



## Continuity of Care in Medi-Cal Managed Care (Updated 2023)

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#### Introduction

Continuity of Care (“COC”) is critical to Medi-Cal beneficiaries in a variety of circumstances, including when a provider leaves a member’s Medi-Cal managed care plan, when coverage of a Medi-Cal benefit changes from fee-for-service (FFS) to managed care, when a beneficiary moves from FFS Medi-Cal into a managed care plan, or moves into Medi-Cal managed care from Covered California after a change of circumstances, or when a plan member’s enrollment changes from one Medi-Cal health plan to another. COC protections typically allow Medi-Cal beneficiaries to continue receiving existing treatments (including medications) without having to go through additional prior authorization processes for a period of time after a transition, and in some cases also permit Medi-Cal beneficiaries to continue seeing providers who are out-of-network with their Medi-Cal managed care plan for a period of time. Lack of COC can lead to significant 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.

There are a number of laws and policies that govern COC for Medi-Cal beneficiaries, depending on the situation. Some of these protections are specific to Medi-Cal while others are more broadly applicable to people enrolled in certain licensed managed care plans in California. This fact sheet provides an overview of the laws and regulations that require COC for Medi-Cal beneficiaries.

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## **COC protections for Medi-Cal beneficiaries who are required to move from one Medi-Cal managed care plan to a new plan starting in 2024**

In 2021 DHCS initiated the process to reprocure the Commercial plans that participate in Medi-Cal managed care, with the intent of entering into new managed care contracts with those plans beginning 2024.<sup>1</sup> As a result of the reprocurement, on January 1, 2024, the Medi-Cal managed care plan options in many counties will change, which will require many beneficiaries to change plans.<sup>2</sup> DHCS will require the plans that are receiving new members as a result of these changes (“the receiving plans”) to provide COC to the beneficiaries who were required to change plans on January 1, 2024.<sup>3</sup> Receiving plans are required to ensure that they contract with at least 90% of transitioning members’ primary care providers, to mitigate the potential for gaps in care during the transition.<sup>4</sup> In addition, the plans that will no longer be participating in Medi-Cal managed care in any given county (“the exiting plans”) will be required to share information in advance about their members who are transitioning in order to facilitate COC during the transition period.<sup>5</sup> As discussed in Part X, *infra*, Beneficiaries who are required to change plans in 2024 may also be eligible for extended COC protections under the California Knox-Keene Act, in addition to the protections outlined below.<sup>6</sup>

### **COC to continue seeing pre-existing providers for up to 12 months**

Beneficiaries who mandatorily transition into a new Medi-Cal managed care plan as a result of DHCS’s reprocurement have the right to request COC with their existing providers.<sup>7</sup> This right arises when a beneficiary is mandatorily moved into a new Medi-Cal managed care plan on January 1, 2024, and their provider does not participate in the receiving plan’s network.<sup>8</sup>

California’s COC policy allows beneficiaries to request up to 12 months of COC with a provider with whom they have a pre-existing relationship.<sup>9</sup> This COC option is available for primary care providers, specialists, Enhanced Care Management (ECM) providers, providers of Community Supports Services (CSS), Skilled Nursing Facility (SNF) services, Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD) services, providers of Community-Based Adult Services (CBAS), and select ancillary service providers: dialysis centers, physical therapists, occupational therapists, respiratory therapists, mental health providers, Behavioral Health Treatment (BHT) providers, speech therapy providers, Doulas, and Community Health Workers (CHWs).<sup>10</sup> COC is not available to facilitate beneficiaries’ continuing to receive care from other ancillary providers who are out-of-network in their new Medi-Cal managed care plan, such as radiology, laboratory, non-emergency medical transportation (NEMT), non-medical transportation (NMT), and other ancillary services; nor is it available for providers who are not enrolled in Medi-Cal.<sup>11</sup> Medi-Cal managed care plans are only required to provide COC for covered benefits.<sup>12</sup>

The beneficiary must request continuity from their new managed care plan. The plan must approve such continued care when: 1) the provider is willing to accept the Medi-Cal managed care plan's contract rates or Medi-Cal FFS rates; 2) the provider meets the plan's applicable professional standards and has no disqualifying quality of care issues; 3) the provider is a California State Plan approved Provider; and 4) the plan determines that a valid pre-existing relationship exists between the beneficiary and provider.<sup>13</sup> A quality-of-care issue means the health plan can document concerns with the provider's quality-of-care such that the provider would not be eligible to provide services to any other health plan members.<sup>14</sup>

The plan must notify beneficiaries whether continuity of care will be provided within 30 days of their request for non-urgent requests.<sup>15</sup> Plans must provide continuity of care within 15 days of request if the beneficiary has upcoming appointments or health needs that require immediate attention, and within three days of request where there is a risk of harm to the beneficiary if treatment is discontinued.<sup>16</sup> If the plan is unable to reach an agreement with an out-of-network provider, or the plan has documented quality of care issues with the provider, the plan must offer the enrollee an in-network provider alternative.<sup>17</sup> Beneficiaries may appeal COC decisions using the grievance and appeal processes available in Medi-Cal.<sup>18</sup>

### **Enhanced COC for Special Populations**

Beyond the COC protections described above, DHCS is requiring receiving plans to provide additional COC for certain populations, which includes beneficiaries:

- with authorizations to receive Community Supports
- receiving Complex Care Management
- enrolled in 1915(c) waiver programs
- receiving in-home supportive services (IHSS)
- enrolled in California Children's Services (CCS)/CCS Whole Child Model
- receiving foster care, and former foster youth through age 25
- in active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- taking immunosuppressive medications, immunomodulators, and biologics
- receiving treatment for end-stage renal disease (ESRD)
- living with an intellectual or developmental disability (I/DD) diagnosis
- living with a dementia diagnosis
- in the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
- pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- receiving specialty mental health services (adults, youth, and children)

- receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- receiving hospice care
- receiving home health
- residing in Skilled Nursing Facilities (SNF)
- with authorizations to receive Community Supports
- receiving Complex Care Management
- residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- receiving hospital inpatient care
- post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- newly prescribed DME (within 30 days of January 1, 2024)
- receiving Community-Based Adult Services<sup>19</sup>

