Cal MediConnect Continuity of Care for New CMC Beneficiaries

Welcome

Introduction

COC Requirements

Provisional COC Grant

When does COC apply?

What if a member changes plans?

When is COC not required?

Requirements for Delegated Entities

Requesting COC

CMC COC Retroactive Requests

Referrals by OON providers

Required Time-frames for Processing CMC COC Requests

Upon Completion of Processing CMC Requests for COC

Extended Continuity of Care Option

Additional Requirements for CMC COC : DME, Transportation, and Other Ancillary Services

CMC COC is Not Approved

CMC COC Assessment

Exit Course

Welcome

00:37

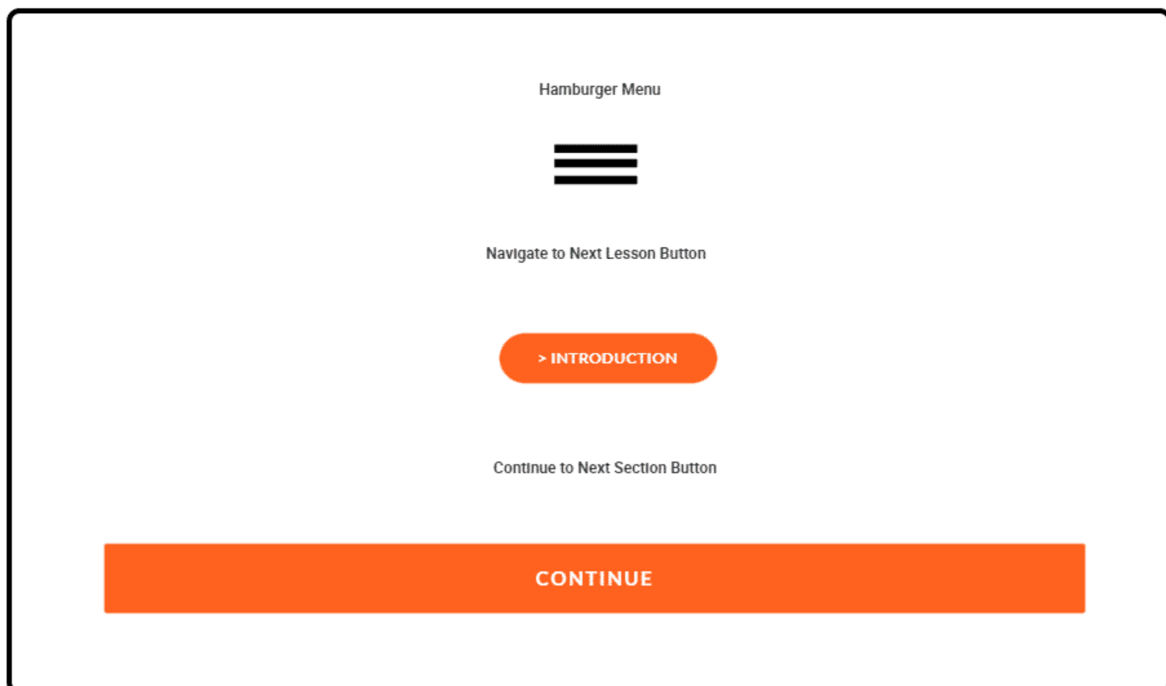
Welcome to CMC Cal MediConnect Continuity of Care for New CMC Beneficiaries

We have a great deal of important information to cover, so let’s get started. My name is Rob and my name is Janet, we will be your hosts during this course.

Located in the upper left hand corner you will find what we call the hamburger menu. You can track your progress, and see what topics you need to complete. You can always revisit pages you have previously completed. But you can not skip ahead in the training without interacting with all the content of each page.

The course is designed with an automatic bookmark mechanism. When you return to the course you will continue from your automatic bookmark.

Below is an image of the navigation buttons and icons used in this presentation. If you do not see the CONTINUE button it means you have not completed the lesson or you need to simply scroll down the page.



Navigation Buttons

Introduction

> INTRODUCTION

Introduction

00:50

This learning module will be an overview of Continuity of Care. We will cover the following questions:

1. What if a member changes plans?
2. When is Continuity of Care not required?
3. What are the requirements for delegated entities?
4. What is the process for requesting Continuity of Care?
5. How do Retroactive Request work?
6. What are Referrals by Out of Network Providers (OONP)?
7. Determining if a new beneficiary has an existing relationship with their requested Out of Network Providers (OONP)?
8. What are the required time-frames for processing Cal MediConnect Continuity of Care Requests?
9. Reasons for not approving Cal MediConnect Continuity Of Care.
10. Requirements after the request is completed.

