CMC01005: Continuity of Care

CA Health Plan Compliance Training

May 2022

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Continuity of Care (COC) for Cal MediConnect (CMC)

Requirements:

- ❑ Defined in Welfare and Institutions (W&I) Code, §14182.17 and §14132.275.
- ❑ Exists in three-way contracts between CMS, DHCS and the managed care plans.
- ❑ CMS and DHCS requires that beneficiaries continue to have access to medically necessary items and services, as well as medical and LTSS providers.

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Requirements:

- CMS and DHCS requires that beneficiaries continue to have access to medically necessary items and services, as well as medical and LTSS providers.
  - To ensure that continuity of care and coordination of care requirements are met, managed care plans must perform Health Risk Assessments (HRA) within the timeframes specified in DPL 15-005.
  - As part of the HRA beneficiaries must be asked if there are upcoming health care appointments or treatments scheduled and assist them in initiating the COC process at that time if they choose to do so.

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Requirements:

- Medicare Part D transition rules and rights will continue as provided in current law and regulation for the entire integrated formulary.
- Plans and delegates must attempt to determine if beneficiaries have pre-existing provider relationships through previous utilization data, the HRA process, and contact with the beneficiary and/or their providers as needed.

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Granted upon member request provided the following circumstances exist:

- Beneficiary has an existing relationship with a PCP or specialty provider. The existing relationship means the beneficiary has seen an out-of-network PCP or specialist at least once during the 12 months prior to the date of member's initial enrollment in the MMP for a non-emergency visit.
- Provider is willing to accept, at minimum, payment from the plan based on current Medicare or Medi-Cal fee schedule, as applicable.
- Provider does not have any documented quality of care concerns that would cause the MMP to exclude the provider from its network.

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COC applies when:

- COC policies apply regardless of whether a beneficiary voluntarily joins or passively enrolls in a managed care plan (.e.g., if a beneficiary opted out of CMC and later decided to join).
- If a beneficiary opts out or disenrolls from CMC and later re-enrolls in CMC, the beneficiary has the right to a 12-month COC period, regardless of whether or not the beneficiary received COC in the past.

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When a member changes plans:

If a beneficiary changes managed care plans, the COC period may start over one time.

If the beneficiary changes plans a second time (or more), the COC period does not start over, meaning that the beneficiary does not have the right to a new 12-month period.

If a beneficiary changes plans, this COC policy does not extend to the providers in the previous plan's network, who now may be out-of-network providers in the new plan.

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Plans are not required to provide COC with OON providers when:

Services are not covered by Medi-Cal or Medicare.

Providers of durable medical equipment (DME), transportation, other ancillary services, or carved-out services (however, CMS and DHCS require each plan to ensure that each beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers (and/or)

The provider does not agree to abide by the plan's utilization management policies or a reimbursement.

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Requirements for Delegated Entities:

- ❑ When a beneficiary transitions into a plan and has an existing relationship with a PCP that is in-network or a contracted network, as determined through:
  - ❑ HRA process; or
  - ❑ Review of prior utilization data; or
  - ❑ Beneficiary request
- ❑ The member must be assigned to the previously utilized PCP, unless the beneficiary chooses a different PCP.
- ❑ Since plans contract with delegated entities, it must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network.

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Requirements for Delegated Entities:

- ❑ When a beneficiary transitions into a plan and has an existing relationship with a PCP or specialist that is in-network and beneficiary wishes to continue to see these providers for the COC period.
- ❑ Regardless of whether or not these providers are in the network of the prime plan's delegated entity to which the beneficiary is assigned as long as the COC requirements are met.
  - ❑ Example: If a beneficiary has an existing PCP and a specialist with the assigned Independent Physicians Association (IPA) #1 as well as a specialist in another IPA #2, where both IPAs are delegated entities of the same MMP, the MMP must assign the beneficiary to IPA #1 and allow beneficiary to continue treatment with both specialists. The COC agreement for the specialist in IPA #2 would last for up to 12 months for both Medicare and/or Medi-Cal services.

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Process for requesting COC:

Beneficiaries, their authorized representatives on file with Medi-Cal, or their providers, may make a direct request to a plan or delegate for COC.