DHCS will work with the exiting plans to identify members of these populations for the receiving plans before January 1, 2024.<sup>20</sup> For these populations, the receiving plan must affirmatively reach out to any of the member's providers who are not in its network and attempt to establish a COC agreement without the member having to make a request for COC.<sup>21</sup> The receiving plan must work closely with the beneficiary's care manager, if applicable.<sup>22</sup> In addition, the receiving plan must closely monitor the beneficiary's utilization over the first six months of 2024 to ensure that the beneficiary does not experience any gaps in care.<sup>23</sup>

### **COC for beneficiaries receiving Enhanced Care Management (ECM)**

To reduce disruptions in care for transitioning beneficiaries, DHCS is requiring receiving plans to contract with Enhanced Care Management (ECM) providers who contracted with exiting plans "to the maximum extent possible."<sup>24</sup> Where a transitioning member is receiving ECM services before the transition, and the ECM provider participates in the receiving plan's network, the receiving plan should take steps to ensure that the beneficiary can continue receiving ECM without any gaps in care.<sup>25</sup> If the receiving plan is not able to reach an agreement with a transitioning beneficiary's ECM provider, the plan must arrange for the beneficiary to continue care with their pre-existing out-of-network ECM Provider for up to 12 months.<sup>26</sup>

### **COC for beneficiaries receiving Community Support Services (CSS)**

If the exiting plan and receiving plan offer the same CSS, even if there are differences in amount, duration or scope of the service covered, the receiving plan is obligated to bring the exiting plan's CSS providers into its network "to the maximum extent possible."<sup>27</sup> Where the

exiting plan and receiving plan offer the same CSS, the receiving plan must honor existing authorizations for CSS for at least the length of time originally authorized or 12 months, whichever is shorter.<sup>28</sup> In this situation, the receiving plan should take steps to ensure that the beneficiary can continue receiving ECM without any gaps in care.<sup>29</sup> If the receiving plan is not able to reach an agreement with a transitioning beneficiary's CSS provider, the plan must arrange for the beneficiary to continue care with their pre-existing out-of-network CSS Provider for up to 12 months.<sup>30</sup>

If the exiting plan and receiving plan do not offer the same CSS, the receiving plan is encouraged, but not required, to honor transitioning beneficiary's existing authorizations for CSS for up to 12 months.<sup>31</sup> Similarly, the receiving plan is encouraged, but not required, to arrange for COC for the transitioning beneficiary to continue care with their pre-existing out-of-network CSS Provider for up to 12 months.<sup>32</sup> If the receiving plan chooses not to honor an existing authorization for CSS, the plan must assess the beneficiary's needs and coordinate care to other necessary services, including ECM, to ensure an appropriate transition for the beneficiary.<sup>33</sup>

### Beneficiaries with existing specialist appointments

Beneficiaries may request COC to see an out-of-network specialist with whom they have an appointment scheduled after the transition, even if they do not have a pre-existing relationship with that specialist.<sup>34</sup> However, if the Medi-Cal managed care plan is able to arrange an appointment with an in-network specialist on or before the scheduled appointment date, it is not obligated to provide COC with the out-of-network specialist.<sup>35</sup> If an appointment with an in-network specialist is not available on or before the scheduled appointment date, the Medi-Cal managed care plan should make a "good faith effort" to provide COC with the out-of-network specialist.<sup>36</sup>

### COC to continue certain authorized services during the transition

For beneficiaries who are mandatorily moved into a new Medi-Cal managed care plan on January 1, 2024, the receiving plan must also ensure that they maintain access to active courses of treatment and previously authorized services without disruption.<sup>37</sup> Receiving plans must provide six months of COC for any active courses of treatment and authorizations in effect between January 1, 2024 and July 1, 2024 automatically, that is, without the need for the beneficiary to make a request.<sup>38</sup> To facilitate this, the receiving plan must be able to accept authorizations from transitioning members' providers no later than November 1, 2023.<sup>39</sup> The exiting plans will also be required to share information with the receiving plans to facilitate COC.<sup>40</sup> After the six month COC period has expired, the receiving plan must work with the beneficiary and their providers to determine an appropriate course of treatment going forward.<sup>41</sup>

**COC for beneficiaries using the Transplant Benefit**

To ensure that beneficiaries who are undergoing a transplant do not experience any disruptions in care during the transition, DHCS is requiring all receiving plans to include any Center of Excellence (COE) Transplant Programs that contracted with the exiting plans in their networks when possible.<sup>42</sup> If the receiving plan is not able to reach an agreement with an existing plan's COE Transplant Program, the receiving plan must attempt to reach a COC agreement with any out-of-network providers in the program who are providing care to its new members, for the duration of their need to access the Transplant Program.<sup>43</sup> The receiving plans must pay these providers the applicable FFS rate for their services.<sup>44</sup> If the receiving plan is also not able to reach an agreement with the providers, it must explain the reasons it was not able to reach an agreement to DHCS, and must arrange with the hospital where the Transplant Program is located to continue the beneficiary's care without interruption.<sup>45</sup> The receiving plan may reassess medical necessity for beneficiaries to continue receiving the transplant benefit after July 1, 2024, and may adjust the beneficiary's care plan based on the reassessment as clinically appropriate.<sup>46</sup>

**COC for beneficiaries receiving inpatient hospital care**

If a beneficiary is receiving inpatient hospital care when they transition to a new plan on January 1, 2024, the receiving plan must initiate contact with the hospital and coordinating transitional care services.<sup>47</sup> To facilitate a smooth transition, the exiting plan must inform the receiving plan of beneficiaries known to be receiving inpatient care on December 22, 2023, and must update that information daily through January 9, 2024.<sup>48</sup> In addition to contacting the hospital, the receiving plan must also contact the beneficiary's Primary Care provider while they are admitted.<sup>49</sup> The exiting plan and receiving plan must work with the hospital to clarify payment responsibility during the transition period and ensure that the beneficiary is not balance billed for covered Medi-Cal services.<sup>50</sup>

