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Continuity of Care in Medi-Cal

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Introduction

Continuity of Care ("COC") is critical to the successful transition of Medi-Cal beneficiaries moving from fee-for-service (FFS) Medi-Cal into a managed care plan for the first time or from one health plan to another. While there are legal requirements that entitle Medi-Cal beneficiaries to continue services when benefits are being terminated or reduced, the continuation of services based on membership in a group or maintaining access to existing providers is an additional right beneficiaries have under COC. The loss of COC can lead to significant and even catastrophic disruptions in care, beneficiary and provider dissatisfaction, and increased medical and administrative costs for providers, for health plans and the State. Notwithstanding this fact, the lack of information about COC has made these rights difficult to enforce. The transition of seniors and persons with disabilities ("SPDs") from fee-for-service plans to managed care plans in 2011 is one such example: more than eighty percent of SPDs did not know that they had the right to continue seeing their current provider.[1] Further, many FFS providers that had been serving SPDs refused to join managed care plans or to provide the transition population with COC.[2] As California prepares to expand Medi-Cal managed care to new geographic locations, and to new populations, advocates, consumers and providers must understand when COC protections apply in order to avoid such dire consequences from disruptions in care. This fact sheet provides an overview of the laws and regulations that require COC for Medi-Cal beneficiaries.

I. COC protections allow Medi-Cal beneficiaries to continue services.

There are a variety of laws that govern COC for Medi-Cal beneficiaries; Some protect access to particular services or access to an existing provider for a course of treatment or for a period of time, and others protect a specific population of beneficiaries. Additionally, some of these protections are specific to Medi-Cal while others are more broadly applicable to consumers in certain types of managed care plans in California.

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Because these rules are fragmented, it is difficult to explain them in a simple or straightforward manner.

A. Prescription Drug Specific COC

All Medi-Cal beneficiaries who are newly enrolled in a managed care plan are entitled to continue use of any (single-source) prescription drug, whether or not the drug is covered by the plan, as long as the prescription was in effect immediately prior to the date of their enrollment in the plan.[3] This protection applies to those who are newly enrolled in Medi-Cal, newly enrolled in Medi-Cal managed care, or have switched from one managed care plan to another.[4] A health plan must continue to cover and provide these prescription drugs for a new enrollee until a plan doctor makes a determination that the prescription is no longer needed.[5]

B. Service and Provider Specific COC under the Knox Keene Act

The following continuity of care provisions from the Knox-Keene Act apply to all Medi-Cal beneficiaries who either (1) are enrolled in a KKA licensed managed care plan and who had been receiving services from a doctor or who was terminated from the plan;[6] or (2) are a newly covered enrollee in a health plan who, at the time his or her coverage became effective, was receiving services from a non-participating provider for one of the conditions listed.[7] The beneficiaries are entitled to complete their course of treatment for these conditions with the non-participating or terminated provider for the following conditions:

- Acute Condition: A health plan must provide COC for the full duration of an acute condition, such as pneumonia. “Acute condition” is defined as “a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.”[8]

- Serious Chronic Condition: A health plan is required to continue services for a serious chronic condition, such as diabetes or heart disease, for a maximum of twelve months from the contract termination date or twelve months from the effective date of coverage for a newly covered enrollee. “Serious chronic condition” is defined as “a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.”[9] Unless twelve months have passed, the health plan must ensure the coverage of services for “a period of time necessary” to complete treatment and arrange for a safe transfer of the enrollee to another plan or nonparticipating provider.[10]

- Pregnancy: A health plan must provide COC for the full duration of a pregnancy. "Pregnancy" is not only limited to the three trimesters of pregnancy, but also the immediate postpartum period.[11]

- Terminal Illness: A health plan is required to continue services for a terminal illness for the duration of the illness. "Terminal illness" is defined as "an incurable or irreversible condition that has a high probability of causing death within one year or less."[12]

- Care of baby or toddler: A health plan must provide up to twelve months of COC for care of a child between birth and age thirty-six months.[13]

