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

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

Date:

MMCD Duals Plan Letter 13-XXX

To: ALL MEDI-CAL MANAGED CARE PLANS PARTICIPATING IN CAL MEDICONNECT

Subject: CONTINUITY OF CARE

Purpose
The purpose of this Duals Plan Letter (DPL) is to clarify and provide guidance about continuity of care provided by Medicare and Medi-Cal Managed Care Plans (MMPs) that are participating in the Duals Demonstration Project, called "Cal MediConnect."

Background
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities through shifting service delivery away from institutional care to home- and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a Duals Demonstration, called "Cal MediConnect." It will be implemented no sooner than April 1, 2014, in the following eight counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Alameda, Santa Clara, and San Mateo. It will serve beneficiaries who are both Medi-Cal and Medicare eligible (dual-eligible beneficiaries). Cal MediConnect will combine the full continuum of acute, primary, institutional, and home- and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by MMPs. Dual-eligible beneficiaries will be notified of their right to select a Participating Plan no fewer than sixty (60) days prior to the effective date of enrollment and will receive a notice regarding implementation of the program ninety (90) days prior. When no active choice has been made, enrollment into an MMP may be conducted using a seamless, passive enrollment process that provides the opportunity for beneficiaries to make a voluntary choice to enroll or disenroll from the Participating Plan at any time. Beneficiaries who chose to disenroll will still receive their Medi-Cal services from a Medi-Cal managed care plan.

Continuity of care requirements for Cal MediConnect are defined at Welfare and Institutions (W&I) Code §14182.17. These requirements are also set forth in the Memorandum of

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Understanding (MOU) between CMS and the Department of Health Care Services (DHCS) which establishes the following requirements:

- CMS and California will require MMPs to ensure that beneficiaries continue to have access to medically necessary items, services, and medical and long-term service and support providers.
- The State will require participating MMPs to follow continuity of care requirements established in current law.
- As part of a process to ensure that continuity of care and coordination of care requirements are met, MMPs must perform an assessment process within 90 days of a beneficiary's enrollment in the participating Plan. A plan's inability to fulfill this requirement for any particular beneficiary has no impact on that beneficiary's right to be notified of and receive continuity of care protections.
- Upon beneficiary request, MMPs must allow beneficiaries to maintain their current providers -- including, for example, physicians, specialists, surgeons, podiatrists, clinical psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, dentists, physician assistants, or chiropractors -- and service authorizations at the time of enrollment for:
  - A period up to 6 months for Medicare services if ~~all of the following~~ criteria are met under W&I Code §14132.275(k)(2)(A):
  - A period of up to 12 months for Medi-Cal services if ~~all of the following~~ criteria are met under W&I Code §14182.17(d)(5)(G).
- Part D transition rules and rights will continue as provided for in current law and regulation for the entire integrated formulary associated with the MMP.

Also consistent with the provisions of the MOU, the following exceptions are allowable:

An MMP is not required to provide continuity of care for services not covered by Medi-Cal or Medicare. In addition, the following providers are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services.

MMPs may choose to not provide continuity of care with an out-of-network provider when:

- ~~The ability to~~There is no demonstration~~e~~ of an existing relationship between the beneficiary and provider ~~does not occur~~,
- The provider is not willing to accept payment from the MMP based on the current Medicare or Medi-Cal fee schedule, as applicable, ~~and~~ or

Comment [A1]: The criteria does not follow.

Comment [A2]: "Ancillary services" needs to be defined.

Comment [A3]: We would prefer "and" but under the current rules it is "or"

- The MMP would otherwise exclude the provider from its provider network due to documented quality of care concerns.

Under these circumstances, a quality-of-care issue means an MMP 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 MMP beneficiaries.

Cal MediConnect Continuity of Care Requirements

Continuity of Care - Provider Relationships
MMPs are required to offer continuity of care to all Cal MediConnect beneficiaries who have an existing relationship with a primary or specialty care provider with some exceptions. An existing relationship means the beneficiary has seen an out-of-network primary care provider at least once or specialty care provider at least twice during the twelve months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit.

All Cal MediConnect beneficiaries with pre-existing provider relationships who make a continuity of care request to the plan must be given the option to continue treatment for up to six months with an out of network Medicare provider and twelve months with an out of network Medi-Cal provider.

