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DATE: December 7, 2018

ALL PLAN LETTER 18-008 (REVISED)
SUPERSEDES ALL PLAN LETTER 15-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO TRANSITION INTO MEDI-CAL MANAGED CARE

PURPOSE:

The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to clarify continuity of care requirements for Medi-Cal members who transition into Medi-Cal managed care.¹ This APL supersedes APL 15-019.² *Revised text is found in italics.*

POLICY:

Medi-Cal members 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 contract, with some exceptions. All MCP members 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 members 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 member 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 member 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.

¹ Continuity of care provisions for dual-eligible members (members eligible for both Medi-Cal and Medicare) in the Cal MediConnect program can be found at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx> .

² APLs can be accessed at the following link: <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx> .

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 the 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 members);
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.

MCPs are 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: durable medical equipment, transportation, other ancillary service, and carved-out service providers.

If a member changes MCPs, the 12-month continuity of care period may start over one time. If the member changes MCPs a second time (or more), the continuity of care period does not start over as the member does not have the right to a new 12 months of continuity of care. If the member returns to Medi-Cal FFS and later reenrolls in an MCP, the continuity of care period does not start over. If a member changes MCPs, this continuity of care policy does not extend to providers that the member accessed through their previous MCP.

MCP Processes

Members, 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 member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the member. The continuity of care process begins when the MCP starts the process to determine if the member 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 must retroactively approve a continuity of care request and reimburse providers for services that were already provided if the request meets all continuity of care requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the MCP
- Have dates of service after December 29, 2014³
- Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive continuity of care reimbursement

Retroactive continuity of care reimbursement requests must be submitted within 30 calendar days of the first service to which the request applies.

Validating Pre-existing Relationship

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 member or his or her provider may also provide information to the MCP that demonstrates a pre-existing relationship with the provider. A member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the MCP makes this option available to the member.

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 member.

Request Completion Timeline

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

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member'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 member.

³ The first APL that addressed retroactive requests for continuity of care was APL 14-021, which was dated December 29, 2014.

A continuity of care request is considered completed when:

- The MCP notifies the member, in the manner outlined above, that the request has been approved;
- The MCP and the out-of-network Medi-Cal FFS provider are unable to agree to a rate;
- The MCP has documented quality of care issues with the Medi-Cal FFS provider; 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 the MCP and the out-of-network Medi-Cal 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 member an in-network alternative. If the member does not make a choice, the member will be referred or assigned to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to file a grievance.

If a provider meets all of the necessary requirements, including entering into a letter of agreement or contract with the MCP, the MCP must allow the member 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 member to have access to that provider for the shorter period of time.

At any time, members 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 member.

Upon approval of a continuity of care request, the MCP must notify the member 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 member's care at the end of the continuity of care period.
- The member's right to choose a different provider from the MCP's provider network.

The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition the member's care to an in-network provider at the end of the continuity of care period. This process includes engaging with the member 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

MCPs may choose to work with a member's out-of-network provider past the 12-month continuity of care period; however, MCPs are not required to do so to fulfill the obligations under this APL or the MCP contract.

Member and Provider Outreach and Education

MCPs must inform members of their continuity of care protections and must include information about these protections in member information packets and handbooks. This information must include how the member 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 members 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 member to another out-of-network provider without authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary, if the MCP does not have an appropriate provider within its network.

NON-SPECIALTY MENTAL HEALTH SERVICES – CONTINUITY OF CARE FOR APPROVED PROVIDER TYPES:

MCPs are required to cover outpatient mental health services, as outlined in APL 17-018, for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition, as defined by the current Diagnostic and Statistical Manual.⁴ County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who meet the medical necessity criteria for SMHS. DHCS recognizes that the medical necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment (*EPSDT*) benefit, the impairment component of the SMHS medical necessity criteria for members under 21

⁴ APL 17-018, "Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services."

years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet medical necessity criteria for SMHS.⁵

MCPs must provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive non-specialty mental health services from the MCP. In this situation, the continuity of care requirement only applies to psychiatrists and/or mental health provider types that are permitted, through California's Medicaid State Plan, to provide outpatient, non-specialty mental health services (referred to in the State Plan as "Psychology").⁶

The MCP must allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network MHP provider in accordance with the requirements in this APL. After the continuity of care period ends, the member must choose a mental health provider in the MCP's network for non-specialty mental health services. If the member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the MCP for non-specialty mental health services, the 12-month continuity of care period may start over one time. If the member requires SMHS from the MHP subsequent to the continuity of care period, the continuity of care period does not start over when the member returns to the MCP or changes MCPs (i.e., the member does not have the right to a new 12 months of continuity of care).