- Scheduled or Recommended Procedure: A health plan must provide COC when a procedure, such as surgery, has been scheduled or recommended within 180 days of the date that the previously in-network provider's contract was terminated or within 180 days of the effective date of coverage for a newly covered enrollee.[14]

II. Population Specific COC Protections

A. Seniors and Persons with Disabilities

SPDs who are transitioned into managed care have additional protections to ensure that they have continued access to prescription medications. They are entitled to a 30-day authorization to continue any prescription drugs if their request for an exemption for mandatory enrollment in managed care is denied.[15] In addition, DHCS has clarified that plans must fill any prescriptions for a new or refilled drug prescribed by a transitioning SPD's current provider if it is on the health plan's formulary.[16] If a SPD's current provider prescribes a new drug that is not on the plan's formulary, the plan must notify the pharmacist that prior authorization is required, and it must make a decision whether to fill the prescription within 24-hours based upon medical justification provided by the prescribing doctor.[17] If a SPD's current provider prescribes a non-formulary medication refill as part of ongoing treatment, the plan must cover the drug while it makes a determination of whether the drug is medically necessary, and until it notifies the beneficiary's doctor of its decision and develops a care plan with the beneficiary's based on her or his medical needs.[18]

As DHCS continues to mandatorily transition SPDs into Medi-Cal managed care, those new managed care enrollees may request to continue seeing their existing FFS providers for up to 12 months.[19] DHCS has limited the providers for whom this option may be requested to those defined in Health and Safety Code Section 1373.96(l)(1)—i.e., a physician, surgeon, doctor of podiatric medicine, clinical psychologist, marriage

and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant, or chiropractor—excluding those who provide carved out Medi-Cal services (e.g. Specialty Mental Health Services), or services not covered by Medi-Cal.[20] The SPD must request continuity from their new managed care plan, which must approve such continued care when: 1) it finds, using FFS utilization data, that the enrollee has seen the provider any time in the last twelve months; 2) the provider is willing to accept the higher of either the plan's contracted rate or the Medi-Cal FFS rate; and 3) the provider meets the plan's professional standards and has no disqualifying quality-of-care issues.[21] The plan must notify SPD enrollees within 30 days of their request whether they will be able to continue seeing an out-of-network provider; if the plan is unable to reach an agreement with an enrollee's out-of-network provider, the plan will assign the enrollee to a network provider, instead.[22] While the majority of SPDs have already transitioned in to managed care plans in 2011, there are some beneficiaries who will still be able to take advantage of this requirement.

B. Children transitioning into Medi-Cal from Healthy Families

The Healthy Families Program (HFP) to Medi-Cal transition required the development of implementation plans to ensure state and county systems readiness, health plan network adequacy, and continuity of care with the goal of ensuring no disruption in services and continued access to coverage for all transitioning children.[23] For children transitioning into a different managed care plan, consideration of the child's primary care provider (PCP) was taken into account when enrolling the child in a Medi-Cal plan.[24] When there are no available plan contracts with a child's existing PCP, the plan into which the child is enrolled must allow the enrollee to remain with his or her current PCP for up to 12 months if the provider agrees to accept its rates and the plan has no quality of care concerns with the provider.[25] If the plan is unable to reach an agreement with the provider, or if there are quality concerns, the plan must report to DHCS as to how it is providing continuity of care.[26] While most of this transition has already occurred, there are a few children still transitioning that are able to take advantage of this requirement.

C. Individuals transitioning into Medi-Cal from LIHPs

As enrollees in California's Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) component are moved into Medi-Cal effective January 1, 2014, DHCS will inform enrollees which Medi-Cal plan(s) their primary care providers contract with.[27] Enrollees are required to be enrolled into a plan that contains their primary care provider, when possible. When more than one plan contains an enrollee's primary care provider and the enrollee does not choose one plan, DHCS will enroll the person into one of the plans that contains that primary care provider according to its usual default formula.[28] If an enrollee's primary care provider does not contract with any of the Medi-

Cal plans in the area and the person does not choose a plan, DHCS will enroll the person into a plan according to its usual default formula.[29]

