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**DATE:** July 5, 2016

*REVISED* DUALS PLAN LETTER 16-002  
SUPERSEDES DUALS PLAN LETTER 15-003

**TO:** CAL MEDICCONNECT MEDICARE-MEDICAID PLANS

**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-Medicaid Plans (MMPs) that are participating in the Duals Demonstration Project, called Cal MediConnect. *Revisions to the previously released April 11, 2016 version of this DPL are reflected in italics and strike-out for ease of reference.*

**BACKGROUND:**

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs) by shifting service delivery away from institutional care to home and community-based settings. To implement this goal, the Legislature passed and Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 37, Statutes of 2013), which authorized the implementation of the Coordinated Care Initiative (CCI).

The three major components of CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for Duals (individuals eligible for Medicare and Medicaid) that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for Duals; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD Duals.

The seven CCI counties participating in Cal MediConnect are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Cal MediConnect is a voluntary program; however, those Duals who opt-out of Cal MediConnect must still enroll in a Medi-Cal managed care health plan (MCP) for their Medi-Cal benefits

(including Duals who are enrolled in a Medicare Advantage [MA] plan). Full-benefit Duals enrolled in an MCP for their Medi-Cal benefits and who opt-out of Cal MediConnect, or are not eligible for Cal MediConnect, will continue to receive their Medicare services either through Medicare fee-for-service (FFS) or an MA plan.

Continuity of care requirements for Cal MediConnect are defined in Welfare and Institutions (W&I) Code, Sections (§§) 14182.17 and 14132.275. These requirements are also set forth in the three-way contract<sup>1</sup> (contract) between the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the MMPs. The contract establishes the following requirements:

- CMS and DHCS require each MMP to ensure that beneficiaries continue to have access to medically necessary items and services, as well as medical and LTSS providers;
- DHCS requires each participating MMP to follow continuity of care requirements established in current law;
- As part of the process to ensure that continuity of care and coordination of care requirements are met, MMPs must perform Health Risk Assessments (HRA) within the timeframes specified in DPL 15-005.<sup>2</sup> As part of the HRA, MMPs must ask beneficiaries if there are upcoming health care appointments or treatments scheduled and assist them in initiating the continuity of care process at that time if they choose to do so;
- Upon beneficiary request, MMPs must allow beneficiaries to continue receiving services from out-of-network providers for primary and specialty care services and maintain their current providers and service authorizations at the time of enrollment for:
  - Pursuant to contract section 2.8.4.1.1, a period up to six months for Medicare services if the criteria are met under W&I Code §14132.275(l)(2)(A); and
  - Pursuant to contract section 2.8.4.1.2, a period of up to 12 months for Medi-Cal services if the criteria are met under W&I Code §14182.17(d)(5)(G).
- Medicare Part D transition rules and rights will continue as provided in current law and regulation for the entire integrated formulary associated with the MMP.

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<sup>1</sup> The three-way contract between CMS, DHCS, and the MMP is available at:

<http://www.calduals.org/implementation/cci-documents/cci-fact-sheets/contracts-mous/>.

<sup>2</sup> DPL 15-005 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-005.pdf>.

**CAL MEDICONECT PROVIDER CONTINUITY OF CARE REQUIREMENTS:**

*Effective October 1, 2016*, MMPs must attempt to determine if beneficiaries have pre-existing provider relationships through previous utilization data, the HRA process, and, as needed, contact with the beneficiary and/or their providers.

Upon beneficiary request, or other authorized person as noted below, MMPs must offer continuity of care with out-of-network providers to all Cal MediConnect beneficiaries if all of the following circumstances exist:

- A beneficiary has an existing relationship with a primary or specialty care provider. An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) *or a specialty care provider* at least once ~~or a specialty care provider at least twice~~ during the 12 months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit;
- The provider is willing to accept, at a minimum, payment from the MMP based on the current Medicare or Medi-Cal fee schedule, as applicable; and
- The provider does not have any documented quality of care concerns that would cause the MMP to exclude the provider from its network.

