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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: *December 13, 2013*

DUALS PLAN LETTER 13-005
(REVISED)

TO: ALL MEDI-CAL MANAGED CARE PLANS PARTICIPATING IN CAL MEDICONNECT

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."

BACKGROUND:
In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities by shifting service delivery away from institutional care to home- and community-based settings. Governor Brown enacted the Coordinated Care Initiative (CCI) by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

A component of the CCI is a Duals Demonstration Project, called "Cal MediConnect." It will be implemented no sooner than April 1, 2014, in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, and San Mateo. Cal MediConnect will serve beneficiaries who are both Medi-Cal and Medicare eligible (dual-eligible beneficiaries), and will combine the full continuum of acute, primary, institutional, and home- and community-based Medicare and Medi-Cal services into a single benefit package delivered through an organized service delivery system administered by an MMP. Dual-eligible beneficiaries will be notified of their right to select a participating plan no fewer than 60 days prior to the effective date of enrollment and will receive a notice regarding implementation of the program 90 days prior. When a beneficiary makes no active choice of a participating plan, he or she will be enrolled into an MMP using a seamless, passive enrollment process; this process provides the opportunity for each beneficiary to make a voluntary choice to enroll or disenroll from the participating plan at any time. A beneficiary who chooses to disenroll will still receive his or her Medi-Cal services from a Medi-Cal managed care health plan.

Continuity of care requirements for Cal MediConnect are defined at Welfare and Institutions (W&I) Code, Section (§) 14182.17. These requirements are also set forth in the Memorandum of Understanding (MOU) between the Centers for Medicare and

Medicaid Services (CMS) and the Department of Health Care Services (DHCS); the MOU establishes the following requirements:

- CMS and DHCS will require each MMP to ensure that each beneficiary continues to have access to medically necessary items, services, and medical and long-term services and supports providers.
- DHCS will require each participating MMP to follow continuity of care requirements established in current law.
- As part of a process to ensure that continuity of care and coordination of care requirements are met, an MMP must perform an assessment process within 90 days of a beneficiary's enrollment in the participating plan.
- Upon beneficiary request, an MMP must allow a beneficiary to maintain his or her current providers and service authorizations at the time of enrollment for:
    - A period up to six months for Medicare services if the criteria are met under W&I Code §14132.275(k)(2)(A).
    - 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.

Also consistent with the provisions of the MOU, the following exceptions are allowable:

1. An MMP is not required to provide continuity of care for services not covered by Medi-Cal or Medicare.
2. In addition, the following providers are not eligible for continuity of care: providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services.
3. An MMP may choose to not provide continuity of care with an out-of-network provider when:
    - The ability to demonstrate an existing relationship between the beneficiary and provider does not occur;
    - The provider is not willing to accept payment from the MMP based on the current Medicare or Medi-Cal fee schedule, as applicable; or
    - The MMP would otherwise exclude the provider from its provider network due to documented quality of care concerns. Under these circumstances, a quality of care issue means an MMP 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 MMP beneficiaries.

CAL MEDICONNECT CONTINUITY OF CARE REQUIREMENTS:
An MMP are required to offer continuity of care to all Cal MediConnect beneficiaries who have an existing relationship with a primary or specialty care provider with some exceptions. An existing relationship means a beneficiary has seen an out-of-network primary 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.

All Cal MediConnect beneficiaries with pre-existing provider relationships who make a continuity of care request to an MMP must be given the option to continue treatment for up to six months with an out-of-network Medicare provider and up to 12 months with an out-of-network Medi-Cal provider.

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 or 12 month period depending on the type of provider. If the beneficiary returns to Fee-for-Service (FFS) Medi-Cal and later reenrolls in Cal MediConnect, the continuity of care period does not start over. If a beneficiary changes MMPs, this continuity of care policy does not extend to in-network providers that the beneficiary accessed through their previous MMP.

<u>MMP Processes</u>
Beneficiaries may make a direct request to an MMP for continuity of care. When this occurs, the MMP must begin to process the request within five working days after receipt of the request. The continuity of care process begins when the MMP determines there is a pre-existing relationship and has entered into an agreement with the provider.

The MMP should determine if a relationship exists through use of data provided by CMS and DHCS to the MMP, 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 determine if the provider is an in-network provider. If the provider is not an in-network provider, 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.

Each beneficiary's continuity of care request must be completed within 30 calendar days from the date the MMP received the request, or *within 15 calendar* days if the beneficiary's medical condition requires more immediate attention*, such as upcoming*

appointments or other pressing care needs. A continuity of care request is considered completed when:

- The beneficiary is informed of his or her right of continued access or if the MMP and the out-of-network FFS 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.

If an MMP and the out-of-network FFS 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 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, beneficiaries may change their provider 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.

<u>MMP Extended Continuity of Care Option</u>
MMPs may choose to work with a beneficiary's out-of-network doctor past the six or twelve month continuity of care period, but MMPs is not required to do so.

<u>Beneficiary and Provider Outreach and Education</u>
MMPs must inform beneficiaries of their continuity of care protections and must include information about these protections in their beneficiary 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 beneficiary 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 and if the MMP does not have an appropriate provider within its network.

Durable Medical Equipment
For DME, MMPs must provide continuity of care for services, but are not obligated to use providers that are determined to have a pre-existing relationship, for the applicable six or twelve months.

Nursing Facilities
A beneficiary who is a long term resident of a nursing facility (NF) prior to enrollment will not be required to change NFs during the duration of the Duals Demonstration Project if the facility is licensed by the California Department of Public Health (CDPH), meets acceptable quality standards, and the facility and MMP agree to Medi-Cal rates in accordance with the three-way contract.

EXISTING 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 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 MMP, until the prescribed therapy is no longer prescribed by the contracting physician.

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 this Section, 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. Health 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.

If you have any questions regarding this DPL, please contact Sarah Brooks, Chief, Program Monitoring and Medical Policy Branch at sarah.brooks@dhcs.ca.gov.

Sincerely,

Original Signed by Margaret Tatar

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