

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Continuity of Care	Policy No.: HS-UM08
Department: Utilization Management	
Cross-Functional Departments: Behavioral Health	
Effective Date: 02/2023	Last Revision Date: 04/2025
Director or Officer Signature: Ana Stenersen, RN, BSN Utilization Management Director	Officer Signature: Maya Heinert, MD, MBA, FAAP Chief Medical Officer

I. Purpose

To describe CenCal Health's policy in accordance with the California of Health Care Services (DHCS) All Plan Letter (APL) 23-022, Continuity of Care for Medi-Cal Beneficiaries who recently enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members who transition into CenCal Health on or after January 1, 2023.

II. Policy

- A. Continuity of Care (COC) benefits are available for Members that meet one or more of the following criteria:
 1. Members who are mandatorily transitioning from Medi-Cal Fee-For-Service to enroll as Members in managed care.
 - a. This includes populations transitioning to Managed Care Plans (MCPs) due to applicable Medi-Cal Expansions, as required by Department of Health Care Services (DHCS).
 2. Members who are transitioning from Medi-Cal managed care plans (MCPs) with contracts expiring or terminating to a new MCP on or after January 1, 2023, due to a contract termination or expiration with the DHCS.
 3. Members who are Medi-Cal only beneficiaries.
 4. Members who are dually eligible for Medicare and Medi-Cal.
- B. CenCal Health shall allow Members to request continuity of care in accordance with 42 CFR 438.62 and APL 23-022.
- C. CenCal Health must provide for the completion of Covered Services at the request of a Member in accordance with H&S Code section 1373.96. CenCal Health shall allow the following Members to request COC for up to twelve (12) months after the enrollment date with CenCal Health if a verifiable pre-existing relationship exists with that Provider, regardless of the Member having a condition listed in Cal. H&S Code section 1373.96
 1. Members who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) and enrolling as a Member in CenCal Health; or

2. Members who are transitioning from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023.
- D. CenCal Health will provide COC when the following requirements are met:
1. CenCal Health is able to determine that the Member has a pre-existing relationship with the Provider (i.e., the Member has seen the Provider at least once within twelve (12) months before enrollment with CenCal Health);
 2. The Provider is willing to accept either CenCal Health's contract rates offered in accordance with Cal. H&S Code section 1373.96(d)(2) or (e)(2), or the Medi-Cal FFS rates;
 3. The Provider meets CenCal Health's applicable professional standards and has no disqualifying quality of care issues; and
 4. The Provider is a California State Plan approved Provider.
- E. CenCal Health shall provide COC, for up to 12 months with an Out Of Network (OON) Provider when the following requirements are met:
1. CenCal Health is able to determine that the Member has a pre-existing relationship with the OON Provider (i.e., the Member has seen the OON Provider at least once within twelve (12) months before enrollment with CenCal Health);
 2. The OON Provider is willing to accept either CenCal Health's contract rates offered in accordance with Cal. H&S Code section 1373.96(d)(2) or (e)(2), or the Medi-Cal FFS rates;
 3. The OON Provider meets CenCal Health's applicable professional standards and has no disqualifying quality of care issues; and
 4. The OON Provider is a California State Plan approved Provider.
- F. CenCal Health shall extend COC to primary care Providers, specialists, and select ancillary Providers, including physical therapy; occupational therapy; respiratory therapy; behavioral health therapy; and speech therapy Providers.
- G. CenCal Health shall comply with Cal. H&S Code section 1373.96, which offers additional protections for Members to continue seeing a terminated or non-participating Provider, at a Member's, Authorized Representative's, or Provider's request.
- H. Member and Provider Outreach
1. CenCal Health should inform Members of their COC protections and include information about these protections in Member information packets, handbooks, and on CenCal Health's website. This information shall include how a Member, Authorized Representative, and Provider may initiate a COC request with CenCal Health.

III. Procedure

A. COC Requests

1. CenCal Health shall accept COC requests submitted from the Member, Authorized Representative, or Provider over the telephone, according to the requestor's preference, and does not require the requestor to complete and submit a paper or online form if the requestor prefers to make the request by telephone.
2. To complete a COC request, CenCal Health shall request from an Out-of-Network (OON) Provider all relevant treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulation.
3. CenCal Health may choose to work with the member's OON Provider past the 12-month COC period but is not required to do so to fulfill its obligations.

