Policy

Approver Name: Rebecca Stokes, RN **Title**: AVP of Health Care Services **Signature**: 	**Policy No.**: HCS-407 **Policy Title**: Continuity of Care (COC) and Access to Care for New and Existing Members **Department Name**: Health Care Services (HCS) **Effective Date**: 04/03/2017
Approver Name: David Valdez, MD **Title**: CMO **Signature**: 	**Reviewed and Revised Date**: 11/29/2017; 03/21/2018; 01/25/2019; 08/23/2019; 12/04/2019;10/23/2020; 11/03/2021; 08/19/2022, 05/11/2023; 02/01/2024; 04/02/2024; 10/23/2024 **Review Only Date**:
Approval Date: HCSC 01/04/2018; HCSC 03/29/2018; HCSC 02/15/2019 (QIC 11/25/2019); HCSC 08/30/2019; HCSC 12/13/2019 (QIC 01/07/2020) ; HCSC 05/27/2021 (QIC 06/09/2021); HCSC 11/29/2021 (QIC 12/3/2021) HCSC 08/31/2022 (QIC 09/14/2022) HCSC 07/10/2023 (QIC 07/14/2023) HCSC 02/21/2024 (QIHETC 02/28/2024) HCSC 04/25/2024 (QIHETC 05/02/2024) HCSC 11/20/2024 (QIHETC 12/06/2024)	**Supersedes and replaces**: MHT-HCS-UM032 Continuity and Transition of Care & MHT-HCS-LTSS124 Continuity of Care for STAR+PLUS Members; **Date**: 01/04/2018; 02/15/2019

Entity:
☒MHT - Molina Healthcare of Texas, Inc.
☒MHTIC - Molina Healthcare of Texas Insurance Company

Line of Business:
☐All
☒ CHIP
☐Medicare-Medicaid Programs (MMP)
☐Medicare
☒STAR ☒ STAR+PLUS
☐Health Insurance Marketplace
☐Other: _____

I. PURPOSE

The purpose of this policy is to describe how Molina ensures continuity of care (COC) and access to care for all members.

II. POLICY

Molina ensures COC and access to care for members with existing providers, members receiving current treatments, and prior authorized services at the time of enrollment that fall within continuity of care guidelines and regulatory requirements. Molina also provides

coverage for out of network providers, when necessary services are not available within the network.

Molina ensures that all members receive COC for medical, behavioral health, managed long-term services and supports (MLTSS), durable medical equipment (DME), and pharmacy benefits with their existing services as appropriate per regulatory requirements, to ensure care of newly enrolled members is not disrupted or interrupted. Molina ensures that new members maintain current services with their existing providers during the transition period. During this period, Molina contracts with the members' existing out of network provider or if the provider is not willing to accept the agreement, Molina facilitates a safe transition to a network provider.

A. Molina provides continued health care services in accordance with federal and state regulatory requirements for:
    1. New members who are currently under management of a non-contracted provider/facility for an active course of treatment and who are eligible for continuation of coverage as per regulatory requirements.
    2. Existing members who are currently under management of a provider/facility when a contract with Molina terminates or a provider who has changed their provider group(s). Molina assists members with transitioning to another provider as appropriate based on member preference.
    3. New and existing members whose network providers are not located within a reasonable distance from their respective place of residence.
    4. New members who are taking non-formulary drugs or medications that require prior authorization.
B. COC is administered within all applicable benefit limits and requirements.
C. All members are notified of their COC rights in the Molina Member Handbook..
D. With prior authorizations, Molina advises members and providers in advance of receiving care that is not covered at an in-network level.
E. On an ongoing basis and as appropriate, Molina contacts providers not already part of the Molina contracted network with information on becoming credentialed as in-network providers.
F. Members can request to transition to an in-network provider during an active course of treatment per regulatory requirements.

Molina ensures that services are provided in a culturally competent manner and to promote equitable access to all members, including but not limited to the following:

A. Members with limited English proficiency or reading skills.
B. Members of ethnic, cultural, racial, or religious minorities.
C. Members with disabilities.
D. Members who identify as lesbian, gay, bisexual, or other diverse sexual, orientations.
E. *Members who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex.
F. Members living in rural areas and other areas with high levels of deprivation.
G. Members otherwise adversely affected by persistent poverty or inequality.

*Coverage for gender affirming services may vary by state and federal regulations.