Only those providers who treat beneficiaries, who are eligible for COC, as previously noted, may make a request for COC.

Plans and delegates must, at a minimum, accept request for COC over the phone, according to the requestor’s preference, and cannot require the requester to complete and submit paper or computer form. To complete a telephone request, the Plan or delegate may take any necessary information from the requester over the telephone.

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Retroactive Requests:

- ❑ Plans and its delegates must accept and approve retroactive requests for COC and claim payments that meet all COC requirements noted, with exception of the requirement to abide by Plan/delegates Utilization Management (UM) policies.
- ❑ Services that are the subject of the request must have occurred after the beneficiary's enrollment and UM must have the ability to demonstrate that there was an existing relationship between the beneficiary and provider for retroactive requests.

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Retroactive Requests:

- In addition, retractive requests must be approved if they meet the following requirements:
  - Have dates of services (DOS) that occur after September 29, 2014.
  - Have DOS within 30 calendar days of the first DOS for which the provider is requesting, or has previously requested, COC retroactive reimbursement; and
  - Are submitted within 30 calendar days of the first service for which retroactive COC is being requested or denial from another entity when the claim was incorrectly submitted.
    - The plan must accept retroactive requests that are submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity.

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Referrals by OON providers:

- An approved OON (COC covered) provider must work with the plan and its contracted network and cannot refer the beneficiary to another OON provider without authorization from the plan.
- Should an additional OON provider be needed, the plan or its delegate will make the referral, if medically necessary, if the plan or its delegate does not have an appropriate provider within its network.

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Determining existing relationship with requested OON provider:

- ❑ Plan or its delegate may determine if a relationship exists with the OON provider through use of data provided by CMS and DHCS, such as FFS utilization data from Medicare or Medi-Cal.
- ❑ A beneficiary may not attest to a pre-existing relationship (instead actual documentation must be provided) unless this option is made available to him or her through the appropriate UM department (delegate or plan).

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Requirements to contact the OON provider:

- ❑ Following identification of a pre-existing relationship, the plan or delegate 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 COC relationship for the beneficiary.

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Required timeframes for processing CMC COC requests:

- Plans or its delegates must begin processing COC requests within 5 working days from receipt of the request; and
- Must complete responses to each request within:
  - 30 calendar days from the date of receipt; or
  - 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
  - If there is a risk of harm to the beneficiary, the request must be completed within 3 days.
  - If the health plan/its delegate and the out-of-network FFS or prior health plan provider are unable to agree to a rate; or
  - If the health plan/its delegate makes a good faith effort to contact the provider who is non-responsive for 30 calendar days: or

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Required timeframes for processing CMC COC requests:

- ❑ If the health plan/its delegate has documented quality of care issues with the provider, or
- ❑ If the member is outside of the 12-month COC period or
- ❑ If the member has recently transitioned to the health plan/its delegate but has been with another health plan and has already had two CMC COC periods.

❑ If a provider meets all the necessary requirements, including entering into a contract, letter of agreement, single-case agreement, or other form of relationship with the plan or delegate, the plan or delegate must allow the beneficiary to have access to that provider for the length of the COC period unless the provider is only willing to work with the plan or delegate for a shorter timeframe. In this case, the plan or delegate must allow the beneficiary to have access to that provider for the shorter timeframe.

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Requirements after the request process is completed:

- ❑ A beneficiary may change providers at any time regardless of whether or not a COC relationship has been established. Once established, the plan or delegate must work with the provider to establish a care plan for the beneficiary.

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Upon completion of processing CMC requests for COC:

- ❑ Upon completion of COC request, the health plan or its delegates must notify CMC beneficiaries of the following within 7 calendar days:
  - ❑ Request approval or denial; and
    - ❑ If denied, the beneficiary's appeal and grievance rights.
    - ❑ If approved, the duration of the COC arrangement; and
  - ❑ Process to transition beneficiary's care at the end of the COC period; and the beneficiary's right to choose a different provider from the provider network
- ❑ Plans and delegates must also notify beneficiaries 30 calendar days before the end of the COC period about the process that will occur to transition the beneficiary's care at the end of the COC period.
- ❑ Must include engagement with beneficiary and provider before the end of the COC period to ensure continuity of services through the transition to a new provider.