B. Validating Pre-Existing Provider Relationships

1. CenCal Health shall determine if a pre-existing provider relationship exists by using data provided by DHCS or by an MCP with its contract expiring or terminating, such as Medi-Cal FFS utilization data or claims data from an MCP.
2. CenCal Health shall also accept information provided by the Member, Authorized Representative, or Provider to determine if a pre-existing provider relationship exists.
3. After identification of a pre-existing relationship, CenCal Health shall determine if the Provider is within its network.
 - a. If the Provider is a Network Provider, then CenCal Health shall allow the Member to continue seeing the Provider.
 - b. If the Provider is not a Network Provider, CenCal Health shall 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 COC for the Member.

C. COC Timelines

1. CenCal Health shall begin to process non-urgent requests within five working days following the receipt of the COC request.
2. CenCal Health shall complete the COC request with the following timelines:
 - a. Thirty (30) calendar days for non-urgent requests.
 - b. Fifteen (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 identified risk of harm to the Member).

D. Member Notifications

1. Acknowledgement of COC Requests
 - a. CenCal Health shall provide acknowledgment of the COC request advising the Member that the COC request has been received, the

date of receipt, and the estimated timeframe for resolution within the timeframes below:

- i. For non-urgent requests, within seven (7) calendar days of receipt of the COC request.
 - ii. For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three (3) days of receipt of the COC request.
- b. For COC acknowledgements, CenCal Health shall notify the Member by using the Member's known preference of communication or notify the Member using one of the following methods, in the order listed: telephone call, text message, and then notice by mail.

2. COC Decisions

- a. CenCal Health shall attempt to notify the Member of the COC decision via the Member's preferred method of communication or by telephone.
- b. CenCal Health shall send a notice by mail to the Member within seven (7) calendar days within the COC decision.

E. Denials of COC

1. CenCal Health shall include the following information in the notice to Members of a denied COC decision:
 - a. A statement of CenCal Health's decision.
 - b. A clear and concise explanation of the reason for the denial.
 - c. The Member's right to file a grievance or appeal.
2. CenCal Health shall offer the Member a Network Provider alternative if CenCal Health and the OON Provider are unable to reach an agreement because they cannot agree to a rate, or if CenCal Health has documented quality of care issues with the OON Provider.
 - d. If the Member does not make a choice, the Member must be referred to a Network Provider.
3. If CenCal Health 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, CenCal Health is not required to continue the Provider's services.

F. Approvals of COC

1. CenCal Health shall retroactively approve a COC request and reimburse Providers for services that were already provided if the request meets all COC requirements, including the Provider being willing to accept CenCal Health's contract rates or Medi-Cal FFS rates, and the services that are subject to the retroactive request meet the following requirements:
 - a. Occurred after the Member's enrollment into CenCal Health;

- b. Have dates of service that are within 30 calendar days of the first service for which the Provider requests retroactive reimbursement.
2. CenCal Health shall include the following information in the notice to Members of an approved COC decision:
 - a. A statement of CenCal Health's decision.
 - b. The duration of the COC arrangement.
 - c. The process that will occur to transition the Member's care at the end of the COC period.
 - d. The Member's right to choose a different Network Provider.
3. If a Provider meets all the necessary requirements, including entering into a letter of agreement or contract with CenCal Health, the Member shall have access to that Provider for the length of the COC period, unless the Provider is only willing to work with CenCal Health for a shorter timeframe. In this case, CenCal Health shall allow the Member to have access to that Provider for the shorter period of time.
4. When the COC agreement has been established, CenCal Health shall 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.
5. CenCal Health shall notify the Member thirty (30) calendar days before the end of the COC period or sixty (60) days for CCS Members, using the Member's preferred method of communication, about the process that will occur to transition the Member's care to a Network Provider at the end of the COC period.
 - a. The process includes engaging with the Member and Provider before the end of the COC period to ensure continuity of services through the transition to a new Provider.