III. REFERENCE(S):

HCS-802 TDI Prior Authorization
HCS-809 Medicaid Adverse Determinations
HCS-828 Adverse Determination CHIP
HCS-842 TDI Peer to Peer Review
HCS-909 Confidentiality of Medical Records and HCS Information
HCS-303 Concurrent Review
HCS-325 Medicaid Service Authorization
HCS-352 Member and Practitioner Communication
HCS-391 Non-Participating Provider PA (Prior Auth) Requests
NCQA: Population Health Management (PHM) 5 Case Management Process, Element C Factor 12 Individual case management plan and goals
NCQA: Quality Improvement (QI) 5 Delegation of QI
42 C.F.R § 431.52 Payments for services furnished out of state
42 C.F.R § 435.403 State residence
42 C.F.R. § 438.208(b) & (c)(2)-(4) Coordination and continuity of care
Texas Government Code: Title 4, Subtitle I, Chapter 533 Medicaid Managed Care Program: Sec. 533.0061 Provider Access Standards.
Texas Insurance Code: Title 6, Subtitle C, Chapter 843, Section. 843.151 Rules
HHSC Uniform Manage Care Contract (UMCC): Section 4.3.4 Access to Care; 4.3.6.7 Continuity of Care; 4.3.12 Disease Management (DM)/Health Home Services; 8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.3 Access to Care; 8.1.12.2 Access to Care for MSHCN; 8.2.1 STAR+PLUS Continuity of Care and Out-of-Network Providers; 8.2.1.1 HCBS LTSS Continuity of Care; 8.3.2.6. Transition Plan for New STAR+PLUS Members; 8.3.2.10 Prioritization Plan; 8.4.5 CHIP Continuity of Care and Out-of-Network Providers
Texas Administrative Code: Title 1, Part 15, Chapter 353, Subchapter A, Rule §353.4: Managed Care Organization Requirements Concerning Out-of-Network Provider
Texas Administrative Code: Title 1, Part 15, Chapter 353, Subchapter E, Rule §353.411: Accessibility of Services

Procedure

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I. PURPOSE

The purpose of this procedure is to describe how Molina ensures continuity of care (COC) and access to care for all members.

II. PROCEDURE

Molina Healthcare Services (HCS) Utilization Management (UM) and Service Coordination (SC) and staff provide all members with COC and access to care based on regulatory

requirements. In the case of multiple regulatory entities such as federal and state, HCS staff adhere to the most stringent requirement.

A. If services cannot be provided by a contracted provider, Molina identifies and authorizes services outside of its provider network.

B. Molina provides continued health care services in accordance with federal and state regulatory guidelines for:
    1. New members who are currently under management of a non-contracted provider/facility for an active course of treatment and who are eligible for continuation of coverage.
    2. Existing members who are currently under management of a provider/facility when a contract with Molina terminates, or a provider who has changed their provider group(s). Molina assists members with transitioning to another provider as appropriate based on member preference.
    3. New and existing members whose network providers are not located within a reasonable distance from their respective place of residence.
    4. New members who are taking non-formulary drugs or medications that require prior authorization.

C. Medicaid
    1. Molina provides members who are pregnant access to Network providers for prenatal care. If a member past the 24th week of pregnancy wants to change her OB/GYN to a Molina participating provider, the member will be allowed to do so if the provider to whom the member wishes to transfer agrees to accept the member in the last trimester of pregnancy. Molina will permit pregnant members past the 24th week to remain under the care of their current OB/GYN through the member's postpartum checkup and authorize services, even if the provider is out-of-network.
    2. New members receive COC for:
        a. Active course of treatment with a non-contracted provider for period of time necessary to complete the course of treatment, and arrange a safe transfer to another provider, but not to exceed 90 days from enrollment.
        b. For no more than nine months in the case of a member, who at the time of enrollment in the health plan, has been diagnosed with and is receiving treatment for a terminal illness.
    3. Molina must ensure that the care of newly enrolled members is not disrupted and/or interrupted:
        a. Whose health or behavioral health condition has been treated by specialty care providers or
        b. Whose health could be placed in jeopardy if covered services are not provided. This shall include contacting a member's former managed care organization (MCO) to request information regarding the member's needs, current medical necessity determinations, authorized care and service plans or Individual Service Plans (ISPs).
    4. Molina must respond to requests from other MCOs for information, including but not limited to, information regarding the member's needs, current medical

necessity determinations, authorized care, service plans or ISPs, or other documents pertinent to the health and well-being of a former member.

