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**DATE:** August 26, 2015

ALL PLAN LETTER 15-019  
(SUPERSEDES ALL PLAN LETTER 14-021)

**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 15-003 at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-003.pdf>.

**POLICY:**

Medi-Cal beneficiaries assigned a mandatory aid code and who 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 state law and the MCP contracts, with some exceptions. All MCP beneficiaries with pre-existing provider relationships who make a continuity of care request to an 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 have 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 existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
  - a. 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.
2. The provider is willing to accept the higher of the MCP's contract rates or Medi-Cal FFS rates;

3. The provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues (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);
4. The provider is a California State Plan approved provider; and
5. The provider supplies the MCP with 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 regulations.

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 following the 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 must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to 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 concurring with 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 must notify the beneficiary 30 calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes 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 these protections 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 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 must not 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.

#### **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.

To ensure that continuity of care and coordination of care requirements are met, the MCP must ask these beneficiaries if there are upcoming health care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time 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 must contact the beneficiary by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial beneficiary contact process. The MCP must make a good faith effort to learn from and obtain information from the beneficiary so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

The MCP must honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by the MCP. A new assessment is considered 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 must, 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 is considered completed by the MCP if the beneficiary 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 DIAGNOSED WITH AUTISM SPECTRUM DISORDER:**

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 beneficiaries diagnosed with Autism Spectrum Disorder (ASD).

In accordance with the requirements listed in this APL and APL 14-011, MCPs must provide continued access to out-of-network BHT providers (continuity of care) for up to 12 months.

The requirements noted above in this APL regarding provider acceptance of rates, provider quality, and an existing provider relationship are also applicable for BHT. For BHT, an existing relationship means a beneficiary has seen the out-of-network BHT provider at least one time during the six months prior to transitioning responsibility of BHT services from the Regional Center to the MCP, or the date of the beneficiary's initial enrollment in the MCP if enrollment occurred on, or after, September 15, 2014. If the beneficiary has an existing BHT service relationship, as defined above, with an in-network provider, the MCP must assign the beneficiary to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement 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 they 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>.

#### Transition of BHT Services from a Regional Center to an MCP

DHCS will provide MCPs with a list of beneficiaries receiving BHT services who will transition from the Regional Center to the MCP. MCPs must consider every beneficiary transitioning from a Regional Center as an automatic continuity of care request. DHCS will also provide MCPs with beneficiary utilization and assessment data from the Regional Center prior to the service transition date. MCPs are required to use DHCS-supplied utilization data to identify each beneficiary's BHT provider and proactively contact the provider or providers to begin the continuity of care process, regardless of whether a beneficiary's parent or guardian files a request for continuity of care. If the data file indicates that multiple providers of the same type meet the criteria for continuity of care, the MCP should attempt to contact the beneficiary's parent or guardian to determine his or her preference. If the MCP does not have access to beneficiary data that identifies an existing BHT provider, the MCP must contact the beneficiary's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist it in offering continuity of care, as appropriate. If the Regional Center is unwilling to release specific provider rate information to the MCP, then the MCP may negotiate rates with the continuity of care provider without being bound by the usual requirement that the MCP offer at least a minimum FFS-equivalent rate. If the MCP is unable to complete a continuity of care agreement, the MCP must ensure that all ongoing services continue at the same level with an MCP in-network provider until the MCP has conducted a comprehensive diagnostic evaluation and assessment, as appropriate, and established a treatment plan.

#### **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 Welfare and Institutions Code Section (§)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 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 a 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.

**PREGNANT AND POST-PARTUM BENEFICIARIES:**

As noted above, H&S Code §1373.96 requires health plans in California to, at the request of a beneficiary, provide for the completion of covered services relating to pregnancy, during pregnancy and immediately after the delivery (the post-partum period), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan provider. These requirements will apply for pregnant and post-partum beneficiaries and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to H&S Code §1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal beneficiaries who are assigned a mandatory aid code and are transitioning from Medi-Cal FFS into an MCP have the right to request out-of-network provider continuity of care for up to 12 months in accordance with MCP contracts and the general requirements listed in this APL. This requirement is applicable to any existing Medi-Cal FFS provider relationship that is allowed under the general requirements of this APL (continuity of care for beneficiaries transitioning from FFS to managed care).

**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 Operations Division contract manager.

Sincerely,

*Original Signed by Sarah C. Brooks*

Sarah Brooks, Deputy Director  
Health Care Delivery Systems  
Department of Health Care Services