



TOBY DOUGLAS
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

DATE: December 29, 2014

ALL PLAN LETTER 14-021
(SUPERSEDES ALL PLAN LETTER 13-023)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL BENEFICIARIES WHO
TRANSITION 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 into Medi-Cal managed care. Continuity of care provisions related to dual eligible beneficiaries (beneficiaries eligible for Medi-Cal and Medicare) in the Cal MediConnect program can be found in Duals Plan Letter 14-004 at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2014/DPL14-004.pdf>.

POLICY:

Medi-Cal beneficiaries assigned a mandatory aid code that are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with California 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 to 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 MCP.

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 the 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 provider (PCP) or specialist 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, unless otherwise specified in this APL.

For the purposes of this APL, 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, provider continuity of care protections do not extend to the following providers: durable medical equipment, transportation, other ancillary services, and carved-out services.

If a beneficiary changes MCPs, the 12-month 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 12 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 providers that the beneficiary accessed through their previous MCP.

MCP Processes

Beneficiaries, their authorized representatives on file with Medi-Cal, or their provider, 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. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the beneficiary. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the beneficiary. The continuity of care process begins when the MCP starts the process to determine if the beneficiary has a pre-existing relationship with the provider.

MCPs shall accept requests for continuity of care over the telephone, according to the requester's preference, and shall not require that the requester complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

MCPs shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above, and in 1-3 below. The services that are the subject of the request must have occurred after the beneficiary's enrollment into the MCP, and the MCP 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 MCP. MCPs shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after the effective date of this APL;
2. 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
3. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested.

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.

Request Completion Timeline

Each continuity of care request must be completed within the following timeline:

- Thirty calendar days from the date the MCP received the request;
- Fifteen 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 of continued access;
- The MCP and the out-of-network FFS or prior MCP 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.

Requirements after the Request Process is Completed

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 referred or assigned to an in-network provider. If the beneficiary disagrees with the result of the continuity of care process, the beneficiary maintains the right to pursue a grievance and/or appeal.

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 to an in-network 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.

Upon approval of a continuity of care request, the MCP must notify the beneficiary of the following within seven calendar days:

- The request approval;
- 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 MCP's provider network.

The MCP shall also notify the beneficiary 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 shall 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.

MCP Extended Continuity of Care Option

An MCP may choose to work with the beneficiary's out-of-network provider past the 12-month continuity of care period, but the MCP is not required to do so to fulfill its obligations under this APL.

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. The MCP must translate these documents into threshold languages and make them 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 Welfare & Institutions (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).

The MCP beneficiaries with mild to moderate impairment resulting from a mental health diagnosis 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 of the State's §1115 Medicaid Demonstration Waiver, "A Bridge to Reform," DHCS transitioned 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 LIHP 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 was 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 PCP whenever possible. MCPs must assign transition beneficiaries to their LIHP PCP according to the LIHP data provided by DHCS.

COVERED CALIFORNIA TO MEDI-CAL TRANSITION:

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a beneficiary's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning beneficiaries.

As part of the process to ensure that continuity of care and coordination of care requirements are met, the MCP shall ask the beneficiary if there are upcoming health care appointments or treatments scheduled and assist the beneficiary to initiate the continuity of care process at that time, if the beneficiary chooses to do so, according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new beneficiary enrolls in Medi-Cal, the MCP shall contact the beneficiary by telephone call, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph shall be included in this initial beneficiary contact process. The MCP shall make a good faith effort to learn from and obtain information from the beneficiary that will assist the MCP to honor active Prior Treatment Authorizations and/or establish out-of-network provider continuity of care as described below.

The MCP shall honor any active Prior Treatment Authorizations for up to 60 days or until a new assessment is completed by the MCP. A new assessment has been completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active Prior Treatment Authorization. The Prior Treatment Authorizations must be honored without a request by the beneficiary or the provider.

The MCP shall, at the beneficiary's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the DHCS policy requirements listed in APL 13-023 for other transitioning populations regarding out-of-network continuity of care. The APL is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-023.pdf>.

SENIORS AND PERSONS WITH DISABILITIES FFS TREATMENT AUTHORIZATION REQUEST CONTINUITY UPON MCP ENROLLMENT:

For a newly enrolled Seniors and Persons with Disabilities (SPDs), the MCP must honor any active FFS Treatment Authorization Requests (TARs) for up to 60 days or until a new assessment is completed by the MCP. A new assessment has been completed by the MCP if the member has been seen by an MCP-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active Prior Treatment Authorization. The FFS TAR must be honored as outlined above without a request by the beneficiary or the provider.

BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER:

The MCPs are responsible for providing Early and Periodic Screening, Diagnosis, and Treatment services for beneficiaries ages 0 to 21. Effective September 15, 2014, the services include medically necessary Behavioral Health Treatment (BHT) Services such as Applied Behavioral Analysis and other evidence-based behavioral intervention

services that develop or restore, to the maximum extent practicable, the functioning of the beneficiaries diagnosed with Autism Spectrum Disorder (ASD).

In accordance with the requirements listed in this APL and APL 14-011, MCPs shall provide continued access to out-of-network BHT providers for up to 12 months beginning September 15, 2014.

The beneficiary must have an existing relationship with the BHT provider. An existing relationship means a beneficiary has seen the out-of-network BHT provider at least twice during the 12 months prior to September 15, 2014, or the date of his or her initial enrollment in the MCP if enrollment occurred on or after September 15, 2014.

Retroactive requests for BHT services are limited to services that were provided after September 15, 2014 or the date of the beneficiary's enrollment into the MCP if the enrollment date occurred after September 15, 2014.

MCPs must continue ongoing BHT services until MCPs have conducted a comprehensive diagnostic evaluation and assessment, and established a treatment plan. MCPs may refer to the Continuity of Care section of APL 14-011 for additional requirements and information regarding continuity of care for BHT services for beneficiaries diagnosed with ASD. APL 14-011 is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-011.pdf>.

EXISTING 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 MCP-contracting provider.

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 §1373.96, 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. This APL does not alter an MCP's obligation to fully comply with the requirements of §1373.96. In addition to the requirements set forth in this APL, each MCP must allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a beneficiary a longer period of

treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. 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 only be used to preserve continuity of care with a Medi-Cal FFS provider under the circumstances described above in this paragraph. MCPs are required to consider MERs that have been 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. APL 13-013 is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-013.pdf>.

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 Sarah C. Brooks

Sarah Brooks, Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services