5. Additionally, Molina must comply with the requirements of 42 C.F.R. § 438.208(b) & (c)(2)-(4), related to coordination and continuity of care.
6. Upon notification from a member or provider of the existence of a prior authorization, Molina must ensure members receiving services through a prior authorization from either another managed care organization (MCO) or fee for service (FFS) Medicaid receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following for acute care services: (1) 90 calendar days after the transition to Molina, (2) until the end of the current authorization period, or (3) until Molina has evaluated and assessed the member and issued or denied a new authorization. For MLTSS, authorizations are honored for 6 months or until the end of current authorizations or Molina assesses the member and issues a denial or new authorization.
7. Molina must provide a transition plan for members enrolled in the STAR+PLUS program. Texas Health and Human Services Commission (HHSC)/previous STAR+PLUS MCO will provide Molina with information such as detailed service plans and names of current providers, for newly enrolled members already receiving long term services and supports (LTSS), including nursing facility (NF) services, Behavioral Health (BH) services, including substance use disorder treatment options, opiate addiction treatment, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) at the time of enrollment with Molina. Molina must ensure that current providers are paid for medically necessary and functionally necessary covered services that are delivered in accordance with the member's existing services and plan of care after the member is enrolled in Molina and until the transition plan is developed.
    a. Within 30 days of receiving notice of member's Molina enrollment, Molina will follow a transition planning process that includes:
        i. Review of any existing service plans;
        ii. Preparation of a transition plan that ensures continuous care under the member's existing HHSC/previous STAR+PLUS MCO service plan while Molina conducts an appropriate assessment and development of a new plan, if needed; and
        iii. If DME or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, Molina will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay; and payment to the existing provider of service under the existing authorization for up to six months, until the Molina has completed the assessment and service plans and issued new authorizations.
    b. The transition plan will remain in place until Molina contacts the member or the member's representative and coordinates modifications to the member's current plan. Molina must ensure existing services continue and that there are no breaks in services. Molina must ensure the member or member's representative is involved in the assessment process and fully

informed about options, is included in the development of the transition plan and is in agreement with the plan when completed.

c. If DME or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, Molina will coordinate and follow through to ensure that the member receives the necessary supportive equipment and supplies without undue delay.

d. Molina will ensure payment to the existing provider of service under the existing authorization for up to six months, until the Molina has completed the assessment and service plans and issued new authorizations.

8. If a member resides in a nursing facility, an assisted living facility, an adult foster care home, or receives supported employment or employment assistance, and the provider is terminated or otherwise leaves the network Molina must notify the member of the upcoming change within ten (10) days of receiving final termination notice from the provider or ten days prior to the Molina's effective date of termination, whichever is earlier.
9. Existing members receive COC through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for chronic or acute medical condition for ongoing qualifying services upon discontinuation of a contract between Molina Healthcare and the member's provider or facility if;
    a. The provider was not discontinued due to quality of care issues;
    b. The provider agrees to provide services to the member;
    c. The provider accepts the regulatory payment rates.
10. HCS staff assists with coordination between Women and Infant and Children (WIC) program and network providers as appropriate.

D. CHIP:

1. New members receive COC for:
    a. Active course of treatment with a non-contracted provider for period of time necessary to complete the course of treatment and arrange a safe transfer to another provider but not to exceed 90 days (3months) from enrollment.
    b. Members past the 24th week of pregnancy while under the care of a non-contracted provider through delivery of the child, postpartum care, and the follow-up checkup within the first six (6) weeks of delivery for safe transfer to another provider.
    c. For no more than nine months in the case of a member, who at the time of enrollment in the health plan, has been diagnosed with and is receiving treatment for a terminal illness. HCS staff assists members with special healthcare needs with coordination between Women and Infant and Children (WIC) program and network providers as appropriate.
2. Molina must ensure that the care of newly enrolled members is not disrupted /interrupted. Upon notification Molina must ensure members receiving services through a prior authorization from another managed care organization (MCO) receive continued authorization of those services for the same amount, duration, and scope for the shortest period of one of the following for acute care services: (1) 90 calendar days after the transition to Molina, (2) until the end of the current

authorization period, or (3) until Molina has evaluated and assessed the member and issued or denied a new authorization.