COC Requirements

> REQUIREMENTS

COC Requirements

COC Requirements

Continuity of care requirements for Cal MediConnect are defined in Welfare and Institutions (W&I) Code, Sections (§§) 14182.17 and 14132.275. These requirements are also set forth in the three-way contract (contract) between the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS), and the managed care plans.

1. CMS and DHCS requires that beneficiaries continue to have access to medically necessary items and services, as well as medical and LTSS providers.

2. As part of the process to ensure that continuity of care and coordination of care requirements are met, managed care plans must perform Health Risk Assessments (HRA) within the time-frames specified in DPL 15-005.

3. 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 continuity of care process at that time if they choose to do so.

4. CMC members must be allowed to continue receiving services from previous providers for primary and specialty care services and maintain their current providers and service authorizations at the time of enrollment for up to 12 months, provided they meet the COC requirements.

5. Medicare Part D transition rules and rights will continue as provided in current law and regulation for the entire integrated formulary.

6. Plans and delegates must attempt to determine if beneficiaries have pre-existing provider relationships through previous utilization data, the HRA process, and, as needed, contact with the beneficiary and/or their providers.

Provisional COC Grant

> PROVISIONAL

Provisional COC Grant

CMC COC should be granted upon a member request provided all the following circumstances exist:

1. A beneficiary has an existing relationship with a primary or specialty care provider. An existing relationship means the beneficiary has seen an out-of-network primary care provider (PCP) or a specialty care provider at least once

during the 12 months prior to the date of his or her initial enrollment in the MMP for a non-emergency visit

2. The provider is willing to accept, at a minimum, payment from the plan based on the current Medicare or Medi-Cal fee schedule, as applicable.

3. The provider does not have any documented quality of care concerns that would cause the MMP to exclude the provider from its network.

When does COC apply?

> COC APPLIED

When does COC apply?

Continuity of care policies apply regardless of whether a beneficiary voluntarily joins or passively enrolls in an managed care plan (e.g., if a beneficiary opted out of Cal MediConnect and later decided to join).

If a beneficiary opts out or dis-enrolls from Cal MediConnect and later re-enrolls in Cal MediConnect, the beneficiary has the right to a 12 month continuity of care period, regardless of whether the beneficiary received continuity of care in the past.

What if a member changes plans?

> CHANGING PLAN

What if a member changes plans?

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

- If a beneficiary changes plans, this continuity of care 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.

When is COC not required?

> COC NOT REQ.

When is COC not required?

Plans are not required to provide continuity of care with an out-of-network provider if any of the following circumstances exist:

1. The services are not covered by Medi-Cal or Medicare

2. The providers are 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

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

Requirements for Delegated Entities

> REQUIREMENTS

Requirements for Delegated Entities

When a beneficiary transitions into L.A. Care, and has an existing relationship with a PCP that is in L.A .Care or a PP or PPG’s network, as determined through:

- the 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 L.A. Care contracts with delegated entities, it must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network

When a beneficiary transitions into a plan and has an existing relationship with a PCP and/or specialist that is in the primary plan's network, and he or she wishes to continue to see these providers, the plan must allow the beneficiary to continue treatment with these providers for the continuity of care period.

This is regardless of whether these providers are, or are not, in the network of the prime plan's delegated entity to which the beneficiary is assigned, as long as the continuity of care requirements are met.

EXAMPLE: If a beneficiary has an existing relationship with a PCP and a specialist with the assigned Independent Physicians Association #1 (IPA #1) as well as a specialist in another IPA (IPA #2), where both IPAs are delegated entities of the same MMP, the MMP must assign the beneficiary to IPA #1 and allow the beneficiary to continue treatment with both specialists. The continuity of care agreement for the specialist in IPA #2 would last for up to 12 months for both Medicare and/or Medi-Cal services.

Requesting COC

> REQUESTING

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 continuity of care.

Only those providers who treat beneficiaries, who are eligible for continuity of care, as noted above, may make a request for continuity of care.

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

CMC COC Retroactive Requests

> RETROACTIVE

CMC COC Retroactive Requests

L.A. Care and its delegates must accept and approve retroactive requests for continuity of care and claim payments that meet all continuity of care requirements noted, with the exception of the requirement to abide by L.A. Care/delegates utilization management policies.

The 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.

In addition to the above, retroactive requests must be approved if they meet the following requirements:

- Have dates of services that occur after September 29, 2014
- Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
- Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested or denial from another entity when the claim was incorrectly submitted. L.A. Care 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.