In addition, DHCS will permit transitioning LIHP enrollees to request to continue seeing their existing LIHP specialists for up to 12 months.[30] DHCS has limited the providers for whom this option may be requested to those who provide "physician services that are the responsibility of the [Medi-Cal plan] and are not . . . 1) other types of care such as durable medical equipment (DME) or ancillary services, 2) services that are not covered by Medi-Cal, and 3) services that are not the responsibility of the [plan] (services carved out of managed care)."[31] LIHP enrollees must request continuity from their new managed care plans, which must approve such continued care when: 1) they finds evidence of an existing relationship between the enrollee and the provider; 2) the provider is willing to accept the payment based on the current Medi-Cal fee schedule; and 3) the plan would not exclude the provider from its network due to quality-of-care issues.[32] DHCS will provide more information about this option in its final LIHP Transition Plan, and in other guidance expected in late 2013.

D. Dual Eligibles who enroll in a combined Medicare and Medi-Cal managed care plan in Eight Demonstration Counties

In April, 2014, DHCS plans to implement a demonstration project in eight counties that will allow those dually eligible for Medicare and Medi-Cal to enroll in integrated managed Medicare and Medi-Cal managed care plans – called Cal MediConnect plans – if they wish.[33] The eight demonstration counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.[34]

DHCS will work to include as many Medicare and Medi-Cal providers as possible in Cal MediConnect to pave the way for a smooth transition. Cal MediConnect plans are also tasked with reaching out to non-participating providers to attempt to include them in their networks.[35] In addition, Cal MediConnect plans are required to contract with all willing and licensed Multi-Purpose Senior Services Programs (MSSPs) and Community-Based Adult Services (CBAS) programs, which should ensure that enrollees may continue services with existing providers of those services.[36] Cal MediConnect plans are also encouraged to contract with licensed nursing facilities that serve the dual eligible population.[37]

Dual eligible enrollees in the demonstration counties who choose to enroll in Cal MediConnect, may request to continue treatment with their out-of-network Medicare and Medi-Cal providers.[38] Enrollees may request up to six months of continued care with Medicare providers of specialty and primary care. [39] The Cal MediConnect plan must approve such continued care when: 1) the enrollee demonstrates that she or he has seen the provider at least twice in the past 12 months, 2) the provider is willing to accept payment based on the current Medicare fee schedule, and 3) the plan would not

exclude the provider from its network due to documented quality-of-care issues.[40] The enrollee may request continued care from Medi-Cal PCPs, specialty care providers, and nursing facilities (but not providers of ancillary services) for up to 12 months.[41] The Cal MediConnect plan must approve such continued care when: 1) enrollee demonstrates that she or he has seen the provider at least twice in the past 12 months, 2) the provider will accept the higher of either plan's rate for the service, or the applicable Medi-Cal FFS rate, and 3) it determines that the provider meets applicable professional standards and has no disqualifying quality-of-care issues.[42] To demonstrate that she or he has seen a provider at least twice in the past 12 months, an enrollee may request claims or encounter data from the state, may provide documentation from the provider, or may self-attest.[43] DHCS will provide additional guidance on the option to continue care with out-of-network providers in Cal MediConnect in late 2013 or early 2014. Dual eligibles are also afforded specific continuity protections for prescription medications by Medicare Part D.[44]

E. Persons Receiving Long Term Services and Supports in Eight Demonstration Counties

In April, 2014, DHCS will also implement a second demonstration project in the same eight counties described above that will require most adults, including dual eligibles, to receive their Medi-Cal services, including long term services and supports, through managed care.[45] Multipurpose Senior Services Program (MSSP) services, In-Home Support Services (IHSS) and nursing facility services will only be available through managed care in those counties.[46] Dual eligibles who do not enroll in a Cal MediConnect plan will still be required to enroll in a Medi-Cal managed care plan to receive long term services and supports.[47]