E. Contracting Arrangement with Providers

1. HCS staff ensures appropriate provider access and a smooth transition for each member utilizing COC for all medical, ancillary, behavioral health, and MLTSS benefits.
2. Providers under contract with Molina are required, in the event of contract termination, to provide continued services to members who retain eligibility with Molina under the terms and conditions of the plan contract or by law of operation. These services are provided at the same compensation rates as prior to contract termination and are maintained at this rate until the services being rendered to the member are completed.
3. Providers who terminate contract agreements with Molina and providers who change provider group affiliation are required to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileges, utilization management, peer review and quality assurance requirements.
4. If a provider refuses to provide services to members under the same terms and conditions of the terminating contract, Molina offers to compensate the provider at rates pursuant to regulatory requirements. In the event that the provider refuses to provide services to members under those terms and conditions, Molina does not provide continued services with that provider beyond the contract termination date.
5. Molina does not provide continued services with any provider who has a contract terminated or not renewed due to medical disciplinary reasons.
6. Non-contracted providers must agree to contract with Molina under the same terms and conditions as outlined within regulatory requirements. If the non-contracted provider does not agree to comply or does not comply with those contractual terms and conditions, Molina only maintains services with providers until a new service provider is obtained.

F. Continuity of care in a nursing facility (NF) or assisted living facility (ALF) when there is a change of ownership (CHOW)

If member resides in a NF or ALF and the provider undergoes a CHOW, Molina must ensure continuity of care such that the care of its enrolled members residing in the NF or ALF that underwent a CHOW is not disrupted or interrupted, and its members continue to receive services authorized prior to the CHOW. Molina must ensure members receiving services through a prior authorization receive continued authorization of those services for the same amount, duration, and scope until the end of the current authorization period, or until Molina has evaluated and assessed the member and issued or denied a new authorization.

G. Notification of Right to COC and Access to Care

Molina provides:

1. Notice to all members of their rights to COC/access to care and rights to receive a copy of this policy including the EOC/Member Handbook, which is mailed to every new member upon enrollment and annually thereafter.
2. Notification to members regarding a provider who is terminating a contract with Molina and corresponding COC/access to care procedures according to regulatory requirements.
3. Notification to members regarding out of network requests for initial and continuing authorizations of covered services following COC/access to care guidelines

H. Requests for COC
   1. Transition and COC access to care information is gathered from a variety of sources, including but not limited to:
      a. Member Enrollment Department
      b. Customer Service Department
      c. Service Coordinator follow-up
      d. Health Risk Assessment (HRA) outreach call
      e. Medical, behavioral health, and MLTSS provider
      f. Member or member's designated representative self-referral
      g. Non-contracted provider on behalf of the member
      h. Utilization and claims data
   2. When COC requests reach Molina Member and Provider Contact Center (MPCC), the staff notifies HCS within one business day of receipt.
   3. The HCS staff documents receipt of the COC in Molina's electronic health management platform.
   4. The designated Molina HCS staff, depending on the line of business, has the primary responsibility for assisting the member and the provider with coordinating services to ensure COC and access to care.
   5. HCS staff ensures that appropriate personnel, including the primary care provider (PCP), other treatment providers, and the interdisciplinary care team (ICT), as applicable, are kept informed of those members that are engaged in Service Coordination.
   6. HCS staff will contact the previous provider for any information required to coordinate continuity of care for the member.
   7. When services are part of a global period (e.g. post hospitalization, outpatient surgery) and are provided by a contracted provider, no authorization is required. HCS staff informs the requestor of these findings.

I. COC Determination:
   1. Molina's Medical Director makes the final COC decision based on the present condition and the potential clinical effect that a change of provider would have on the member's treatment and clinical condition. A final decision may be confirmed after a clinical review, assessment, or a discussion with the PCP, receiving medical group, ICT and other providers involved with the member's care as applicable.
   2. The decision to approve or deny the COC request is made within regulatory timelines. When guidelines are not specified, Molina refers to its guiding

documents for turnaround times. Per applicable regulatory requirements, upon decision Molina may notify the member and treating provider via telephone and/or in writing. A Molina Medical Director is available to discuss the COC medically necessary decision with the member and or treating provider, if requested.