Continuity of care policies apply regardless of whether a beneficiary voluntarily joins or passively enrolls in an MMP (e.g., if a beneficiary opted out of Cal MediConnect and later decided to join an MMP). If a beneficiary opts out or disenrolls from Cal MediConnect and later reenrolls in Cal MediConnect, the beneficiary has the right to a ~~six~~ 12 month continuity of care period, regardless of whether the beneficiary received continuity of care in the past.

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~~ 12 month period. If a beneficiary changes MMPs, this continuity of care policy does not extend to the providers in the previous MMP's network, who now may be out-of-network providers in the new MMP.

Consistent with the provisions of the contract, MMPs are not required to provide continuity of care with an out-of-network provider if any of the following circumstances exist:

- The services are not covered by Medi-Cal or Medicare;
- The providers are providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services (however, CMS and DHCS require each MMP to ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers as noted in the "Background" section above in this DPL); and/or

- The provider does not agree to abide by the MMP's utilization management policies or a reimbursement rate as defined above.

#### Requirements for Delegated Entities

- When a beneficiary transitions into an MMP, and has an existing relationship with a PCP that is in the MMP's network, as determined through 1) the HRA process; 2) review of prior utilization data; or 3) beneficiary request, the MMP must assign the beneficiary to the PCP, unless the beneficiary chooses a different PCP. If the MMP contracts with delegated entities, it must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network;
- As a reminder, when a beneficiary transitions into an MMP, has an existing relationship with a PCP and/or specialist that is in the MMP's network, and he or she wishes to continue to see these providers, the MMP must allow the beneficiary to continue treatment with these providers for the continuity of care period. This is regardless of whether these providers are, or are not, in the network of the prime plan's delegated entity to which the beneficiary is assigned, as long as the continuity of care requirements are met. For example, if a beneficiary has an existing relationship with a PCP and a specialist with the assigned Independent Physicians Association #1 (IPA #1) as well as a specialist in another IPA (IPA #2), where both IPAs are delegated entities of the same MMP, the MMP must assign the beneficiary to IPA #1 and allow the beneficiary to continue treatment with both specialists. The continuity of care agreement for the specialist in IPA #2 would last for ~~up to six months for Medicare services and~~ up to 12 months for *both Medicare and/or Medi-Cal services*.

#### Procedures for Requesting Continuity of Care

Beneficiaries, their authorized representatives on file with Medi-Cal, or their providers, may make a direct request to an MMP for continuity of care. Only those providers who treat beneficiaries, who are eligible for continuity of care, as noted above, may make a request to the MMP for continuity of care.

MMPs must, at a minimum, accept requests for continuity of care over the telephone, according to the requestor's preference, and cannot require the requester to complete and submit a paper or computer form. To complete a telephone request, the MMP may take any necessary information from the requester over the telephone.

MMPs must accept and approve retroactive requests for continuity of care and claim payments that meet all continuity of care requirements noted above, with the exception of the requirement to abide by the MMP's utilization management policies. The services that are the subject of the request must have occurred after the beneficiary's enrollment into the MMP, and the MMP must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider prior to the beneficiary's

enrollment into the MMP. MMPs must approve any retroactive requests that meet the following requirements:

- Have dates of services that occur after September 29, 2014;
- Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
- Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted. The MMP must accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare FFS claim), an MA plan, or the prime plan instead of the delegated IPA.

When a request for continuity of care is made, the MMP must begin to process the request within five working days after receipt of the request. However, as noted below, the request must be completed in three days if there is a risk of harm to the beneficiary. The continuity of care process begins when the MMP starts the process to determine if there is a pre-existing relationship and enters into an agreement with the provider.

The MMP should determine if a relationship exists through use of data provided to the MMP by CMS and DHCS, such as FFS utilization data from Medicare or Medi-Cal. A beneficiary or his or her provider may also provide information to the MMP that 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 MMP makes this option available to him or her.

Following identification of a pre-existing relationship, 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.

#### Request Completion Timeline

Each continuity of care request must be completed within:

- 30 calendar days from the date the MMP receives the request;
- 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three calendar days if there is risk of harm to the beneficiary.