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Extended COC option:

- Plans and delegates may choose to work with a beneficiary's out-of-network provider past the 12-month COC period but are not required to do so.

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Beneficiary and provider outreach and education:

- ❑ Plans must inform beneficiaries or their authorized representatives, of COC protections within 30 days of beneficiary enrollment, which must include information about these protections in information packets and handbooks.
- ❑ Information must include how a beneficiary and provider initiate a COC request with the plan. These documents must be translated into threshold languages and must be made available in alternative formats, upon request.
- ❑ Plans and delegates must provide training to call center and other staff who come into regular contact with beneficiaries about the COC protections.

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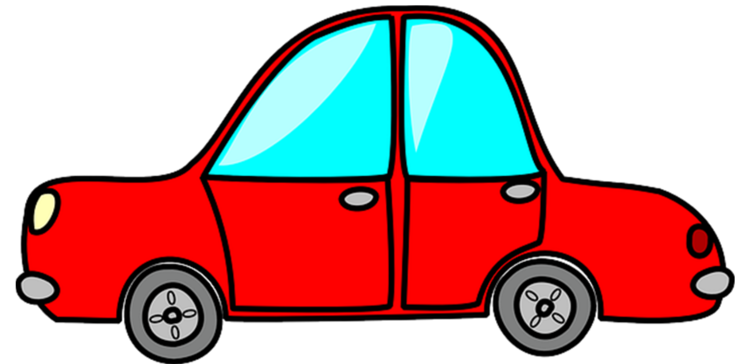
Additional requirements for DME, transportation, other ancillary services:

- ❑ For DME, transportation and other ancillary services, CMS and DHCS require the plan and its delegates to ensure that each CMC beneficiary continues to have access to medically necessary items and services, as well as medical and LTSS providers.
  - ❑ Plans and delegates are not obligated to use OON providers who are determined to have a pre-existing relationship for DME, transportation and other ancillary services.



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Additional requirements for Skilled Nursing Facilities (SNFs):

- ❑ When a new CMC member is in a SNF upon enrollment, this serves as an automatic request for CMC COC in the SNF.
- ❑ A beneficiary who is a SNF resident at the time of enrollment will not be required to change SNFs during the duration of CMC if the facility is licensed by the CA Department of Public Health, meets acceptable quality standards, and the facility and pan agree to Medicare rates is the service is a Medicare service, or Medi-Cal rates if the service is a Medi-Cal service, in accordance with the three-way contract.
- ❑ Is a SNF resident leaves and then requires a return to a SNF level of care due to medical necessity, the beneficiary has the right to return to the same SNF under the Leave of Absence and Bed hold policies (See DPL 14-002 for more information on these policies), and COC policies contained in this DPL.

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Additional requirements for pharmacy:

- ❑ Beneficiaries must be allowed continued use of any single-source drugs that are part of a prescribed therapy by a contracted or non-contracted provider in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the plan. The drug must be provided until the prescribed therapy is no longer prescribed.

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Care plan requirement for approved COC:

- When COC agreement has been established, the plan or its delegate must work with the provider to establish a care plan for the beneficiary.

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When the CMC COC is not approved:

- ❑ The plan or its delegates must offer the beneficiary an in-network alternative:
  - ❑ If the beneficiary does not make a choice from the alternatives offered, the beneficiary is to be referred or assigned to an in-network provider and notified by a modification letter.
  - ❑ If the beneficiary disagrees with the result of the COC process, the beneficiary maintains a right to pursue a grievance and/or appeal.

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Additional requirements:

- ❑ Since the health plan is a Knox-Keene Act licensed plan, additional requirements pertaining to COC are set forth in Health and Safety (H&S) Code §1373.96.
- ❑ Under the section of this code, plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, care of a newborn child between birth and 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment.
- ❑ All health care service plans in CA are required to, at the request of a beneficiary or their authorized representative, provide for the completion of covered services by a terminated or non-participating health plan provider.
- ❑ Health care service plans must allow for the completion of these services for certain timeframes, which are specific to each condition.
- ❑ See H&S code for further information.

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