3. HCS staff work in collaboration with the member, member's designated representative, ICT, the member's assigned medical group, and other providers including the non–contracted provider (if applicable), to create and implement an individualized member centric care plan. The collaboration aids the case manager to assure that all health care services are provided in a timely and appropriate manner to the member.
4. The COC plan and the consent with the member are incorporated in the member's ICP and are documented in a Molina electronic health management platform.
5. The HCS staff confirms that the new member's PCP has obtained copies or has access to all available member files and medical records. The staff obtains approval from the new member prior to making copies of any medical records or other confidential information. Molina Healthcare maintains Health Insurance Portability and Accountability Act (HIPAA) compliance with all member records and information.

J. Members Transitioning between Managed Care Organizations (MCO)
When the applicable federal or state agency facilitates standard file formats and data sharing, Molina will ensure the following:

1. Data will be deposited into a centralized repository, accessible to all necessary functional areas.
2. Data may include but is not limited to relevant member clinical information such as existing prior and concurrent authorizations, completed assessments, current care plans.
3. Pharmacy data and claims data for care management review.
4. Data will be shared within required regulatory timeframes.
5. Molina will share relevant and required information with any Contractor or MCO as required via agreed upon information sharing format, which may include data transmission, naming convention and file formats.
6. Molina will generate a High-Risk Member List that becomes the primary means of transferring the case.
7. When Molina is the receiving MCO, Molina staff will review the High-Risk Member List and accompanying clinical documentation, and Molina staff will determine if a warm transfer process is needed, and if so will initiate via Service Coordinator to Service Coordinator contact.
8. In a "warm transfer" situation, the two Service Coordinators will discuss member's unique situation, review the case, discuss a synopsis of the member's status and any recent changes in conditions, and answer the receiving Service Coordinator's questions.
9. If warranted/indicated by member's situations, the two Service Coordinators shall call the member and/or their legal authorized representative together.

10. The two Service Coordinators together shall address all of the member's or legal authorized representative's concerns, discuss the transition process, share contact information, obtain member preferences, and attempt to alleviate any imminent risks.
11. Based upon review of clinical documentation and/or other information, if available, Molina will manage these members as deemed necessary.

III. SCOPE

Healthcare Services (HCS); Chief Medical Officer (CMO) Policy and Benefit; Clinical Management and Policy; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS)

V. DEFINITION(S)

Active Course of Treatment – treatment that meets one of the following criteria:

1. An ongoing course of treatment for:
    a. A life-threatening condition
    b. A serious acute condition; or
    c. A condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes
2. Beginning the 24th week of pregnancy through the postpartum period

Course of Treatment - a prescribed physician order for a specific individual in treatment for a specific condition where treatment was initiated prior to enrollment.

Life-Threatening Condition - a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.

Serious Acute Condition - a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy.

VI. REFERENCE(S):

HCS-802 TDI Prior Authorization
HCS-809 Medicaid Adverse Determinations
HCS-828 Adverse Determination CHIP
HCS-842 TDI Peer to Peer Review
HCS-909 Confidentiality of Medical Records and HCS Information
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Medicaid Uniform Managed Care Contract – Access Standards

Figure: 1 TAC §353.411(a)(1)

Provider Type		Distance in Miles[2]			Travel Time in Minutes		
		Metro County	Micro County	Rural County	Metro County	Micro County	Rural County
Behavioral Health-Outpatient		30	30	75	45	45	90
Hospital- Acute Care		30	30	30	45	45	45
Prenatal		10	20	30	15	30	40
Primary Care Provider[1]		10	20	30	15	30	40
Specialty Care Provider[1]	Cardiovascular Disease	20	35	60	30	50	75
	ENT (otolaryngology)	30	60	75	45	80	90
	General Surgeon	20	35	60	30	50	75
	OB/GYN	30	60	75	45	80	90
	Ophthalmologist	20	35	60	30	50	75
	Orthopedist	20	35	60	30	50	75
	Pediatric Sub-Specialists	20	35	60	30	50	75
	Psychiatrist	30	45	60	45	60	75
	Urologist	30	45	60	45	60	75
Occupational, Physical, or Speech Therapy		30	60	60	45	80	75
Nursing Facility		75	75	75	N/A	N/A	N/A
Main Dentist (general or pediatric)		30	30	75	45	45	90
Dental Specialists	Pediatric Dental	30	30	75	45	45	90
	Endodontist, Periodontist, or Prosthodontist	75	75	75	90	90	90
	Orthodontist	75	75	75	90	90	90
	Oral Surgeons	75	75	75	90	90	90

[1] Services include acute, chronic, preventive, routine, or urgent care for adults and children.

[2] Each Texas county is designated by HHSC as Metro, Micro, or Rural.