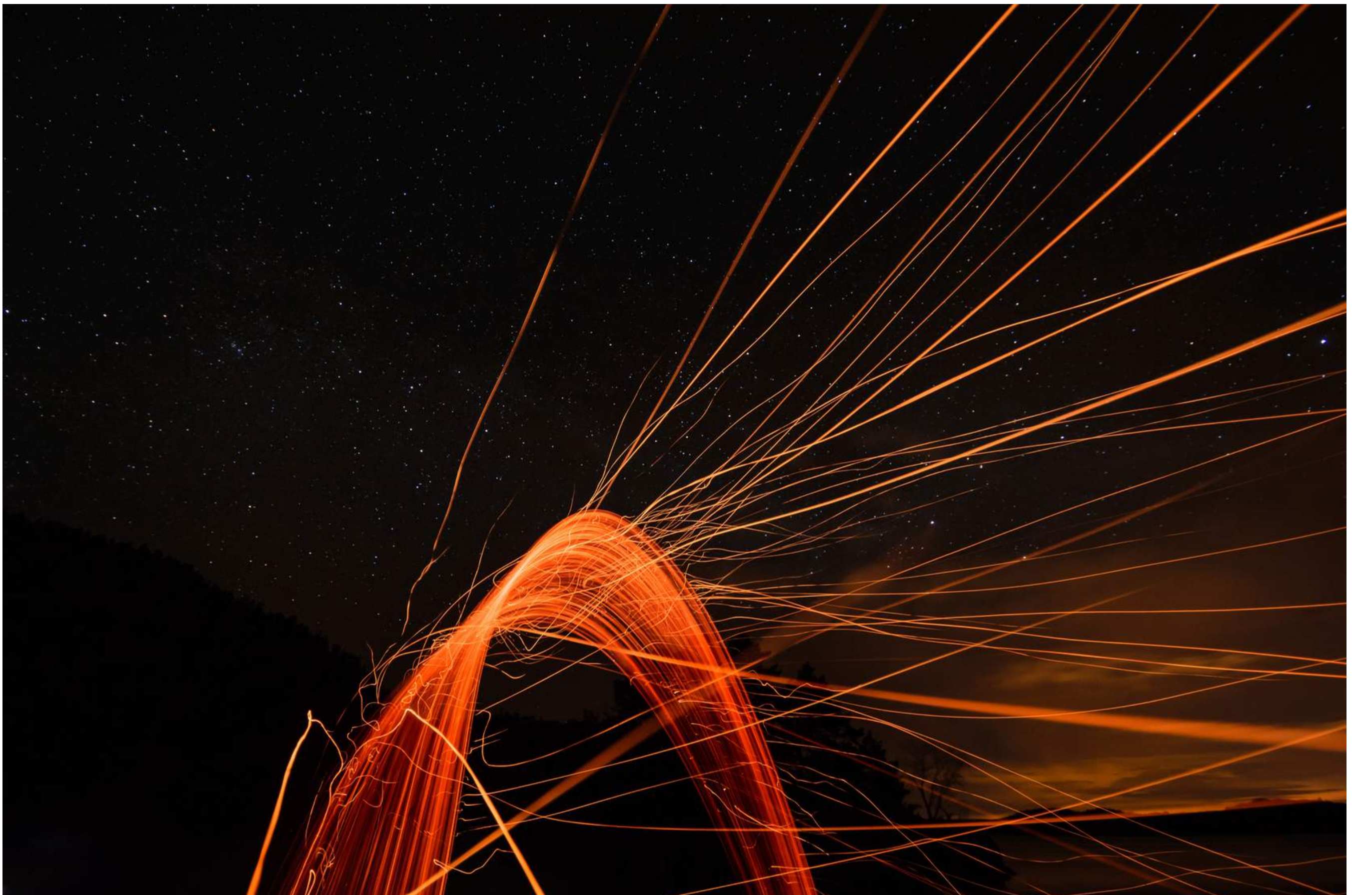
Referrals by OON Providers

> REFERRALS OON

Referrals by OON providers

An approved out-of-network (COC covered) provider must work with the plan and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from the plan.

Should an additional OON provider referral 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.



An approved out-of-network (COC covered) provider must work with the plan and its contracted network and cannot refer the beneficiary to another out-of-network provider without authorization from the plan.

Should an additional OON provider referral 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.

Determining if a New CMC beneficiary has an Existing Relationship with their Requested OON (out of network) Provider

- L.A. Care 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 or his or her provider may also provide information that demonstrates a pre-existing relationship with a provider.
    - A beneficiary may not attest to a pre-existing relationship (instead actual documentation must be provided) unless this option is made available to him or her through the appropriate UM department (delegate or L.A. Care).

Requirements to Contact the OON Provider

Following identification of a pre-existing relationship:

The entity (L.A. Care 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 continuity of care relationship for the beneficiary.

Required Time-frames for Processing CMC

> PROCESSING

Required Time-frames for Processing CMC COC Requests

- L.A Care Health Plan or its delegates must begin processing COC requests within five working days from receipt of the request

  and

- Must complete their responses to each request within

  - 30 calendar days from the date of receipt,

  or

- within 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 in three days.