If a beneficiary changes MMPs, the continuity of care period may start over one time. If the beneficiary changes MMPs 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 six or twelve months depending on the type of provider. If the beneficiary returns to Fee-for-Service (FFS) Medi-Cal and later reenrolls in Cal MediConnect, the continuity of care period does not start over

Continuity of Care - Services
MMPs are required to offer continuity of care of covered services a Cal MediConnect beneficiary was receiving prior to enrollment in the MMP for the applicable six-month and twelve-month continuity of care periods.

Existing Continuity of Care Provisions under California State Law
Under the Knox Keene Act, beneficiaries also have the right to continue receiving services in certain circumstances in addition to the six month and twelve month continuity of care periods established for Cal MediConnect beneficiaries. California Health and Safety (H&S) Code §1373.96 requires all Knox-Keene licensed health plans 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

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Comment [A4]: We believe that the standard for establishing an existing relationship should be the same for specialty and primary care providers and mirror the standard outlined in the SPD transition. See our attached comments.

Comment [A5]: The COC periods should be available anytime a beneficiary transitions from plan to plan or from FFS to a plan. See our attached comments. For example, a beneficiary could enter a plan, switch plans, and then years later rejoin Cal MediConnect. Continuity of care should be afforded when this beneficiary transitions back into Cal MediConnect.

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other procedures that were previously authorized as a part of a documented course of treatment. Health plans 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 (Attachment 1).

Comment [A6]: Need to clarify certain sections of this Attachment 1- see our attached comments.

MMP Processes

Beneficiaries may make a direct request to an MMP for continuity of care. When this occurs, the MMP must begin to process the request within five working days after receipt of the request. The MMP should determine if a relationship exists through use of data provided by CMS and DHCS to the MMP, such as FFS utilization data from Medicare or Medicaid. A beneficiary or his or her provider may also provide information to the MMP 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 OR the relationship is determined through existing Medicare and Medi-Cal utilization data) unless the MMP makes this option available to him or her.

Following identification of a pre-existing relationship, the MMP must determine if the provider is an in network provider. If the provider is not an in network provider, the MMP 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 MMP received the request, or sooner if the beneficiary's medical condition requires more immediate attention.

Comment [A7]: This process should be more automatic and streamlined - we have provided recommendations in our attached comments.

If a MMP and the out-of-network FFS provider are unable to reach an agreement because they cannot agree to a rate or the MMP has documented quality-of-care issues with the provider, the MMP will offer the beneficiary an in-network alternative and inform the beneficairy of the MMP's procedures for obtaining an out-of-network referral. 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 Medicare and Medi-Cal processes.

If a provider meets all of the necessary requirements including agreeing to a letter of agreement or contract with the MMP, the MMP 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 MMP for a shorter timeframe. In this case, the MMP 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 MMP must work with the provider to establish a care plan for the beneficiary.

MMP Extended Continuity of Care Option
Each MMP may choose to work with the beneficiary's out-of-network doctor past the applicable- 6-month or 12-month continuity of care period, but the MMP is not required to do so.

Beneficiary and Provider Outreach and Education
MMPs must inform beneficiaries of their continuity of care protections and must include information about them in beneficiary information packets and handbooks. These documents must be translated into threshold languages and made available in alternative formats such as Braille, large-font print, and electronic formats. MMPs 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 MMP Network
An approved out-of-network provider must work with the MMP and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from the MMP. In such cases, the MMP will make the referral, if medically necessary and if the MMP does not have an appropriate provider within its network.

Durable Medical Equipment
For DME, MMPs must provide continuity of care for services, but not providers, for the applicable six- or twelve-months.

Nursing Facilities
Enrollees who have been in a nursing facility for 6 months or longer prior to enrollment will not be required to change NF facilities during the duration of the Demonstration if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and plan agree to Medi-Cal rates in accordance with the three-way contract. If a beneficiary has resided in a facility for fewer than 6 months, the beneficiary has the right to continue to reside in the facility for the 12-month continuity of care period, provided that the nursing facility meets acceptable quality standards and the facility accepts the plan's rate.

Prescription Drugs
Beneficiaries can continue to receive Part D Medicare covered prescription drugs pursuant to Part D transition rules. For prescription drugs covered by Medi-Cal, in accordance with W&I Code §14185(b), MMPs 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 Plan, until a doctor makes a determination that the prescribed therapy is no longer needed. Moreover, under Welfare & Institutions Code § 14182(b)(22), dual

Comment [A8]: COC protections should also apply to providers. See our attached comments.

Comment [A9]: We believe that this protection should apply to anyone residing in a facility at the time of enrollment (not limited to those residing in a facility for fewer than six months).