Medi-Cal managed care enrollees in the eight demonstration counties will be able to continue MSSP, IHSS, and nursing facility services with their current providers through their Medi-Cal managed care plans. Medi-Cal managed care plans are required to contract with all licensed MSSP sites to ensure that enrollees will be able to continue receiving services from their current providers.[48] Authorization of In-Home Supportive Services (IHSS) will continue to be administered by the county, and enrollees who receive IHSS will retain their right to hire and fire their providers, ensuring continuity of IHSS providers.[49] For those enrollees who reside in an out-of-network nursing facility, plans are required to provide at least six months of continuity of care before moving enrollees to a new in-network facility.[50]

Conclusion

As DHCS continues to move more Medi-Cal populations into mandatory managed care, COC is critical to ensure that these enrollees do not suffer catastrophic disruptions in care. Since the responsibility of requesting COC lies with the enrollee, DHCS must ensure that enrollees have sufficient information about their COC rights to make them effective. Those who are providing direct services to transition populations should also focus on informing these populations about their COC rights and assisting them in contacting their respective health plans.

Endnotes

[1] CARRIE GRAHAM ET AL., CAL. HEALTHCARE FOUND., THE EXPERIENCES OF SENIORS AND PERSONS WITH DISABILITIES WHO TRANSITIONED TO MEDI-CAL MANAGED CARE 17 (2013), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20Sacto03282013SPDsTransitionMediCalManagedCare.pdf.

[2] THE HENRY J. KAISER FAMILY FOUND., TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: INSIGHTS FROM CALIFORNIA 6-7 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.

[3] CAL. WELF. & INST. CODE § 14185(b).

[4] *Id.*

[5] *Id.*

[6] CAL. HEALTH & SAFETY CODE § 1373.96(b)(1); *see also* CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 9 § 16.B (2011) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_TwoPlanBoilerplate-Web.6-1-11.pdf; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 9 § 16.B (2011) (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_GMCBoilerplate-Web.6-1-11.pdf. Not all COHS are Knox-Keene licensed, and unlicensed plans are not subject to Knox-Keene COC requirements by contract. Instead they are simply exhorted to describe their activities "designed to assure the provision of . . . coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management." CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 4 § 7.I (2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_COHS_Boilerplate.pdf.

[7] CAL. HEALTH & SAFETY CODE § 1373.96(b)(2).

[8] *Id.* § 1373.96(c)(1).

[9] *Id.* § 1373.96(c)(2).

[10] *Id.*

[11] *Id.* § 1373.96(c)(3).

[12] *Id.* § 1373.96(c)(4).

[13] *Id.* § 1373.96(c)(5).

[14] *Id.* § 1373.96(c)(6).

[15] *Id.* § 14182(b)(22).

[16] CAL.HEALTH & HUMAN SERVS. AGENCY, DEPT. HEALTH CARE SERVS., EXTENDED CONTINUITY OF CARE FOR SENIORS AND PERSONS WITH DISABILITIES FREQUENTLY ASKED QUESTIONS 5 (2011), *available at* http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ContinuityCare/SPD%20FAQ_ENG_1011.pdf.

[17] *Id.*

[18] *Id.*

[19] CAL. WELF. & INST. CODE § 14182(b)(13). DHCS has announced that SPDs in the 18 "regional model" rural counties, which are slated to begin general Medi-Cal managed care enrollment in November 2013, will transition into managed care sometime in spring 2014. In addition, dual eligible SPDs in eight demonstration counties are slated to transition into managed care in April 2014.

[20] Letter from Jane Ogle, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans 2 (Sep. 21, 2011) [hereinafter MMCD APL 11-019]

("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."), *available at* http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-019.pdf; *see also* CAL.HEALTH & HUMAN SERVS. AGENCY, *supra* note 16.

[21] *See* CAL. WELF. & INST. CODE § 14182(b)(13); *see also* MMCD APL 11-019, *supra* note 20.

[22] CAL.HEALTH & HUMAN SERVS. AGENCY, *supra* note 16 at 1.

[23] CAL. WELF. & INST. CODE § 14005.27(e)(2).

[24] CAL. WELF. & INST. CODE § 14005.27(e)(1)(C).

