



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

DATE SEP 21 2011

MMCD All Plan Letter 11-019

TO ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT EXTENDED CONTINUITY OF CARE FOR SENIORS AND PERSONS WITH
DISABILITIES

PURPOSE

The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (health plans) of the extended continuity of care requirements for Seniors and Persons with Disabilities (SPDs) who are transitioning from Medi-Cal fee-for-service (FFS) into Medi-Cal managed care.

BACKGROUND

The Medicaid Demonstration Waiver granted under Section 1115 of the Social Security Act (1115 Demonstration Waiver) permits mandatory enrollment of SPD Medi-Cal only beneficiaries into Medi-Cal managed care health plans (health plans). Enrollment began June 1, 2011 and is ongoing.

The 1115 Demonstration Waiver Special Terms and Conditions ensure extended continuity of care for SPDs transitioning into health plans by requiring health plans to allow SPDs to request out-of-network access with the SPD's current Medi-Cal FFS provider. For purposes of this APL, this is referred to as the "extended continuity of care period" for SPDs.

Access to the SPD's FFS provider must be allowed for 12 months from their initial enrollment into managed care. This does not apply to SPDs:

- Who were already enrolled in a health plan prior to June 1, 2011.
- Who became newly eligible or regained eligibility for Medi-Cal on or after June 1, 2011.

New Medi-Cal SPDs (eligible June 1, 2011 or after) must enroll in a health plan and obtain services from providers that are part of the health plan network.

In addition to the extended continuity of care period for SPDs, the health plan must ensure that all health plan beneficiaries, including SPDs, obtain all other medically necessary Medi-Cal services, which includes completion of covered services, in compliance with Health and Safety Code Section 1373.96.

REQUIREMENTS

Newly enrolled SPDs who choose to continue receiving services from their current out-of-network FFS provider can request continued access to that provider by contacting their health plan. For purposes of the extended continuity of care period for SPDs, the Department of Health Care Services (DHCS) is using the definition of an individual provider found in Health and Safety Code Section 1373.96. However, health plans are not required to work with providers who meet this definition if the providers offer carved out Medi-Cal services, or services not covered by Medi-Cal. Therefore, out-of-network FFS providers can include physicians, surgeons and specialists, but do not include providers of durable medical equipment, transportation, other ancillary services, or carved out services. Availability of carved out services is not impacted by the mandatory enrollment of SPDs into managed care.

Health plans must continue to provide access to the FFS provider for 12 months as long as all of the following requirements are met:

1. The SPD has an ongoing relationship with that provider.
2. The health plan determines there are no quality of care issues with that provider.
3. The provider agrees to accept the health plan's contracted rates or Medi-Cal FFS rates, whichever is higher, in accordance with Welfare and Institutions Code Section 14182(b) (13).

An ongoing relationship will be determined by the health plan by identifying whether the SPD has seen the requested out-of-network provider at least once within the last 12 months. The link between the newly enrolled SPD and the out-of-network provider must be established by the health plan using FFS utilization data provided by DHCS.

A quality of care issue means that a health plan can document concerns with the provider's quality of care to the extent that the provider would not be eligible to provide services to any other health plan members.

If the three requirements listed on Page 2 are met, the health plan must allow the SPD to have access to that provider for the entire length of the extended continuity of care

period unless the provider is only willing to work with the health plan for a shorter timeframe. In this case, the health plan must allow the SPD to have access to that provider for the shorter period of time.

If a health plan and the out-of-network FFS provider are unable to reach an agreement because the provider will not accept payment from the health plan or the health plan has documented quality of care issues with the provider, the SPD will have to work with the health plan to select an in-network primary care provider and any necessary specialist providers. If the SPD does not make a choice, the SPD will be assigned to an in-network provider.

Health plans must begin processing requests for extended continuity of care within five working days from receipt of the request. Health plans must then contact the provider and verify that a current relationship exists. Each request must be completed within 30 calendar days from the date the health plan receives the request or sooner if the SPD's medical condition requires more immediate attention.

If an SPD changes health plans, their extended continuity of care period does not start over. The new health plan will follow the same procedures and allow out-of-network access to the FFS provider for the remainder of the 12-month period (from the time of initial enrollment into managed care) as long as the three requirements specified on Page 2 are met.

An approved out-of-network FFS provider must work with the health plan and its contracted network and cannot refer the SPD to another out-of-network FFS provider without prior authorization from the health plan. In such cases, the health plan will make the referral, if medically necessary, and if the health plan does not have the required type of provider within its network.

Prescriptions for new or refilled drugs prescribed by a SPD member's current FFS provider will be filled if they are listed on the health plan's formulary of approved drugs. For a new prescription that is not on the formulary, the pharmacist will be informed by the health plan that prior authorization is required. The health plan must make a decision within 24 hours based upon medical justification requested from the prescribing out-of-network FFS provider. A non-formulary medication refill that is part of ongoing treatment may be subject to concurrent review by the plan, during which time the medication must be covered until the doctor has been notified of the health plan's decision and a care plan has been agreed upon with the prescribing physician that is appropriate for the beneficiary's medical needs, as required by Health and Safety Code Section 1367.01.

If you have any questions regarding this APL, please contact your MMCD Contract Manager.

Sincerely,

Original Signed by Jane Ogle

Jane Ogle, Deputy Director
Health Care Delivery Systems