G. Referrals to Out of Network (OON) Providers

1. CenCal Health shall 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 CenCal Health.
 - a. In such cases, CenCal Health will make the referral, if Medically Necessary, if CenCal Health does not have an appropriate Provider within its network.

H. COC Period

1. If a Member changes MCP by choice following the initial enrollment in CenCal Health or if a Member loses coverage, then later regains MCP eligibility during the 12-month COC period, the 12-month COC period for a pre-existing Provider may start over one time.

2. If a Member changes health plans or loses coverage and then later regains MCP eligibility a second time (or more), the COC period does not start over, and the Member does not have the right to a new 12-month COC.
 3. If a Member returns to Medi-Cal FFS, if applicable, and later re-enrolls in an MCP, including CenCal Health, the COC period does not start over.
- I. Scheduled Appointments with Specialist
1. CenCal Health shall 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 at the Member's, Authorized Representative's, or Provider's request.
 2. If a Member, Authorized Representative, or Provider requests to keep an authorized and scheduled specialist appointment with an OON Provider that the Member has not seen in the previous 12 months and there is no established relationship with the OON Provider, CenCal Health shall arrange for the Member to keep the appointment or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider.
 3. If CenCal Health is unable to arrange a specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider, CenCal Health shall 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 CenCal Health, it does not establish the requisite pre-existing provider relationship for the Member to submit a COC request.
- J. Prior Treatments Authorizations
1. All Members have the right to continue receiving Medi-Cal services covered under CenCal Health's contract when transitioning to an MCP even in circumstances in which the Member does not continue receiving services from their pre-existing Provider.
 2. CenCal Health must arrange for 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.
 3. When a Member would like their OON Provider to provide a service and they have a pre-existing relationship with the OON Provider, the Member may make a COC request if they are mandatorily transitioning from Medi-Cal FFS to a MCP, transitioning from a MCP with its contract expiring or terminating to a new MCP on or after January 1, 2023, or if the conditions in Cal. H&S Code section 1373.96 are met.
 - a. CenCal Health shall make a good faith effort to enter an agreement if all COC requirements are met.
 4. Following a Member's mandatory transition from Medi-Cal FFS to CenCal Health or from an MCP with its contract expiring or terminating to CenCal Health on or after January 1, 2023:

- a. Active prior treatment authorizations for services remain in effect for ninety (90) days and must be honored by CenCal Health without a request by the Member, Authorized Representative, or Provider;
 - b. CenCal Health shall arrange for 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;
 - c. After ninety (90) days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by CenCal Health, whichever is shorter;
 - d. If CenCal Health does not complete a new assessment, the active treatment authorization remains in effect and after ninety (90) days, CenCal Health may reassess the Member's prior treatment authorization at any time.
 5. CenCal Health shall consider a new assessment complete if the Member has been seen in-person and/or via synchronous telehealth by a Network Provider who 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.
 6. If CenCal Health is reassessing Enhance Care Management (ECM) authorizations after ninety (90) days, CenCal Health must reassess against ECM discontinuation criteria, not the ECM Population of Focus (POF) eligibility criteria. Refer to policy MM-CM121 Enhanced Care Management.
 7. CenCal Health shall use treatment authorization request (TAR) data or prior authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for durable medical equipment and medical supplies.
 - a. CenCal Health shall pay claims for prior authorizations or existing authorizations when data is incomplete.
- K. Durable Medical Equipment (DME)
1. CenCal Health shall allow transitioning Members to keep their existing durable medical equipment (DME) rentals and medical supplies from their existing Provider, under the previous prior authorization for a minimum of ninety (90) days following MCP enrollment and until the new MCP is able to reassess, the new equipment or supplies that are in the possession of the Member, and ready for use.
 2. CenCal Health shall honor the continuity of DME and medical supplies without the request by the Member, Authorized Representative, or Provider.
 3. If the DME or medical supplies have not been delivered, CenCal Health shall allow the delivery and for the Member to keep the equipment or supplies for a minimum of ninety (90) days following MCP enrollment and until the new MCP is able to reassess.

- a. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization.
- b. After (ninety) 90 days, the MCP may reassess the Member's authorization at any time and require the Member to switch to a Network DME Provider.