[25] *See id.* § 14005.27(e)(3)(B); CAL. DEPT. OF HEALTH CARE SERVS., HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL: PHASE 3 IMPLEMENTATION PLAN 23 (2013), *available at* http://www.dhcs.ca.gov/services/Documents/Phase%203%20Implementation%20Plan%20-%20Final%205-1-2013.pdf.

[26] CAL. WELF. & INST. CODE § 14005.27(e)(3)(B)*; see also* Cal. Dept. of Health Care Servs., Health Plans FAQ, http://www.dhcs.ca.gov/services/hf/Pages/FAQHealthPlans.aspx (last visited Aug. 20, 2013).

[27] CAL. WELF. & INST. CODE § 14005.61(c)(1); *see also* CAL. DEPT. HEALTH CARE SERVS., LIHP TRANSITION PLANNING: CONTINUITY OF CARE DRAFT PLAN 2 (2013), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Meetings/LIHPTransition-ContinuityofCareFrameworkDRAFT.pdf.

[28] CAL. WELF. & INST. CODE §§ 14005.61(c)(2)-(4).

[29] *Id.* § 14005.61(c)(5).

[30] *See* CAL. DEPT. HEALTH CARE SERVS., *supra* note 27 at 2.

[31] *Id.*

[32] *Id.*

[33] *See generally* MEMORANDUM OF UNDERSTANDING (MOU) BETWEEN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND THE STATE OF CALIFORNIA REGARDING A FEDERAL-STATE PARTNERSHIP TO TEST A CAPITATED FINANCIAL ALIGNMENT MODEL FOR MEDICARE-MEDICAID ENROLLEE: CALIFORNIA DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE BENEFICIARIES (2013) [hereinafter MOU], *available at* https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.

[34] *Id.* § III(C)(1) (page 8).

[35] *See, e.g., id.* § III(E)(2) (page 14).

[36] *Id.* at Appx. 7 §§ IV(c)(iv), (v) (page 85).

[37] *Id.* at Appx. 7 § IV(c)(iii) (page 85).

[38] CAL. WELF. & INST. CODE §§ 14132.275(k)(2)(A) (Medicare), 14182.17(d)(5)(G) (Medi-Cal).

[39] *Id.* § 14132.275(k)(2)(A).

[40] *Id.; see also* MOU, *supra* note 33 at Appx. 7 § V(b)(ii)(1) (page 95).

[41] CAL. WELF. & INST. CODE § 14182.17(d)(5)(G)*;* MOU, *supra* note 33 at Appx. 7 § IV(c)(iii) (page 85).

[42] CAL. WELF. & INST. CODE § 14182.17(d)(5)(G)*;* MOU, *supra* note 33 at Appx. 7 § V(b)(ii)(2) (page 95).

[43] MOU, *supra* note 33 at Appx. 7 §§ V(b)(ii)(1)(a), V(b)(ii)(2)(a) (page 95).

[44] *See* CENTERS FOR MEDICAID & MEDICARE SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, Ch. 6 at 30.4.3 (2010), available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf. Medicare generally provides that if a beneficiary presents a newly written non-formulary prescription at the pharmacy during the COC period, and the pharmacy cannot determine at the point of service whether the

prescription is for ongoing drug therapy, the pharmacy must fill the prescription and the plan must cover the fill. *See id.*

[45] CAL. WELF. & INST. CODE § 14186.2.

[46] *Id.*

[47] *Id.*

[48] *Id.* §§ 14186.3(b)(2)(B), (3)(B).

[49] *Id.* §§ 14186(b)(3), (b)(5)(E), (b)(6)(A); *id.* §§ 14186.35(a)(9), (b); *see also* CAL. DEPT. HEALTH CARE SERVS., IN-HOME SUPPORTIVE SERVICES AND THE COORDINATED CARE INITIATIVE FREQUENTLY ASKED QUESTIONS (2012), *available at* http://www.calduals.org/wp-content/uploads/2012/09/FAQIHSS090512.pdf.

[50] CAL. WELF. & INST. CODE § 14186.3(c)(3).