**COC for Durable Medical Equipment (DME) and Medical Supplies**

Receiving plans must automatically allow transitioning beneficiaries to keep any existing Durable Medical Equipment (DME) rentals and medical supplies that were authorized before their transition.<sup>51</sup> The plan must allow beneficiaries to keep prior authorized DME and medical supplies for at least 6 months after the transition, or longer, until the plan has reassessed the beneficiary and provided the beneficiary with new equipment or supplies.<sup>52</sup> If the beneficiary had previously received authorization for DME or medical supplies that will not be provided until after the beneficiary's transition to the receiving plan, the plan must also allow the beneficiary to keep the equipment or supplies for at least 6 months, until the plan has performed a new assessment.<sup>53</sup> In either scenario, if the plan does not complete a new assessment, the existing authorization will remain in effect for the duration of the treatment

authorization.<sup>54</sup> After 6 months, the plan may reassess the existing authorization at any time and require the beneficiary to see a network provider to continue receiving needed DME or medical supplies.<sup>55</sup>

### **COC for transportation services**

For beneficiaries who had pre-authorization for transportation services before the transition, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), the receiving plan must take steps to ensure that the beneficiary is able to keep their existing modality of transportation for at least six months after the transition.<sup>56</sup> The plan may require the beneficiary to change to a network transportation provider, however, if an appropriate provider is available.<sup>57</sup> If an appropriate network provider is not able to meet the beneficiary's needs, the receiving plan must make a "good faith effort" to allow the beneficiary to continue receiving transportation services from an out-of-network provider.<sup>58</sup> After 6 months, the plan may reassess the beneficiary's need for transportation.<sup>59</sup>

## **COC protections for Medi-Cal beneficiaries who move from FFS Medi-Cal to Medi-Cal Managed Care**

### **COC to continue seeing pre-existing providers for up to 12 months**

Beneficiaries who mandatorily transition from FFS into a Medi-Cal managed care plan have the right to request COC with Providers.<sup>60</sup> This right arises when a beneficiary is mandatorily moved into Medi-Cal managed care from FFS Medi-Cal on or after January 1, 2023.<sup>61</sup> Consistent with Federal Law, beneficiaries transitioning plans must (a) have access to services consistent with the access they previously had; (b) be permitted to have continued access to services during a transition from FFS to a Medi-Cal managed care plan or from one plan to another; and (c) be permitted to retain their current Provider for a period of time if that Provider is not in the Medi-Cal managed care plan's Network.<sup>62</sup>

The Medi-Cal COC policy allows beneficiaries to request up to 12 months of COC with a provider with whom they have a pre-existing relationship.<sup>63</sup> COC may be requested retroactively.<sup>64</sup> This COC option is available for primary care providers, specialists, skilled nursing facilities, intermediate care facilities, sub-acute care facilities, and select ancillary providers including providers of physical therapy, occupational therapy, respiratory therapy, behavioral health therapy (BHT), and speech therapy.<sup>65</sup> COC is not available to facilitate beneficiaries' continuing to receive care from other ancillary providers who are out-of-network in their new Medi-Cal managed care plan, such as radiology, laboratory, dialysis centers, non-emergency medical transportation (NEMT), non-medical transportation (NMT), and other ancillary services; nor is it available for providers who are not enrolled in Medi-Cal.<sup>66</sup> Medi-Cal managed care plans are only required to provide COC for covered benefits.<sup>67</sup>

The beneficiary must request continuity from their new managed care plan. The plan must approve such continued care when: 1) the provider is willing to accept the Medi-Cal managed care plan's contract rates or Medi-Cal FFS rates; 2) the provider meets the plan's applicable professional standards and has no disqualifying quality of care issues; 3) the provider is a California State Plan approved Provider; and 4) the plan determines that a valid pre-existing relationship exists between the beneficiary and provider.<sup>68</sup> A quality-of-care issue means the health plan can document concerns with the provider's quality-of-care such that the provider would not be eligible to provide services to any other health plan members.<sup>69</sup> In determining whether there is a pre-existing relationship, the plan may take into consideration Medi-Cal FFS data, claims data from another plan, or information from the beneficiary or provider themselves to make this determination.<sup>70</sup>

The plan must notify beneficiaries whether COC will be provided within 30 days of their request unless an exception applies.<sup>71</sup> Plans must provide COC within 15 days of request if the beneficiary has upcoming appointments, and within three days of request where there is a risk of harm to the beneficiary if treatment is discontinued.<sup>72</sup> If the plan is unable to reach an agreement with an out-of-network provider, or the plan has documented quality of care issues with the provider, the plan must offer the enrollee an in-network Provider alternative.<sup>73</sup> If the beneficiary does not select an in-network provider, the plan will assign the enrollee to an in-network provider, instead.<sup>74</sup> Out-of-network providers may be reimbursed for services provided to enrollees up to 30 days before the beneficiary requested COC, if the request is ultimately granted.<sup>75</sup> Beneficiaries may appeal COC decisions using the grievance and appeal processes available in Medi-Cal.<sup>76</sup>

The 12 month period for COC for pre-existing providers can restart once if the beneficiary changes plans or disenrolls and then re-enrolls in Medi-Cal managed care during the initial 12 month period.<sup>77</sup> If the beneficiary changes plans or disenrolls and re-enrolls in Medi-Cal managed care more than once, the COC period will not restart again.<sup>78</sup>

### **Skilled Nursing Facility care for beneficiaries who transition into Medi-Cal managed care on or before June 30, 2023**

Starting January 2023, all Medi-Cal managed care plans must cover Skilled Nursing Facility Services.<sup>79</sup> Previously, Skilled Nursing Facility services were covered in COHS and Coordinated Care Initiative plans, but other Medi-Cal managed care plans covered only the first 30 days of the service, after which the beneficiary was disenrolled to fee-for-service Medi-Cal.<sup>80</sup> As of January 1, 2023, all beneficiaries in FFS Medi-Cal who use Skilled Nursing Facility services are required to enroll in a Medi-Cal managed care plan.<sup>81</sup>

To ensure continuity of care for people in Skilled Nursing Facilities during the transition of these services to Medi-Cal managed care plans, DHCS has put several protections in place. For beneficiaries who were in a Skilled Nursing Facility between January 1 and June 30, 2023, the Medi-Cal plan must automatically allow the beneficiary to remain in the same Skilled Nursing Facility, even if it is out-of-network, for 12 months, as long as the Facility complies with state criteria.<sup>82</sup> Medi-Cal managed care plans are responsible for consulting available data sources to determine if beneficiaries have received care in an out-of-network Skilled Nursing Facility during the 12 months preceding their enrollment in the plan, making them eligible for automatic COC.<sup>83</sup> Following the 12 month automatic COC period, enrollees in Skilled Nursing Facilities may request an additional 12 months of COC from their plan.<sup>84</sup>

