State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: December 24, 2013

ALL PLAN LETTER 13-023

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL BENEFICIARIES WHO TRANSITION FROM FEE-FOR-SERVICE MEDI-CAL INTO MEDI-CAL MANAGED CARE

PURPOSE:
The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to set forth continuity of care requirements for Medi-Cal beneficiaries who transition from Medi-Cal Fee-for-Service (FFS) into Medi-Cal managed care. Continuity of care provisions related to dual eligible beneficiaries (beneficiaries eligible for Medi-Cal and Medicare) can be found in Duals Plan Letter 13-005 at the following link: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf

POLICY:
Medi-Cal beneficiaries assigned a mandatory aid code that are transitioning from Medi-Cal FFS into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with State law and MCP managed care contracts with some exceptions. All MCP beneficiaries with pre-existing provider relationships who make a continuity of care request to the MCP must be given the option to continue treatment for up 12 months with an out of network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they had been receiving through Medi-Cal FFS or through another managed care program.

MCPs must provide continuity of care with an out-of-network provider when:

1. The MCP is able to determine that the beneficiary has an ongoing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
2. The provider is willing to accept the higher of MCP's contract rates or Medi-Cal FFS rates; and
3. The provider meets the MCP's applicable professional standards and has no disqualifying quality-of-care issues.

An existing relationship means the beneficiary has seen an out-of-network primary care or specialist provider at least once during the 12 months prior to the date of his or her initial enrollment in the MCP for a non-emergency visit.

Under these circumstances, a quality-of-care issue means an MCP can document its concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other MCP beneficiaries.

An MCP is not required to provide continuity of care for services not covered by Medi-Cal. In addition, protections do not extend to these providers: durable medical equipment, transportation, other ancillary services, or carved-out services.

If a beneficiary changes MCPs, the continuity of care period may start over one time. If the beneficiary changes MCPs a second time (or more), the continuity of care period does not start over meaning that the beneficiary does not have the right to a new twelve months of continuity of care. If the beneficiary returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a beneficiary changes MCPs, this continuity of care policy does not extend to in-network providers that the beneficiary accessed through their previous MCP.

MCP Processes

Beneficiaries may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days after receipt of the request. The continuity of care process begins when the MCP determines there is a pre-existing relationship and has entered into an agreement with the provider.

The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data. A beneficiary or his or her provider may also provide information to the MCP which demonstrates a pre-existing relationship with a provider. A beneficiary may not attest to a pre-existing relationship (instead actual documentation must be provided) unless the MCP makes this option available to him or her.

Following identification of a pre-existing relationship, the MCP must determine if the provider is an in-network provider. If the provider is not an in-network provider, the MCP must 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 a continuity of care relationship for the beneficiary.

Each beneficiary continuity of care request must be completed within 30 calendar days from the date the MCP received the request, or sooner if the beneficiary's medical

condition requires more immediate attention. A continuity of care request is considered completed when: the beneficiary is informed of his or her right of continued access or if the MCP and the out-of-network FFS provider are unable to agree to a rate, the MCP has documented quality-of-care issues, or the MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

If an MCP and the out-of-network FFS provider are unable to reach an agreement because they cannot agree to a rate or the MCP has documented quality-of-care issues with the provider, the MCP will offer the beneficiary an in-network alternative. If the beneficiary does not make a choice, the beneficiary will be assigned to an in-network provider. Beneficiaries maintain the right to pursue an appeal through the Medi-Cal processes.

If a provider meets all of the necessary requirements including agreeing to a letter of agreement or contract with the MCP, the MCP must allow the beneficiary to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP must allow the beneficiary to have access to that provider for the shorter period of time.

At any time, beneficiaries may change their provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the MCP must work with the provider to establish a care plan for the beneficiary.

MCP Extended Continuity of Care Option
Each MCP may choose to work with the beneficiary's out-of-network doctor past the 12-month continuity of care period, but the MCP is not required to do so.

Beneficiary and Provider Outreach and Education
MCPs must inform beneficiaries of their continuity of care protections and must include information about them in beneficiary information packets and handbooks. This information must include how the beneficiary and provider initiate a continuity of care request with the MCP. These documents must be translated into threshold languages and must be made available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with beneficiaries about beneficiary continuity of care protections.

Provider Referral Outside of the MCP Network
An approved out-of-network provider must work with the MCP and its contracted network and cannot refer the beneficiary to another out-of-network provider without

authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary and if the MCP does not have an appropriate provider within its network.

OUTPATIENT MENTAL HEALTH SERVICES:
Effective January 1, 2014, as established in W&I Code Sections (§§) 14132.03 and 14189, MCPs are required to cover certain outpatient mental health services to beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health diagnosis, as defined in the current Diagnostic and Statistical Manual, except relational problems (i.e., couples counseling or family counseling for relational problems).

These MCP beneficiaries may request continued access to out-of-network Medi-Cal FFS providers for up to 12 months under the provisions of this APL beginning January 1, 2014.

LOW INCOME HEALTH PROGRAM:
Under the Special Terms and Conditions (STCs) of the under the State's Section 1115 Medicaid Demonstration Waiver, "A Bridge to Reform," DHCS will transition approximately 600,000 Low Income Health Program (LIHP) beneficiaries into Medi-Cal MCPs on January 1, 2014. Former LIHP beneficiaries can request continued access to out-of-network Medi-Cal FFS providers for up to 12 months. For these former LIHP beneficiaries, the 12-month timeframe begins on January 1, 2014, regardless of when the request is made in 2014.

These MCP beneficiaries may request continued access to out-of-network providers under the provisions of this APL beginning January 1, 2014.

DHCS has provided LIHP medical home information to MCPs for their assigned LIHP beneficiaries. Furthermore, DHCS has auto-assigned beneficiaries to MCPs that contract with their LIHP primary care provider (PCP) whenever possible. MCPs must assign transition beneficiaries to their LIHP PCP according to the LIHP data provided by DHCS.

EXISITING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:
In addition to the protections set forth above, MCP beneficiaries also have rights to protections set forth in current state law pertaining to continuity of care. In accordance with W&I Code §14185(b), MCPs must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or

non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the contracting physician.

Additional requirements pertaining to continuity of care are set forth in Health and Safety (H&S) Code § 1373.96 and require all health plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under this Section, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment. MCPs must allow for the completion of these services for certain timeframes which are specific to each condition and defined under H&S Code § 1373.96.

MEDICAL EXEMPTION REQUESTS:
A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the Medi-Cal beneficiary's medical condition has stabilized to a level that would enable the beneficiary to transfer to an MCP provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to beneficiaries transitioning from Medi-Cal FFS to an MCP. A MER should not be used to preserve continuity of care with a Medi-Cal FFS provider. MCPs are required to consider MERs that have been clinically denied as an automatic continuity of care request to allow the beneficiary to complete a course of treatment with a Medi-Cal FFS provider in accordance with APL 13-013.

REPORTING:
MCPs may be required to report on metrics related to any continuity of care provisions outlined in this APL, state law and regulations, or other State guidance documents at any time and in a manner determined by DHCS.

If you have any questions regarding this APL, please contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems