3	Do these **processes include communication** between and among the enrollee's **mental health providers** (e.g., psychiatrist, psychologist, and master's-level mental health clinicians) and **medical providers**? (e.g., PCP, specialists)

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3.4	Do these **processes include communication** between and among **Plan's case management clinical staff**?
3.5	Do these **processes include communication** between and among enrollee's mental health providers and medical providers to **ensure appropriate evaluation, screening, diagnosis, and treatment** for SED ,SMI, and autism conditions?
3.6	Do these **processes include communication** between and among **Plan's and facility's** case management clinical **staff**? (if two or more case managers are involved within the Plan)
3.7	Do these processes include communication between and among **Plan's and delegate's** (if any) case management clinical **staff**?
3.8	Do these **processes include communication** between and among **IPA/medical groups** and **Plan's** case management staff?
3.9	Does the Plan disseminate those standards to providers? (e.g., via provider manual)
3.10	Does the Plan monitor providers' adherence to the policies?
3.11	Does the Plan have established policies and procedures for the reasonable protection of patient confidentiality that do not cause undue delay or disruption in care?
3.12	Does the Plan retain full responsibility for assuring continuity of care? (regardless of contractual arrangements with specialized plans to perform some or all activities)

CC-001 - Key Element 4:

4. The Plan has mechanisms to facilitate transitions of care (including enrollee notifications) when a) an individual in a course of treatment enrolls in the Plan, and b) when a medical group or provider is terminated from the network. CA Health and Safety Code section 1367(d); CA Health and Safety Code section 1373.95; CA Health and Safety Code section 1373.96(a) and (b); 28 CCR 1300.67.1.3(b).

Assessment Questions	
4.1	Does the Plan have an effective review mechanism for requests of continuity of care with current non-participating provider?
4.2	Does the Plan have established policies and procedures for the safe transfer of care of new enrollees with acute, serious, or chronic mental health conditions who are currently receiving services from a nonparticipating mental health provider to a participating provider?
4.3	Does the Plan have established policies and procedures addressing planned and unplanned terminations of providers from its provider network?
4.4	Do the policies and procedures address all provider types? (PCPs, specialists, mental health providers, etc.)
4.5	Do the policies and procedures address enrollees receiving treatment for acute or chronic conditions?

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4.6	Does the Plan use adequate review criteria that meet community standards of practice to determine whether current enrollees' treatment/care is transferable to another provider without compromising quality of care?
4.7	Does the Plan clearly define conditions/situations in which premature transfer of care may compromise quality of care?
4.8	Does the policy address situations where an enrollee may be allowed to continue treatment with the previous provider for a specified period of time?
4.9	Does the Plan have an effective mechanism for timely notification of all parties involved (enrollees, participating and non-participating providers) to facilitate safe transition of care?
4.10	Does the Plan have a policy and procedure for block transfer of enrollees? (In the event of a medical group termination.)
4.11	When a block transfer is required, does the Plan ensure that disruption in service and care is prevented?
4.12	When a block transfer is required, does the Plan ensure that enrollees are notified in a timely manner?
4.13	When a block transfer is required, does the Plan ensure that transfers are efficient and cause no unnecessary delay?

CC-001 - Key Element 5:

5. If the Plan contracts with a specialized health care service plan, the Plan has mechanisms to identify and refer enrollees who have co-existing conditions and monitors (at least annually) how effectively medical and mental health providers screen enrollees for co-existing conditions and ensure access to treatment and follow-up.
28 CCR 1300.74.72(g)(4)(C) and (g)(5).

Assessment Questions	
5.1	Does the Plan have established policies and procedures for appropriate screening and timely identification and referral of enrollees diagnosed with co-existing medical and mental health conditions?
5.2	Does the Plan monitor the effectiveness of screening of enrollees for co-existing conditions both in the medical and mental health service delivery segments at least annually?
5.3	Does the Plan have established and implemented policies for monitoring and ensuring timely access to treatment and follow-up of enrollees with co-existing conditions?
5.4	Does the Plan generate useful monitoring data for analysis, tracking and trending and identification of improvement opportunities?
5.5	If problems develop or are identified, does the Plan undertake corrective actions in a timely manner?

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CC-001 - Key Element 6:

6. The Plan monitors and evaluates continuity and coordination of care that enrollees receive (as part of its QM program activities) at least once each year and addresses any identified deficiencies. The Plan regularly monitors performance against defined standards and addresses any deficiencies in a manner consistent with professionally recognized evidence-based standards of practice.
CA Health and Safety Code section 1367(d); 28 CCR 1300.70(a)(3) and (b)(2)(I)(1)(b); 28 CCR 1300.74.72(g)(4).

Assessment Questions	
6.1	Does the Plan monitor and/or measure the exchange of information and its effectiveness between levels of care and/or types of providers?
6.2	Does the Plan regularly measure performance against its standards? (Defined in #1 and #2 above)
6.3	Does the Plan generate useful monitoring data for analysis, tracking, trending, and identification of improvement opportunities?
6.4	Does the Plan implement corrective action and follow-up review to address any deficiencies?
6.5	Do the Plan’s policies ensure continuity of care and ready referral to other providers consistent with good professional practice?

End of Requirement CC-001: Continuity and Coordination of Care

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Statutory/Regulatory Citations

CA Health and Safety Code section 1367(d)
A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:
(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

CA Health and Safety Code section 1367.26(a)(1)
(a) A health care service plan shall provide, upon request, a list of the following contracting providers, within the enrollee's or prospective enrollee's general geographic area:
(1) Primary care providers.