For beneficiaries who newly enroll in a Medi-Cal managed care plan after July 1, 2023, COC will not be automatic, but will be available upon request, as described in more detail above.<sup>85</sup>

### **Intermediate Care Facility care for beneficiaries who transition into Medi-Cal managed care starting on January 1, 2024**

Starting January 2024, all Medi-Cal managed care plans will cover Intermediate Care Facility Services.<sup>86</sup> Previously, Intermediate Care Facility services were covered by COHS plans, but in all non-COHS counties, beneficiaries who required this service were enrolled in fee-for-service Medi-Cal.<sup>87</sup> All beneficiaries in FFS Medi-Cal who use Intermediate Care Facility services will be required to enroll in a Medi-Cal managed care plan starting on January 1, 2024.<sup>88</sup>

To ensure COC for people in Intermediate Care Facilities during the transition of these services to Medi-Cal managed care plans in non-COHS counties, DHCS has put several protections in place. For beneficiaries who are in an Intermediate Care Facility as of January 1, 2024, the Medi-Cal plan must automatically allow the beneficiary to remain in the same Intermediate Care Facility, even if it is out-of-network, for 12 months, as long as the Facility complies with state criteria and Intermediate Care Facility services are medically necessary.<sup>89</sup> Medi-Cal managed care plans are responsible for consulting available data sources to determine if beneficiaries have received care in an out-of-network Intermediate Care Facility during the 12 months preceding their enrollment in the plan, making them eligible for automatic COC.<sup>90</sup> Following the 12 month automatic COC period, enrollees in Intermediate Care Facilities may request an additional 12 months of COC from their plan.<sup>91</sup> People in Intermediate Care Facilities who receive prescription drugs that are billed on a medical or institutional claim must also be allowed to maintain access to their current prescriptions until the person is evaluated by a network provider who recommends a change to their prescriptions.<sup>92</sup>

**Subacute Care Facility care for beneficiaries who transition into Medi-Cal managed care starting on January 1, 2024**

Starting January 2024, all Medi-Cal managed care plans will cover Subacute Care Facility Services.<sup>93</sup> Previously, Subacute Care Facility services were covered by COHS plans, and were covered for adults in five non-COHS counties, but in all other counties, beneficiaries who required this service were enrolled in fee-for-service Medi-Cal after one month of admission to a Subacute Care Facility.<sup>94</sup> All beneficiaries in FFS Medi-Cal who use Subacute Care Facility services will be required to enroll in a Medi-Cal managed care plan starting on January 1, 2024.<sup>95</sup>

To ensure COC for people in Subacute Care Facilities during the transition of these services to Medi-Cal managed care plans, DHCS has put several protections in place. For beneficiaries who are in a Subacute Care Facility as of January 1, 2024, the Medi-Cal plan must automatically allow the beneficiary to remain in the same Subacute Care Facility, even if it is out-of-network, for 12 months, as long as the Facility complies with state criteria and Subacute Care Facility services are medically necessary.<sup>96</sup> Medi-Cal managed care plans are responsible for consulting available data sources to determine if beneficiaries have received care in an out-of-network Subacute Care Facility during the 12 months preceding their enrollment in the plan, making them eligible for automatic continuity of care.<sup>97</sup> Following the 12 month automatic COC period, enrollees in Subacute Care Facilities may request an additional 12 months of COC from their plan.<sup>98</sup>

People in Subacute Care Facilities who are receiving services authorized before the transition, whether authorized as part of the Subacute Care Facility per diem or separately, must also be automatically allowed to continue receiving those authorized services for the duration of the authorization, or six months, whichever is shorter.<sup>99</sup> The person may request to extend the authorization for another six months, or one year if their medical condition requires a prolonged period of skilled nursing care.<sup>100</sup> Before terminating previously authorized services, a plan must ensure that the person is evaluated by a network provider who recommends a change to the authorization as part of the person's new treatment plan.<sup>101</sup>

**Beneficiaries with existing specialist appointments**

Beneficiaries may request COC to see an out-of-network specialist with whom they have an appointment scheduled even if they do not have a pre-existing relationship with that specialist.<sup>102</sup> However, if the Medi-Cal managed care plan is able to arrange an appointment with an in-network specialist on or before the scheduled appointment date, it is not obligated to provide COC with the out-of-network specialist.<sup>103</sup> If an appointment with an in-network specialist is not available on or before the scheduled appointment date, the Medi-Cal managed

care plan should make a “good faith effort” to provide COC with the out-of-network specialist.<sup>104</sup>

### Beneficiaries whose Medical Exemption Request is denied

In some situations, a beneficiary can request a temporary exemption from mandatory enrollment into a Medi-Cal managed care plan when the beneficiary has a serious health condition in order to continue receiving care through FFS Medi-Cal until their health condition has stabilized; this is called a Medical Exemption Request (MER).<sup>105</sup> If a beneficiary’s request for an MER is denied, their Medi-Cal managed care plan must automatically (that is, without the beneficiary initiating the request) consider that MER as a COC request to complete courses of treatment with out-of-network providers.<sup>106</sup> The plan must process the COC request in accordance with the procedures for COC to continue seeing pre-existing providers for up to 12 months described above.<sup>107</sup>

### Beneficiaries with other existing Treatment Authorizations

Even when a beneficiary cannot receive COC to continue seeing a pre-existing provider, Medi-Cal managed care plans must make COC available to allow the beneficiary to continue receiving pre-authorized covered services.<sup>108</sup> Based on available data, the Medi-Cal plan must determine what services are authorized for new enrollees upon enrollment, and facilitate the beneficiary’s receiving authorized services from a network provider, or, if none is available, and out-of-network provider, without delay, for at least 90 days after enrollment.<sup>109</sup> After 90 days, the plan may reassess the beneficiary’s ongoing need for the service, even if the authorization has not yet expired.<sup>110</sup> A new assessment may be completed by a network provider in-person or via synchronous Telehealth; the network provider should review the beneficiary’s current condition and complete a new treatment plan for the beneficiary.<sup>111</sup>