L. Transportation

1. For Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), CenCal Health shall allow Members to keep the modality of transportation under the previous prior authorization with a Network Provider until a reassessment of the Member's continued transportation needs is made by the new MCP.

M. Mental Health Services

1. CenCal Health shall provide continuity of care with an OON Specialty Mental Health Services (SMHS) Provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the mental health plan and instead becomes eligible to receive non-specialty mental health services (NSMHS) from CenCal Health. In this situation, the COC requirement only applies to psychiatrists and/or mental health provider types that are permitted to provide NSMHS.
2. CenCal Health shall allow, at the request of the Member, Authorized Representative, or Provider, up to twelve (12) months of COC with an OON mental health plan Provider in accordance with the COC requirements.
 - a. After the COC period ends, the Member must choose a mental health Provider within CenCal Health's network for NSMHS.

N. Covered California

1. For Members that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage, the following shall occur:
 - a. If the transition is 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, CenCal Health shall ask these Members if there are upcoming health care appointments or treatments scheduled and assist them accordingly.
 - b. If the Member requests COC, CenCal Health must help initiate the process at that time.
 - c. CenCal Health shall contact the new Member by telephone, letter, or other preferred method of communication, no later than fifteen (15) calendar days after enrollment.
 - d. CenCal Health shall 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 COC.

- e. CenCal Health shall honor any active prior treatment authorization without the request by the Member, Authorized Representative, or Provider, for ninety (90) days for services that are covered under its contract.
- f. CenCal Health shall arrange for 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.
- g. After ninety (90) days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by CenCal Health, whichever is shorter.

O. Pregnant and Post-Partum Members and Newborns

- 1. In accordance with Cal. H&S Code section 1373.96, CenCal Health shall, 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 (12-month post-partum period), and a care of a newborn child between birth and age thirty-six (36) months, by a terminated or non-participating health plan Provider.

P. Terminally Ill Members

- 1. In accordance with Cal. H&S Code section 1373.96, CenCal Health shall, 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. Completion of Covered Services shall be provided for the duration of a terminal illness, even if it exceeds twelve (12) months from the contract termination date or 12 months from the effective date of coverage for a new Member.

Q. Medical Exemption Requests (MERs)

- 1. CenCal Health shall consider Medical Exemption Requests (MERs) that have been denied as automatic COC requests to allow Members to complete courses of treatment with OON Providers in accordance with APL 17-007 or subsequent iterations of this APL.

R. Seniors and Persons with Disabilities (SPD) Members

- 1. For newly enrolled SPD Members who request continuity of care, Contractor must provide continued access for up to 12 months to an Out-of-Network Provider with whom the SPD has an ongoing relationship, as long as Contractor has no Quality of Care issues with the Provider and the Provider will accept either CenCal Health or the Medi-Cal FFS Rates, whichever is higher, pursuant to W&I Code section 14182(b)(13) - (14). CenCal Health shall use Medi-Cal FFS utilization data from DHCS to confirm that the SPD has an ongoing relationship with the Provider.

2. CenCal Health shall allow all Members to request continuity of care in accordance with 42 CFR section 438.62 and APL 18-008.
 3. CenCal Health shall provide for the completion of Covered Services at the request of a Member in accordance with H&S Code section 1373.96. All Members with pre-existing Provider relationships 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:
 - a. The Member has seen the Out-of-Network Provider at least once within the 12 months before Enrollment with Contractor;
 - b. The Out-of-Network Provider accepts Contractor's rate offered in accordance with H&S Code section 1373.96(d)(2) or (e)(2); and
 - c. The Out-of-Network Provider meets Contractor's applicable professional standards and has no disqualifying Quality of Care issues.
- S. Reporting
1. CenCal Health shall continue to report on existing metrics related to any continuity of care provision outlined in state law and regulations, or other state guidance documents.
 2. CenCal Health will utilize continuity of care reports to track continuity of care end period and ensure timely written notification to the member.
- T. Corrective Action
1. DHCS may impose corrective action plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23 012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

IV. Definitions:

Authorized Representative: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis (in the place of the parent) who have the authority under applicable law to make health care decisions on behalf of emancipated minors.

Continuity of Care: Services provided to a Member rendered by an OON Provider with whom the Member has a pre-existing provider relationship.