CA Health and Safety Code section 1373.95
(a)(1) A health care service plan, other than a specialized health care service plan that offers professional mental health services on an employer-sponsored group basis, shall file a written continuity of care policy as a material modification with the department before March 31, 2004.
(2) A health care service plan shall include all of the following in its written continuity of care policy:
(A) A description of the Plan's process for the block transfer of enrollees from a terminated provider group or hospital to a new provider group or hospital;
(B) A description of the manner in which the Plan facilitates the completion of covered services pursuant to the provisions of Section 1373.96;
(C) A template of the notice the Plan proposes to send to enrollees describing its policy and informing enrollees of their right to completion of covered services;
(D) A description of the Plan's process to review an enrollee's request for the completion of covered services;
(E) A provision ensuring that reasonable consideration is given to the potential clinical effect on an enrollee's treatment caused by a change of provider.

CA Health and Safety Code section 1373.96
(a) A health care service plan shall at the request of an enrollee, provide the completion of covered services as set forth in this section by a terminated provider or by a nonparticipating provider.
(b)(1) The completion of covered services shall be provided by a 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 described in subdivision (c).
(2) The completion of covered services shall be provided by a nonparticipating 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 described in subdivision (c).

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28 CCR 1300.67.1
Within each service area of a plan, basic health care services shall be provided in a manner, which provides continuity of care, including but not limited to:
(a) The availability of primary care physicians, who will be responsible for coordinating the provision of health care services to each enrollee;
(b) The encouragement of each enrollee to select a primary physician;
(c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee;
(d) The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees;
(e) An adequate system of documentation of referrals to physicians or other health professionals. The monitoring of the follow up of enrollees' health care documentation shall be the responsibility of the health care service plan and associated health professionals.

28 CCR 1300.67.1.3(b)
(b) For any proposed Block Transfer, a plan shall file with the Department a Block Transfer filing that includes, at minimum, all the items of information described in this subsection (b). The Block Transfer filing must be submitted to the Department at least seventy-five (75) days prior to the termination or non-renewal of any Provider Contract with a Terminated Provider Group or a Terminated Hospital.
The Block Transfer filing must be submitted in an electronic format developed by the Department and made available at the Department's website at www.hmohelp.ca.gov and must include, at minimum, all of the following information as appropriate for the type of provider involved:
(1) A form of the written notice that the plan intends to send to Affected Enrollees. The Enrollee Transfer Notice must include:
(A) The name of the Terminated Provider Group or Terminated Hospital. The plan may also add the name of the assigned physician, where appropriate.
(B) A brief explanation of why the transfer is necessary due to the termination of the contract between the plan and the Terminated Provider.
(C) The date of the pending contract termination and transfer.
(D) An explanation to the Affected Enrollee outlining the Affected Enrollee's assignment to a new Provider Group, options for selecting a physician within a new Provider Group, and applicable timeframes to make a new Provider Group selection. The explanation must include a notification to the Affected Enrollee that he or she may select a different network provider by contacting the plan as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.
(E) A statement that the plan will send the Affected Enrollee a new member information card with the name, address and telephone number of the Receiving Provider Group and assigned physician by a specified later date, which will occur prior to the date of the contract termination. Alternatively, the plan may notify the Affected Enrollee of the name, address and telephone number of the new Provider Group and assigned

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physician, or Alternate Hospital, to which the Affected Enrollee will be assigned in the absence of a selection made by the enrollee.
(F) A statement that the Affected Enrollee may contact the plan's customer service department to request completion of care for an ongoing course of treatment from a Terminated Provider. This statement may include either a statement outlining the specific conditions set forth in California Health and Safety Code section 1373.96(c), or an explanation to the Affected Enrollee that his or her eligibility is conditioned upon certain factors as outlined in the plan's written continuity of care policy and evidence of coverage or disclosure form.
(G) The telephone number through which the Affected Enrollee may contact the plan for a further explanation of his or her rights to completion of care, including the plan's written continuity of care policy; and a link that an Affected Enrollee may use to obtain of a downloadable copy of the policy from the plan's website.

28 CCR 1300.70(a)(3)
(a) Intent and Regulatory Purpose.
…
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.
…
(b) Quality Assurance Program Structure and Requirements.
…
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:
…
(I) Inpatient Care.
A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:
1. A plan must have a mechanism to oversee the quality of care provided in an inpatient setting to its enrollees which monitors that:
…
b. if hospital services are fully capitated that appropriate referral procedures are in place and utilized for services not customarily provided at that hospital.

28 CCR 1300.74.72
..
(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:
…

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(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;
(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:
(A) exchange of information,
(B) appropriate diagnosis, treatment and referral, and
(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;
(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities.

28 CCR 1300.80

…

(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.

…

(4) Review of the design, implementation and effectiveness of the internal quality of care review systems, including review of medical records and medical records systems. A review of medical records and medical records systems may include, but is not limited to, determining whether:
(A) The entries establish the diagnosis stated, including an appropriate history and physical findings;
(B) The therapies noted reflect an awareness of current therapies;
(C) The important diagnoses are summarized or highlighted; (Important are those conditions that have a bearing on future clinical management.)
(D) Drug allergies and idiosyncratic medical problems are conspicuously noted;
(E) Pathology, laboratory and other reports are recorded;
(F) The health professional responsible for each entry is identifiable;
(G) Any necessary consultation and progress notes are evidenced as indicated;
(H) The maintenance of an appropriate system for coordination and availability of the medical records of the enrollee, including out-patient, in-patient and referral services and significant telephone consultations.
(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:

…

(E) The appropriate functioning of health professionals and other health personnel, including specialists, consultants and referrals.