### Beneficiaries with Enhanced Care Management (ECM)

For beneficiaries who were receiving ECM services before moving into a Medi-Cal managed care plan, the Medi-Cal managed care plan must automatically ensure that the beneficiary is able to keep receiving ECM.<sup>112</sup> The plan may require the beneficiary to change to a network ECM provider, however.<sup>113</sup> In addition, the plan may reassess the beneficiary’s need for ECM after 90 days even if the existing authorization period has not yet expired.<sup>114</sup> However, the plan must assess the beneficiary’s ongoing need for ECM using the ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria.<sup>115</sup>

### Beneficiaries with Durable Medical Equipment (DME) and Medical Supplies

Medi-Cal managed care plans must automatically allow newly enrolling beneficiaries to keep any existing Durable Medical Equipment (DME) rentals and medical supplies that were authorized before their enrollment in the plan.<sup>116</sup> The plan must provide COC for these

equipment and supplies automatically upon information about the authorization, without the need for the beneficiary or provider to request COC.<sup>117</sup> The plan must allow beneficiaries to keep prior authorized DME rentals and medical supplies for at least 90 days after enrollment, or longer, until the plan has reassessed the beneficiary and provided the beneficiary with new equipment or supplies.<sup>118</sup> If the beneficiary had previously received authorization for DME or medical supplies that will not be provided until after the beneficiary's enrollment in the Medi-Cal managed care plan, the plan must also allow the beneficiary to keep the equipment or supplies for at least 90 days, until the plan has performed a new assessment.<sup>119</sup> In either scenario, if the plan does not complete a new assessment, the existing authorization will remain in effect for the duration of the treatment authorization.<sup>120</sup> After 90 days, the plan may reassess the existing authorization at any time and require the beneficiary to see a network provider to continue receiving needed DME or medical supplies.<sup>121</sup>

### **Beneficiaries with Transportation Services**

For beneficiaries who had pre-authorization for transportation services before moving into a Medi-Cal managed care plan, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), the Medi-Cal managed care plan must automatically ensure that the beneficiary is able to keep their existing modality of transportation.<sup>122</sup> The plan may require the beneficiary to change to a network transportation provider, however.<sup>123</sup> In addition, the plan may reassess the beneficiary's need for transportation even before the existing authorization period expires.<sup>124</sup>

### **COC protections for Medi-Cal beneficiaries who move from Covered California to Medi-Cal Managed Care plan.**

When a person who was previously enrolled in Covered California moves into Medi-Cal managed care coverage as the result of an eligibility determination, the Medi-Cal managed care plan must make a good faith effort to obtain information from the beneficiary about any active and ongoing treatments or medications.<sup>125</sup> To facilitate these efforts, the Medi-Cal managed care plan must attempt to contact the new enrollee within 15 days of enrollment.<sup>126</sup> The Medi-Cal managed care plan must honor any active treatment authorizations for up to 90 days or until a new assessment is completed by the plan, however, the plan may require the beneficiary to receive care from an in-network provider if one is available.<sup>127</sup> After 90 days, the active authorization will remain in effect for the duration of the treatment authorization or until completion of a new assessment, whichever is shorter.<sup>128</sup> This new assessment may be done in-person or via synchronous Telehealth by a Network Provider.<sup>129</sup> The Medi-Cal managed care plan must honor these active treatment authorizations even without a request for COC by the enrollee or the provider.<sup>130</sup>

In addition, when a person who was previously enrolled in Covered California moves into Medi-Cal managed care coverage, they have a right to continue seeing an out-of-network provider for up to 12 months.<sup>131</sup> The process for such requests is the same as for beneficiaries newly transitioning to Medi-Cal managed care from FFS Medi-Cal.<sup>132</sup>

### **Special protections for American Indians and Alaska Natives receiving care from Indian Health Care Providers**

Qualifying American Indians and Alaska Natives are exempt from mandatory managed care enrollment in Two-Plan, Geographic Managed Care (GMC), and Regional Model counties; however, they must enroll in managed care in COHS and Single Plan counties.<sup>133</sup> Qualifying American Indians and Alaska Natives who are enrolled in Medi-Cal are also entitled to access care from Indian Health Care Providers, regardless of whether the Indian Health Care Provider participates in their Medi-Cal managed care plan's network, without incurring any additional out-of-pocket costs.<sup>134</sup> Thus, any qualifying American Indian or Alaska Native beneficiary who is newly required to enroll into managed care as a result of the managed care model changes that go into effect on January 1, 2024, or who choose to enroll into a managed care plan at any time are entitled to see Indian Health Care Providers, even if those providers are not included in their managed care plan's network.<sup>135</sup> This protection applies regardless of whether the beneficiary has a pre-existing relationship with the Indian Health Care provider.<sup>136</sup>

### **Special COC protections for beneficiaries receiving Specialty Mental Health Services**

Medi-Cal managed care plans are responsible for covering non-specialty mental health services, such as psychological testing.<sup>137</sup> Individuals who need specialty mental health services, such as crisis intervention services, access those services through County Mental Health Plans.<sup>138</sup> In some situations, the condition of a beneficiary who has been receiving specialty mental health services will stabilize such that the person no longer requires specialty mental health services from the County Mental Health Plan, and instead will transition to receiving non-specialty mental health services from their Medi-Cal managed care plan.<sup>139</sup> In this situation, the beneficiary is eligible for COC to receive non-specialty mental health services from the same provider who provided their specialty mental health services when the provider is able to provide the needed non-specialty mental health services, even if that provider is out-of-network with their Medi-Cal managed care plan, for up to 12 months.<sup>140</sup> If the beneficiary later receives specialty mental health services from the out-of-network provider, the beneficiary may be eligible for a second COC period of up to 12 months.<sup>141</sup>