Reasons for Not Approving CMC COC

- If the services are not covered by Medi-Cal or Medicare

or

- If L.A. Care/its delegate and the out-of-network FFS or prior Health Plan provider are unable to agree to a rate;

or

- If L.A. Care/its delegate makes a good faith effort to contact the provider who is non-responsive for 30 calendar days:

or

- If L.A. Care/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 L.A. Care/its delegate but has been with another health plan and has already had 2 CMC COC periods.

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

At any time, a beneficiary may change providers regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the plan or delegate must work with the provider to establish a care plan for the beneficiary.

Requirements after the Request Process is Completed

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

At any time, a beneficiary may change providers regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the plan or delegate must work with the provider to establish a care plan for the beneficiary.

Upon Completion of Processing CMC

Requests for COC

> UPON COMPLET...

Upon Completion of Processing CMC Requests for COC

Upon completion of a continuity of care request, L.A. Care or its delegates must notify CMC beneficiaries of the following within seven (7) calendar days:

- The request approval or denial, and

  – if denied, the beneficiary's appeal and grievance rights

  – if approved, the duration of the continuity of care arrangement; and

- the process that will occur to transition the beneficiary's care at the end of
- the continuity of care 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 continuity of care period about the process that will occur to transition the beneficiary's care at the end of the continuity of care period.

This process must include engaging with the beneficiary and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

Extended Continuity of Care Option

Extended Continuity of Care Option

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

Beneficiary and Provider Outreach and Education

Plans must inform beneficiaries, or their authorized representatives, of continuity of care protections within 30 days of beneficiary enrollment, and must include information about these protections in information packets and handbooks.

This information must include how a beneficiary and provider initiate a continuity of care 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 continuity of care protections.

Additional Requirements for CMC COC:
DME, Transportation, and Other Ancillary Services

ADDITIONAL REQ.

Additional Requirements for CMC COC : DME, Transportation, and Other Ancillary Services

For DME, transportation and other ancillary services, CMS and DHCS require L.A. Care 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. L.A. Care and its delegates are not obligated to use out-of-network providers who are determined to have a pre-existing relationship for DME, transportation and other ancillary services.

Additional requirements for CMC COC: Skilled Nursing Facilities

Facilities

When a new CMC member in a SNF upon enrollment, this serves as an automatic request for CMC COC in the SNF.

If a Skilled Nursing Facility (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 where he/she previously resided under the Leave of Absence and Bedhold policies (See DPL 14-002 for more information on these policies), and the continuity of care policies contained in this DPL.

A beneficiary who is a resident of a SNF at the time of enrollment will not be required to change SNFs during the duration of Cal MediConnect if the facility is licensed by the California Department of Public Health, meets acceptable quality standards, and the facility and plan

agree to Medicare rates if 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.

Additional CMC COC Requirements: Pharmacy

Single Source Drugs

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

Requirement for Care Plan for Approved COC

When the continuity of care agreement has been established, L.A. Care or its delegate must work with the provider to establish a care plan for the beneficiary.

Not Approved

> NOT APPROVED

CMC COC is Not Approved

L.A Care 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 continuity of care process, the beneficiary maintains the right to pursue a grievance and/or appeal.

Additional Requirements

Since L.A. Care is a Knox-Keene Act licensed plan, additional requirements pertaining to continuity of care are set forth in Health and Safety (H&S) Code §1373.96

All health care service plans in California 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.

Under this section of the H&S Code 1373.96, plans are required to complete services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment.

Health care service plans must allow for the completion of these services for certain time-frames, which are specific to each condition. See H & S code for further information.

CMC COC Assessment

The assessment is the final module in this instructional. When you have completed the assessment close this browser window to exit the instructional.

> ASSESSMENT

CMC COC Assessment

Question

01/04

CMC COC should be granted when which of the following circumstances exist:

- ○ Provider has no documented quality or credentialing issues.
- ○ Provider must be willing to accept payment based on the current Medicare or Medi-Cal fee schedule.
- ○ Evidence the beneficiary has an existing relationship with the primary or specialty care provider.
- ○ All of the above.

Question

02/04

Which of the following reasons are valid for not approving CMC COC?

- ◯ Services are not covered by Medi-Cal or Medicare.
- ◯ If the member is outside of the 12 month COC period.
- ◯ If L.A. Care/its delegate has documented quality of care issues with the provider.
- ◯ All the above.

Question

03/04

L.A. Care Health Plan or its delegates must begin processing COC requests within five working days from receipt of the request:

- True
- False

Question

04/04

If there is a risk of harm to the beneficiary, the request must be completed in five days.

- ◯ True
- ◯ False

Exit Course

To exit the tutorial click the **Exit Course** button below.

EXIT COURSE