Contracted or Participating Provider: a provider (individual physician, group, practice, or hospital) that is contracted with CenCal Health.

Covered Services: those health care services, set forth in Cal. W&I Code §§ 14000 et seq. and 14131 et seq., 22 C.C.R. §§ 51301 et seq., 17 C.C.R. §§ 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California § 1115 Medicaid Demonstration Project, the Plan's contract with DHCS, and APLs that are made the responsibility of the Plan pursuant to the California § 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Medically Necessary: reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under Cal. W&I Code § 14059.5(a) and 22 C.C.R. § 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 U.S.C. § 1396d(r)(5), as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. The Plan must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member or Enrollee: means a Potential Member who has enrolled with CenCal Health.

Network Provider: any Provider or entity that has a Network Provider Agreement with CenCal Health, CenCal Health's subcontractor, or CenCal Health's downstream subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the 2024 Medi-Cal Managed Care Agreement. A Network Provider is not a subcontractor or downstream subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: a written agreement between a Network Provider and CenCal Health, Subcontractor, or Downstream Subcontractor.

Provider: 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.

Risk of Harm: imminent and serious threat to the health of the Member.

Service Area: the county or counties that the Plan is approved to operate in under the terms of its contract with DHCS. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Terminating Provider: a provider (individual physician, group practice, or hospital) that is contracted with CenCal Health and is terminating their contract; or a provider whose contract is terminated by CenCal Health.

V. References:

- A. California Health & Safety Code 1373.96
- B. 42 CFR 438.62
- C. 2024-C DHCS Medi-Cal Contract Exhibit A, Attachment III, Section 5.2.12
Continuity of Care for Seniors and Persons with Disabilities
- D. APL 23-022: 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

VI. Cross Reference:

A. Policy and Procedures (P&P):

1. HS-CM25: Enhanced Care Management
2. HS-BH05: Mental Health Services

VII. Attachments: N/A

Utilization Management

Internal and External Oversight	
Line of Business (LOB): Medi-Cal ☒ Dual Special Needs Plan (D-SNP) ☐ N/A ☐	
Regulatory Oversight: CMS ☐ DHCS ☒ DMHC ☐ N/A ☐	
Required for NCQA Accreditation: No ☒ Yes ☐	
Committee Oversight: ☐ Anti-Fraud Committee (AFC) ☐ Board of Directors (BOD) ☐ Community Advisory Board (CAB) ☐ Customer Experience Committee (CEC) ☒ Compliance Committee (CC) ☐ Delegation Oversight Committee (DOC) ☐ Member Support Committee (MSC) ☐ Network Management Committee (NMC) ☐ Provider Review and Credentialing Committee (PRCC) ☐ Pharmacy and Therapeutics Committee (P&TC) ☐ Quality Improvement and Health Equity Committee (QIHEC) ☒ Utilization Management Committee (UMC) ☐ N/A	

Revision History					
P&P Revision Date	Leader Review and Approval	Reason for Revisions	Revision Effective Date	Regulatory Approval Date	Compliance Committee Approval Date
05/2025	Ana Stenersen, Utilization Management Director Maya Heinert, MD, MBA, FAAP Chief Medical Officer	DSNP Annual Review changed Numbering from MM-UM08 to current	08/2025	N/A	10/2025

11/2024	Chris Hill, MBA, BS, RN Health Services Officer; Sue Fischer, RN, MA Director of Medical Manageme nt	Annual P&P Review	01/2025	N/A	MM/YYYY
10/2023	Christopher Hill, RN, MBA, Health Services Officer	2024 Template Migration	02/2023	N/A	
02/2023	Ana Stenersen Rita Washington Christopher Hill	Requireme nts and 2024 DHCS Medi-Cal Managed Care Agreemen t. Will replace current version of MM-UM-08.	02/2023	2023	
02/2021	Medical Managem ent Director	Revised to include MOT Revisions	02/2022	2021	

10/2022	Medical Managem ent Director	Revised to address CAP. Approved via the closure of CAP on 12/12/22	02/2022	12/2022	
08/2017	Medical Managem ent Director	P&P Established	08/2017	N/A	