## Knox-Keene Act circumstance-specific COC protections

Most—but not all—Medi-Cal managed care plans are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the California Knox-Keene Act.<sup>142</sup> The Knox Keene Act includes its own provisions that require licensed plans to provide COC to allow an enrollee to continue certain types of care with an out-of-network provider when the provider leaves their plan, or when the person has newly enrolled into a plan.<sup>143</sup> California has incorporated the Knox-Keene COC Protections to apply to all beneficiaries enrolled in a Medi-Cal managed care plan, and thus, all Medi-Cal managed care enrollees are entitled to these additional protections.<sup>144</sup> To be eligible to continue seeing a provider who is not in the network of an enrollee’s new plan, the enrollee must not have had any option to choose a plan that included that provider.<sup>145</sup> While in many cases, these COC protections overlap with other protections described above, in some situations they may allow for an enrollee to continue receiving certain services from out-of-network providers beyond the period otherwise authorized. Medi-Cal managed care plans should use available data to identify existing treatment authorizations whenever possible.<sup>146</sup> Enrollees are eligible for these additional COC protections that allow them to continue seeing out-of-network providers for specific services in six scenarios:

- **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.<sup>147</sup> Thus, MCPs must provide for the completion of Covered Services with out-of-network providers relating to pregnancy, during pregnancy and the post-partum period (12 months after birth).<sup>148</sup> Beneficiaries who have written documentation of being diagnosed with a maternal mental health condition may also receive COC for 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.<sup>149</sup>
- **Terminal Illness:** A health plan is required to provide COC for beneficiaries to receive care from out-of-network providers 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.”<sup>150</sup>
- **Care of baby or toddler:** A health plan must provide up to 12 months of COC with an out-of-network provider who is providing care to a child between birth and age thirty-six months.<sup>151</sup>
- **Acute Condition:** A health plan must provide COC for the full duration of an acute condition, such as pneumonia, to allow enrollees to continue seeing out-of-network

providers who are treating that condition.<sup>152</sup> "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."<sup>153</sup>

- **Serious Chronic Condition:** A health plan is required to provide COC to allow enrollees to continue receiving services delivered by an out-of-network provider for a serious chronic condition for the period necessary to complete the course of treatment and arrange for a safe transfer to another, in-network, provider.<sup>154</sup> "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."<sup>155</sup> 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 provider.<sup>156</sup>
- **Scheduled or Recommended Procedure:** A health plan must provide COC to allow an enrollee to undergo a procedure, such as surgery, performed by an out-of-network provider when that procedure 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.<sup>157</sup>

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**ENDNOTES**

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<sup>1</sup>See Cal. Dep't Health Care Servs., Request for Proposal #20-10029, [https://www.dhcs.ca.gov/provgovpart/rfa\\_rfp/Pages/CSBmcodmcpHOME.aspx](https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcodmcpHOME.aspx) (last visited Oct. 13, 2023).

<sup>2</sup> Cal. Dep't Health Care Servs., Blue Cross of California Partnership Plan, Blue Shield of California Promise Health Plan, CHG Foundation, Health Net Community Solutions, Inc. and Molina Healthcare of California, Joint Statement on the 2024 Medi-Cal Managed Care Plan Contracts (Dec. 30, 2022), <https://www.dhcs.ca.gov/CalAIM/Pages/MCP-RFP.aspx>; see also Abbi Coursolle, Nat'l Health L. Prog., *Medi-Cal Delivery System Changes in 2023 and 2024* (2023), <https://healthlaw.org/resource/medi-cal-delivery-system-changes-in-2023-and-2024>.

<sup>3</sup> See Cal. Dept. Health Care Servs., *2024 Medi-Cal Managed Care Plan Transition Policy Guide* 26 (2023), [https://www.dhcs.ca.gov/Documents/Managed\\_Care\\_Plan\\_Transition\\_Policy\\_Guide.pdf](https://www.dhcs.ca.gov/Documents/Managed_Care_Plan_Transition_Policy_Guide.pdf) (hereinafter *Transition Policy Guide*). These protections *do not* apply to beneficiaries who voluntarily changes plans after January 1, 2024. See *id.*

<sup>4</sup> *Id.* at 32.

<sup>5</sup> See *id.* at Ch. VIII.

<sup>6</sup> See CAL. HEALTH & SAFETY CODE § 1373.96. The Knox-Keene Act is encoded at *id.* §§ 1340-1399.818.

<sup>7</sup> See *Transition Policy Guide*, *supra* note 3, at 31.

<sup>8</sup> *Id.* at 31-32.

<sup>9</sup> *Id.* at 32.

<sup>10</sup> *Id.* at 33. For special rules for continuity of care for Skilled Nursing Facility services for individuals moved from FFS to Medi-Cal managed care on or before June 30, 2023, see *infra* Page X. For special rules for continuity of care for ICF/DD facility services for individuals moved from FFS to Medi-Cal managed care on or after January 1, 2024, see *infra* Page X. For special rules for continuity of care for sub-acute care facility services for individuals moved from FFS to Medi-Cal managed care on or after January 1, 2024, see *infra* Page X.

<sup>11</sup> See *Transition Policy Guide*, *supra* note 3, at 34, 39.

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 34-35.

<sup>14</sup> *Id.* at 35.

<sup>15</sup> *Id.* at 36.

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* at 38.

<sup>18</sup> *Id.* at 38. For a detailed explanation of the grievance and appeals processes available to Medi-Cal managed care enrollees, see Abbi Coursole, Nat'l Health Law Prog., *Internal Grievances and External Review for Service Denials in Medi-Cal Managed Care Plans* (2017 ed.), <https://healthlaw.org/resource/managed-care-in-california-series-issue-4-internal-grievances-and-external-review>.

<sup>19</sup> *Transition Policy Guide*, *supra* note 3, at 30-31.

<sup>20</sup> *Id.* at 30, 39.

<sup>21</sup> *Id.* at 39-40.

<sup>22</sup> *Id.* at 40, 46-48.

<sup>23</sup> *Id.* at 40, 45-46.

<sup>24</sup> *Transition Policy Guide*, *supra* note 3, at 53.

<sup>25</sup> *Id.*; see also Cal. Dep't Health Care Servs., *CalAIM Enhanced Care Management Policy Guide* 97-98 (2023), <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf> (hereinafter "ECM Policy Guide").

<sup>26</sup> *Transition Policy Guide*, *supra* note 3, at 53.

<sup>27</sup> *Id.* at 56.