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 member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, the MCP must ask these members 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 member enrolls in Medi-Cal, the MCP must contact the member by telephone, letter, or other

⁵ SMHS medical necessity criteria are outlined in Title 9 of the California Code of Regulations (CCR), Sections 1830.205 and 1830.210. The CCR is searchable at: <https://govt.westlaw.com/calregs/Search/Index>

⁶ State Plan Amendment (SPA) 14-012, Attachment 3.1-A is available at: <http://www.dhcs.ca.gov/formsandpubs/laws/Documents/CASPA14-012ApprovedPackageOriginalADA.pdf>

resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. The MCP must make a good faith effort to learn from and obtain information from the member 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 member or the provider.

The MCP must, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the requirements in this APL.

HEALTH HOMES PROGRAM – MEDI-CAL FFS TO MANAGED CARE TRANSITION: MCPs must provide continuity of care with an out-of-network provider, in accordance with the requirements of this APL, for Medi-Cal FFS beneficiaries who voluntarily transition to an MCP to enroll in the Health Homes Program (HHP).⁷ Because HHP services are provided only through the managed care delivery system, continuity of care with out-of-network-providers is not available for HHP services.

PEDIATRIC PALLIATIVE CARE WAIVER TRANSITIONS

DHCS' Pediatric Palliative Care (PPC) Waiver Program is scheduled to end on December 31, 2018.⁸ Most services previously covered under the waiver are covered under EPSDT. For those individuals currently enrolled in MCPs or transitioning from Medi-Cal FFS, the MCPs must provide continuity of care to out-of-network providers who provided Medi-Cal-covered PPC Waiver Program services to the member for services that are also covered by Medi-Cal under EPSDT. MCPs are not required to provide continuity of care for services that were exclusive to the PPC Waiver Program and that are not also covered by Medi-Cal under EPSDT. An MCP must allow, at the request of the member, the provider, or the member's authorized representative, up to 12 months continuity of care with the out-of-network provider in accordance with the requirements in this APL.

⁷ More information on the Health Home Program services can be found here:
<http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx>.

⁸ More information on the Pediatric Palliative Care (PPC) Waiver Program can be found here:
<http://www.dhcs.ca.gov/services/ppc/Pages/default.aspx>

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 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 member or the provider.

BEHAVIORAL HEALTH TREATMENT FOR MEMBERS UNDER THE AGE OF 21 UPON MCP TRANSITION:

MCPs are responsible for providing EPSDT services for members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services that are determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. In accordance with existing contract requirements and the requirements listed in this APL and APL 18-006, Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21, MCPs must offer members continued access to out-of-network BHT providers (continuity of care) for up to 12 months if all requirements in this APL are met. For BHT, an existing relationship means a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from a Regional Center (RC) to the MCP or the date of the member's initial enrollment in the MCP if enrollment occurred on or after July 1, 2018. Further, if the member has an existing relationship, as defined above, with an in-network provider, the MCP must assign the member to that provider to continue BHT services.

Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date into an MCP, or the date of the member's enrollment into the MCP, if the enrollment date occurred after the transition.

MCPs must continue ongoing BHT services until they have conducted an assessment and established a behavioral treatment plan.

Transition of BHT Services from RCs to MCPs

At least 45 days prior to the transition date, DHCS will provide MCPs with a list of members for whom the responsibility for BHT services will transition from RCs to MCPs, as well as member-specific utilization data. MCPs must consider every member transitioning from an RC as an automatic continuity of care request. DHCS will also provide MCPs with member utilization and assessment data from the RC prior to the

service transition date. MCPs are required to use DHCS-supplied utilization data to identify each member's BHT provider(s) and proactively contact the provider(s) to begin the continuity of care process, regardless of whether a member'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 member's parent or guardian to determine their preference. If the MCP does not have access to member data that identifies an existing BHT provider, the MCP must contact the member's parent or guardian by telephone, letter, or other resources, and make a good faith effort to obtain information that will assist the MCP in offering continuity of care. If the RC 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 an evaluation and/or assessment, as appropriate, and established a treatment plan.

MCPs may refer to the Continuity of Care section of APL 18-006 for additional requirements and information regarding continuity of care for transitioning members receiving BHT.

EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:

In addition to the protections set forth above, MCP members 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 members 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 member 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 Code (HSC) Section 1373.96 and require health plans in California to, at the request of a member, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under HSC Section 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 performance of a surgery or other procedure that is authorized by the MCP as a 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 member. This APL

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

PREGNANT AND POST-PARTUM BENEFICIARIES:

As noted above, HSC Section 1373.96 requires health plans in California to, at the request of a member, 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 members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC Section 1373.96 for additional information about applicable circumstances and requirements.

Pregnant and post-partum Medi-Cal members 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 the MCP contract 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 members 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 member's medical condition has stabilized to a level that would enable the member 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 members 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 automatic continuity of care requests to allow members to complete courses of treatment with Medi-Cal FFS providers in accordance with APL 17-007, *Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting, or subsequent iterations of this APL.*

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.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division