A continuity of care request is considered completed when:

- The beneficiary is informed of his or her right to continued access or if the MMP and the out-of-network FFS or prior plan provider are unable to agree to a rate;
- The MMP has documented quality of care issues; or
- The MMP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

#### Requirements after the Request Process is Completed

If an MMP and the out-of-network FFS or prior plan 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. 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 or grievance through the Medicare and Medi-Cal processes.

If a provider meets all of the necessary requirements, including entering into a contract, letter of agreement, single-case agreement, or other form of relationship 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, a beneficiary may change providers 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.

Upon completion of a continuity of care request, MMPs must notify beneficiaries of the following within seven calendar days:

- The request approval or denial, and if denied, the beneficiary's appeal and grievance rights;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the beneficiary's care at the end of the continuity of care period; and
- The beneficiary's right to choose a different provider from the MMP's provider network.

MMPs must also notify beneficiaries 30 calendar days before the end of the continuity of care period about the process that will occur to transition the beneficiary's care at the end of the continuity of care period. This process must include engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

#### MMP Extended Continuity of Care Option

MMPs may choose to work with a beneficiary's out-of-network provider past the ~~six~~ or 12 month continuity of care period, but MMPs are not required to do so.

#### Beneficiary and Provider Outreach and Education

MMPs must inform beneficiaries, or their authorized representatives, of continuity of care protections within 30 days of beneficiary enrollment, and must include information about these protections in information packets and handbooks. This information must include how a beneficiary and provider initiate a continuity of care request with the MMP. These documents must be translated into threshold languages and must be made available in alternative formats, upon request. MMPs must provide training to call center and other staff who come into regular contact with beneficiaries about the 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, if the MMP does not have an appropriate provider within its network.

#### DME, Transportation, and Other Ancillary Services

For DME, transportation and other ancillary services, pursuant to contract section 2.8.4, CMS and DHCS require MMPs to ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers, but MMPs are not obligated to use out-of-network providers who are determined to have a pre-existing relationship, for the applicable ~~six~~ or 12 months.

#### Skilled Nursing Facilities

If a Skilled Nursing Facility (SNF) resident leaves, and then requires a return to a SNF level of care due to medical necessity, the beneficiary has the right to return to the same SNF where he/she previously resided under the Leave of Absence and Bedhold policies (See DPL 14-002 for more information on these policies), and the continuity of care policies contained in this DPL. The specific requirements on the Leave of Absence, Bedhold, or continuity of care policies will apply depending on which policy is applicable in any given circumstance.

In addition, a beneficiary who is a resident of a SNF at the time of enrollment will not be required to change SNFs during the duration of Cal MediConnect if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and MMP agree to Medicare rates if the service is a Medicare service, or Medi-Cal rates if the service is a Medi-Cal service, in accordance with the three-way contract. This provision is automatic, meaning the beneficiary does not have to make a request to the MMP to invoke this right. The MMP must determine the duration of residency through the same process specified previously for verifying a pre-

existing provider relationship, which is through historical utilization data or documentation from the beneficiary or provider.

**ADDITIONAL CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA 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 continued 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 MMP, until the prescribed therapy is no longer prescribed by the contracting physician.

For Knox-Keene Act licensed plans, additional requirements pertaining to continuity of care are set forth in Health and Safety (H&S) Code §1373.96 and require all health care service plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or non-participating health plan provider. Under this section, health care service 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 care service 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.

**BALANCE BILLING PROHIBITION**

Balance billing is the practice of billing beneficiaries for any charges related to covered services that are not reimbursed by Medicare or Medi-Cal. Balance billing is prohibited by state and federal law. A provider may not bill a beneficiary for any charges that are not reimbursed by Medicare or Medi-Cal, if the service is covered by Medicare or Medi-Cal. The only exception is that providers may bill Medi-Cal beneficiaries who have a monthly share of cost obligation, but only until that obligation is met for the applicable month.

If you have any questions regarding this DPL, please contact your Managed Care Operations Division contract manager.

Sincerely,

*Original Signed by Nathan Nau*

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division  
Department of Health Care Services