<sup>28</sup> *Id.* at 55; see also Cal. Dep't Health Care Servs., *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* 69 (2023),

<https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf>.

<sup>29</sup> *Transition Policy Guide*, *supra* note 3, at 57.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at 56.

<sup>32</sup> *Id.* at 57.

<sup>33</sup> *Id.* at 56.

<sup>34</sup> *Transition Policy Guide*, *supra* note 3, at 50.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> See *Transition Policy Guide*, *supra* note 3, at 42-43. DHCS considers an active course to be "a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024 and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition." *Id.* at 43.

<sup>38</sup> *Id.* at 42-43. If the plan does not provide COC automatically for any reason, it must also consider requests for COC from members and their providers. *Id.* at 43.

<sup>39</sup> *Id.* at 43.

<sup>40</sup> *Id.*; see also *id.* at Ch. VIII.

<sup>41</sup> *Id.* at 43.

<sup>42</sup> *Transition Policy Guide*, *supra* note 3, at 40-41.

<sup>43</sup> *Id.* at 41.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 46.

<sup>47</sup> *Transition Policy Guide, supra* note 3, at 47.

<sup>48</sup> *Id.*

<sup>49</sup> *Id.* at 48.

<sup>50</sup> *Id.*

<sup>51</sup> *Transition Policy Guide, supra* note 3, at 48.

<sup>52</sup> *Id.* at 48-49.

<sup>53</sup> *Id.* at 49.

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> *Transition Policy Guide, supra* note 3, at 49-50.

<sup>57</sup> *Id.* at 49.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> See 42 C.F.R. § 438.62; Letter from Dana Durham, Chief Managed Care Quality and Monitoring Division, to All Medi-Cal Managed Care Health Plans 1-2 (Aug. 15, 2023) [hereinafter APL 23-022],

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL23-022.pdf>; see also CAL. HEALTH & SAFETY CODE §1367(d); §1373.96; Cal. Code Regs., tit. 28, §1300.67.1; 42 C.F.R. § 438.62.

<sup>61</sup> APL 23-022, *supra* note 60, at 1-2.

<sup>62</sup> 42 C.F.R. § 438.62.

<sup>63</sup> APL 23-022, *supra* note 60, at 2.

<sup>64</sup> *Id.* at 3.

<sup>65</sup> *Id.* at 3. For special rules for continuity of care for Skilled Nursing Facility services for individuals moved from FFS to Medi-Cal managed care on or before June 30, 2023, and Intermediate and Sub-Acute Care Nursing Facility services for individuals moved from FFS to Medi-Cal managed care on or before January 1, 2024 see *infra*.

<sup>66</sup> APL 23-022, *supra* note 60, at 3.

<sup>67</sup> *Id.* at 3.

<sup>68</sup> See CAL. WELF. & INST. CODE § 14182(b)(13); see also APL 23-022, *supra* note 60, at 3-4 fn.s 9-10.

<sup>69</sup> APL 23-022, *supra* note 60, at 4 fn. 10.

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* at 5.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* at 6

<sup>74</sup> *Id.*

<sup>75</sup> *Id.* at 4.

<sup>76</sup> *Id.* at 6. For a detailed explanation of the grievance and appeals processes available to Medi-Cal managed care enrollees, see Coursolle, *supra* note 18.

<sup>77</sup> APL 23-022, *supra* note 60, at 7.

<sup>78</sup> *Id.*

<sup>79</sup> See CAL. WELF. & INST. CODE § 14184.201(b)(1); Cal. Dep't Health Care Servs., All Plan Letter 23-004 at 2 (Mar. 14, 2023),

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-004.pdf> (hereafter APL 23-004); Cal. Dep't Health Care Servs., CalAIM Long-Term Care Carve-In Transition,

<https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx> (last visited Aug. 23, 2023) (hereafter CalAIM LTC Carve-In Page).

<sup>80</sup> APL 23-004, *supra* note 79, at 1.

<sup>81</sup> CAL. WELF. & INST. CODE §§ 14184.200(a), 14184.201(b)(1); APL 23-004, *supra* note 79, at 1.

<sup>82</sup> APL 23-004, *supra* note 79, at 6-7. The criteria are: the facility is enrolled and licensed by the California Department of Public Health; the facility is enrolled as a Medi-Cal provider; the facility agrees to accept payment rates that meet state requirements; and the facility meets professional standards and has no disqualifying quality-of-care issues. *Id.* at 7.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> *Id.*; see "Certain providers when beneficiaries are mandatorily moved into a Medi-Cal managed care plan," *supra*.

<sup>86</sup> See CAL. WELF. & INST. CODE § 14184.201(c)(1); APL 23-004, *supra* note 79, at 2; CalAIM LTC Carve-In Page, *supra* note 79. For the purposes of this paper, we will use the term "Intermediate Care Facility" to collectively refer to Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Homes, Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) Homes, but not ICF/DD-Continuous Nursing Care Programs. See APL 23-022, *supra* note 60, at 1-2.

<sup>87</sup> APL 23-022, *supra* note 60, at 2.

<sup>88</sup> CAL. WELF. & INST. CODE §§ 14184.200(a), 14184.201(c)(1); APL 23-022, *supra* note 60, at 1. Many people in Intermediate Care Facilities have developmental disabilities that qualify them for Regional Center Services under California's Lanterman Act. The requirement to enroll in a Medi-Cal managed care plan does not change their rights under the Lanterman Act, nor should it change the way they get services through the Regional Center. See *id.* at 3-5.

<sup>89</sup> APL 23-022, *supra* note 60, at 11-12. The criteria are: the facility is licensed by the California Department of Public Health; the facility is enrolled as a Medi-Cal provider; the facility agrees to accept payment rates that meet state requirements; and the facility meets professional standards and has no disqualifying quality-of-care issues. *Id.*

<sup>90</sup> *Id.* at 11.

<sup>91</sup> *Id.* at 12.

