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

TECHNICAL ASSISTANCE GUIDE

CONTINUITY OF CARE

BEHAVIORAL HEALTH SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this June 18, 2024 Technical Assistance Guide renders all other versions obsolete.

BEHAVIORAL HEALTH TAG

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 providers, specialists, facilities, medical groups, case management staff, etc.)
  - 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
- Provider's office medical records
- Policies and procedures for conducting audits of medical records 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.
- Documentation showing that the Plan promotes a standard of provider communication that adequately communicates its health care treatment recommendations to the enrollee
- Related polices, and procedures for maintaining and coordinating enrollee treatment plans and records

CC-001 - Key Element 1:

1. **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.**
   CA Health and Safety Code section 1367(d); 28 CCR 1300.67.1(c) through (e); 28 CCR 1300.80(b)(4).

Assessment Questions	
1.1	Does the Plan have established medical record documentation standards?
1.2	Does the Plan disseminate those standards to providers (e.g., via provider manual)?
1.3	Does the Plan have an effective medical record audit tool that addresses continuity and coordination of care between and among providers?
1.4	Does the Plan regularly conduct medical record audits?
1.5	Does the Plan implement corrective action and complete follow-up review to address any deficiencies?
1.7	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?
1.8	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?
1.9	Does the Plan have standards for timely evaluation, screening, and diagnosis of patients with ASD, SED, and SMI?

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CC-001 - Key Element 2:

2. 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 1368.016(a)(6); CA Health and Safety Code section 1373.95; CA Health and Safety Code sections 1373.96(a) through (c) and (n)(2).

Assessment Questions	
2.1	Does the Plan have an effective review mechanism for requests of continuity of care with current non-participating provider?
2.2	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?
2.3	Does the Plan have established policies and procedures addressing planned and unplanned terminations of providers from its provider network?
2.4	Do the policies and procedures address all provider types?
2.5	Do the policies and procedures address enrollees receiving treatment for acute or chronic conditions?
2.6	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?
2.7	Do the policies and procedures ensure the Plan gives reasonable consideration to the potential clinical effect of a change of provider on the enrollee's treatment for the condition ?
2.8	Does the policy address situations where an enrollee may be allowed to continue treatment with the previous provider for a specified period of time?
2.9	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?
2.10	Does the Plan have a policy and procedure for block transfer of enrollees (in the event of a medical group termination)?
2.11	When a block transfer is required, does the Plan ensure that disruption in service and care is prevented?
2.12	When a block transfer is required, does the Plan ensure that enrollees are notified in a timely manner?
2.13	When a block transfer is required, does the Plan ensure that transfers are efficient and cause no unnecessary delay?

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CC-001 - Key Element 3:

3. The Plan monitors and evaluates continuity of care that enrollees receive (as part of its QM program activities) and addresses any identified deficiencies. CA Health and Safety Code section 1367(d); 28 CCR 1300.70(a)(1) and (3).

Assessment Questions	
3.1	Does the Plan monitor and evaluate the continuity of care that enrollees receive?
3.2	Does the Plan implement corrective action and follow-up review to address any deficiencies regarding the continuity of care that enrollees receive?
3.3	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 1368.016(a)(6)
(a) A health care service plan that provides coverage for professional mental health services, including a specialized health care service plan that provides coverage for professional mental health services, shall, pursuant to subdivision (f) of Section 1368.015, include on its Internet Web site, or provide a link to, the following information:
…
(6) A detailed description of how an enrollee may request continuity of care pursuant to subdivisions (a) and (b) of Section 1373.95.

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 sections 1373.96(a) through (c) and (n)(2)
(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).
(c) The health care service plan shall provide for the completion of covered services for the following conditions:
(1) 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.
(2)(A) 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 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.
(B) Completion of covered services under subparagraph (A) shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered enrollee.
(3)(A) A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
(B) 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 shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
(4) 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 shall 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.
(5) The care of a newborn child between birth and age 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.
(6) Performance of a surgery or other procedure that is authorized by the plan 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.
...
(n) The following definitions apply for the purposes of this section:
...

(2) “Maternal mental health condition” means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

28 CCR 1300.67.1(c) thought (e)
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:
…
(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)(1)(A) through (G)
(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

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)(1), and (3)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
...
(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.

28 CCR 1300.80(b)(4)
(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.