Comment [A10]: As stated above, we believe all facility residents regardless of length of time residing in the facility should be permitted to stay in the facility for the duration of the demonstration.

eligibles who join a Cal MediConnect plan are entitled to additional protections to ensure that they have continued access to prescription medications. They are entitled to a 30-day authorization to continue any prescription drugs if their request for an exemption for mandatory enrollment in managed care is denied. Health plans must fill any prescriptions for a new or refilled drug prescribed by a transitioning enrollee's current provider if it is on the health plan's formulary. If a the enrollee's current provider prescribes a new drug that is not on the plan's formulary, the plan must notify the pharmacist that prior authorization is required, and it must make a decision whether to fill the prescription within 24-hours based upon medical justification provided by the prescribing doctor. If the enrollee's current provider prescribes a non-formulary medication refill as part of ongoing treatment, the plan must cover the drug while it makes a determination of whether the drug is medically necessary, and until it notifies the enrollee's doctor of its decision and develops a care plan with the doctor based on the enrollees' medical needs.

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~~**Existing Continuity of Care Provisions under California State Law**~~

~~In addition to the protections set forth above, Cal MediConnect 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), MMPs 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 Plan, 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. Health plans 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.~~

If you have any questions regarding this APL, please contact Sarah Brooks, Branch Chief, at sarah.brooks@dhcs.ca.gov.

Sincerely,

Margaret Tatar, Chief
Medi-Cal Managed Care Division

Attachment

Attachment 1: Continuity of Care Requirements

H&S Code: Standards
§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).

(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 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. 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.

(3) 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.

(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.

Comment [A11]: this makes sense for terminated providers but not for new enrollees - clarification should be included in the APL.

(d) (1) The plan may require the terminated provider whose services are continued beyond the contract termination date pursuant to this section 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 privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services beyond the contract termination date.

(2) Unless otherwise agreed by the terminated provider and the plan or by the individual provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. Neither the plan nor the provider group is required to

continue the services of a terminated provider if the provider does not accept the payment rates provided for in this paragraph.

(e) (1) The plan may require a nonparticipating provider whose services are continued pursuant to this section for a newly covered enrollee to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the nonparticipating provider does not agree to comply or does not comply with these contractual terms and conditions, the plan is not required to continue the provider's services.

(2) Unless otherwise agreed upon by the nonparticipating provider and the plan or by the nonparticipating provider and the provider group, the services rendered pursuant to this section shall be compensated at rates and methods of payment similar to those used by the plan or the provider group for currently contracting providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the nonparticipating provider. Neither the plan nor the provider group is required to continue the services of a nonparticipating provider if the provider does not accept the payment rates provided for in this paragraph.

(f) The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of completion of covered services with a terminated provider or a nonparticipating provider are the same as would be paid by the enrollee if receiving care from a provider currently contracting with or employed by the plan.

(g) If a plan delegates the responsibility of complying with this section to a provider group, the plan shall ensure that the requirements of this section are met.

(h) This section shall not require a plan to provide for completion of covered services by a provider whose contract with the plan or provider group has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Profession Code, or fraud or other criminal activity.

(i) This section shall not require a plan to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract. This section shall not apply to a newly covered enrollee covered under an individual subscriber agreement who is undergoing a course of treatment on the effective date of his or her coverage for a condition described in subdivision (c).

(j) This section shall not apply to a newly covered enrollee who is offered an out-of-network option or to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

(k) The provisions contained in this section are in addition to any other responsibilities of a health care service plan to provide continuity of care pursuant to this chapter. Nothing in this section shall preclude a plan from providing continuity of care beyond the requirements of this section.

(l) The following definitions apply for the purposes of this section:

(1) "Individual provider" means a person who is a licentiate, as defined in Section 805 of the Business and Professions Code, or a person licensed under Chapter 2 (commencing with Section 1000) of Division 2 of the Business and Professions Code.

(2) "Nonparticipating provider" means a provider who is not contracted with a health care service plan.

(3) "Provider" shall have the same meaning as set forth in subdivision (i) of Section 1345.

(4) "Provider group" means a medical group, independent practice association, or any other similar organization.

Comment [A12]: This should refer to Medicare or Medi-Cal rates - clarification should be put in the APL.

Comment [A13]: This would eliminate these protections for Cal MediConnect participants since participation in Cal MediConnect is voluntary and beneficiaries have the option of staying in FFS Medicare to continue seeing their doctor. Clarification should be put in the APL that these protection do apply to Cal MediConnect and that (j) is not applicable.