<sup>92</sup> *Id.*

<sup>93</sup> See CAL. WELF. & INST. CODE § 14184.201(c)(1); Cal. Dep't Health Care Servs., All Plan Letter 23-027 at 3 (Sep. 26, 2023),

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-027.pdf> (hereafter APL 23-027); CalAIM LTC Carve-In Page, *supra* note 79. For the purposes of this paper, we will use the term "Subacute Care Facility" to collectively refer to adult and pediatric Subacute Care Facilities, as well as subacute care provided by a licensed general acute care hospital with distinct part skilled nursing beds, or by a freestanding certified nursing facility. See APL 23-027, *supra*, at 1; see also Cal. Code Regs., tit. 22, § 51215.6; Cal. Dept. Health Care Servs., *Subacute Care Program*, <https://www.dhcs.ca.gov/provgovpart/Pages/SubacuteCare.aspx> (last visited Nov. 6, 2023).

<sup>94</sup> APL 23-027, *supra* note 93, at 2.

<sup>95</sup> CAL. WELF. & INST. CODE §§ 14184.200(a), 14184.201(c)(1); APL 23-027, *supra* note 93, at 3.

<sup>96</sup> APL 23-027, *supra* note 93, at 7-8. The criteria are: the facility is contracted or in the process of becoming contracted with DHCS's Subacute Contracting Unity; the facility is licensed by the California Department of Public Health; the facility is enrolled as a Medi-Cal provider; the facility agrees to accept payment rates that meet state requirements; and the facility meets professional standards and has no disqualifying quality-of-care issues. *Id.*

<sup>97</sup> *Id.* at 8.

<sup>98</sup> *Id.*

<sup>99</sup> *Id.* at 9, 10.

<sup>100</sup> *Id.* at 9, 10.

<sup>101</sup> *Id.* at 9, 10.

<sup>102</sup> APL 23-022, *supra* note 60, at 7.

<sup>103</sup> *Id.* at 8.

<sup>104</sup> *Id.*

<sup>105</sup> See APL 23-022, *supra* note 60, at 14-15. For a more detailed explanation of the legal standard for MERs, and how to request one, see Disability Rights Cal., *Medi-Cal Exemption Requests (MERs)* (2020), <https://www.disabilityrightsca.org/publications/medi-cal-exemption-requests-mers>.

<sup>106</sup> APL 23-022, *supra* note 60, at 15.

<sup>107</sup> *Id.*; see *infra*.

<sup>108</sup> APL 23-022, *supra* note 60, at 9.

<sup>109</sup> *Id.* at 10.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> APL 23-022, *supra* note 60, at 10.

113 *Id.*

114 *Id.*

115 *Id.* For more information about these criteria, see the ECM Policy Guide, *supra* note 25.

116 APL 23-022, *supra* note 60, at 11.

117 *Id.* The provider who prescribed the equipment or supplies must meet the criteria for COC for providers, described above. *See id.* at 11 fn. 21.

118 *Id.*

119 *Id.*

120 *Id.*

121 *Id.*

122 APL 23-022, *supra* note 60, at 11.

123 *Id.*

124 *Id.*

125 APL 23-022, *supra* note 60, at 14. Such transitions will typically arise either 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. *See id.*; *see also*, Continuity of Care and Managed Care-FAQ Answer 1a, DHCS (Dec. 20, 2022), <https://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx>.

126 APL 23-022, *supra* note 60, at 15.

127 *Id.* at 14.

128 *Id.* at 14.

129 *Id.* at 15.

130 *Id.*

131 *Id.* at 14.

132 *Id.* at 15.

133 42 U.S.C. 1396u-2(a)(2)(C); *see Transition Policy Guide, supra* note 3, at 11. To qualify as an American Indian or Alaska Native for this purpose, a beneficiary must be a member of a Federally recognized Indian tribe, an enrolled Alaska Native, a qualifying urban Indian, or otherwise considered an Indian by the Secretary of the Interior or Secretary of Health & Human Services. 42 C.F.R. §§ 457.10. 438.14(a).

134 42 U.S.C. 1396o(j); 42 C.F.R. §§ 447.56(a)(1)(x), 457.535. An Indian Health Care Provider is defined as "a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)." 42 C.F.R. § 438.14(a); *see also* Cal. Dep't Health Care Servs., All Plan Letter 21-008 (May 12, 2021),

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL-21-008.pdf>.

135 *Transition Policy Guide, supra* note 3, at 11.  
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<sup>136</sup> *Id.*

<sup>137</sup> CAL. WELF. & INST. CODE § 14184.402(b); *see also* Cal. Dep't Health Care Servs., All Plan Letter 22-006 at 3 (Apr. 8, 2022),

<https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf>.

<sup>138</sup> CAL. WELF. & INST. CODE § 14684(a)(7); 9 CAL. CODE REGS. § 1810.247. The criteria used to determine when a beneficiary needs specialty mental health services are set forth in Cal. Dep't Health Care Servs., Behavioral Health Info. Notice 21-073 at 3 (Dec. 10, 2021),

<https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf>.

<sup>139</sup> *See* APL 22-032, *supra* note 60, at 12.

<sup>140</sup> *Id.* Usually, this will mean that the Provider offers both a covered specialty mental health service and a related non-specialty mental health service, such as psychotherapy.

<sup>141</sup> *Id.*

<sup>142</sup> *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

<sup>143</sup> *Id.* § 1373.96.

<sup>144</sup> CAL. WELF. & INST. CODE § 14184.200(a)(2); *see also* APL 23-022, *supra* note 60, at 8-9, 14-15.

<sup>145</sup> CAL. HEALTH & SAFETY CODE § 1373.96(j).

<sup>146</sup> APL 23-022, *supra* note 60, at 11.

<sup>147</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(3).

<sup>148</sup> *Id.*; *see also* APL 22-032, *supra* note X, at 15.

<sup>149</sup> APL 23-022, *supra* note 60, at 9.

<sup>150</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(4); *see also* APL 23-022, *supra* note 60, at 14.

<sup>151</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(5); *see also* APL 23-022, *supra* note 60, at 9, 14.

<sup>152</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(1); *see also* APL 23-022, *supra* note 60, at 8.

<sup>153</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(1).

<sup>154</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(2)(A); *see also* APL 23-022, *supra* note 60, at 8.

<sup>155</sup> CAL. HEALTH & SAFETY CODE § 1373.96(c)(2)(A).

<sup>156</sup> *Id.*

<sup>157</sup> *Id.* § 1373.96(c)(6); *see also* APL 23-022, *supra* note 60, at 9.