THIS CA UPDATE HAS BEEN SENT TO THE FOLLOWING:

COUNTIES:

☒ Imperial
☒ Riverside/San Bernardino
☒ Los Angeles
☐ Orange
☒ Sacramento
☒ San Diego

LINES OF BUSINESS:

☒ Molina Medi-Cal Managed Care
☐ Molina Medicare
☐ Molina Marketplace (Covered CA)

PROVIDER TYPES:

☒ **Medical Group/ IPA/MSO**

Primary Care
☒ IPA/MSO
☒ Directs

Specialists
☒ Directs
☒ IPA

☒ **Hospitals**

Ancillary
☒ CBAS
☒ SNF/LTC
☒ DME
☒ Home Health
☐ Other

Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service APL 23-022

This is an advisory notification to Molina Healthcare of California (MHC) network providers to provide guidance on Continuity of Care (COC) for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care. This APL supersedes APL 22-032

This notification is based on an All-Plan Letter (APL) 23-022, which can be found in full on the Department of Health Care Services (DHCS) website at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-022.pdf

BACKGROUND

Beneficiaries who mandatorily transition from Medi-Cal FFS to enroll as Members with MHC on or after January 1, 2023, have the right to request Continuity of Care with Providers in accordance with federal and state law and the MHC contract, with some exceptions.

WHAT YOU NEED TO KNOW:

POLICY

I. Continuity of Care Requirements

Members may request up to 12 months of COC with a Provider if a verifiable pre-existing relationship exists with that Provider. Additionally, if a Member has one of the conditions listed in Health and Safety Code (HSC) section 1373.96, MHC will provide COC for the completion of a course of treatment for that specific condition by a terminated Provider or by a nonparticipating Provider at the Member's request. Members also have the right to COC for Covered Services and active prior treatment authorizations for Covered Services.

COC protections extend to Primary Care Providers, Specialists, and select ancillary Providers, including physical therapy; occupational therapy; respiratory therapy; BHT; and speech therapy Providers. COC protections do not extend to all other ancillary Providers such as radiology; laboratory; dialysis centers; Non-Emergency Medical Transportation (NEMT); Non-Medical Transportation (NMT); other ancillary services; and non-enrolled Medi-Cal Providers.

A. Processing Continuity of Care Requests

1. Acceptance of Requests

MHC will accept COC requests from the Member, authorized representative, or Provider over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, MHC will take any necessary information from the requester over the telephone.

2. Retroactive Requests

MHC will retroactively approve a COC request and reimburse Providers for services that were already provided if the request meets all COC requirements.

3. Completion of Requests

The COC process begins when MHC receives the COC request. MHC must first determine if the Member has a preexisting relationship with the Provider. MHC will request from an Out-of-Network (OON) Provider all relevant treatment information for the purposes of determining Medical Necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulation.

4. Validating Pre-Existing Relationship

MHC will determine if a relationship exists through use of data provided by DHCS, such as Medi-Cal FFS utilization data or claims data from MHC. A Member, authorized representative, or Provider may also provide information to MHC that demonstrates a pre-existing relationship with the Provider. A Member's self-attestation of a pre-existing relationship is not sufficient proof.

5. Timeline

MHC will begin to process non-urgent requests within five working days following the receipt of the COC request. Additionally, each COC request must be completed within the following timelines from the date MHC received the request:

- 30 calendar days for non-urgent requests;
- 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- As soon as possible, but no longer than three calendar days for urgent requests

6. Member Notifications

MHC will provide acknowledgment of the COC request within the timeframes specified below, advising the Member that the COC request has been received, the date of receipt, and the estimated timeframe for resolution.

- For non-urgent requests, within seven calendar days of the decision.
- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.

7. Provider Referral Outside of the MCP Network

MHC will work with the approved OON Provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the OON Provider does not refer the Member to another OON Provider without authorization from MHC.

8. 12-Month Continuity of Care Period Restart

If a Member changes MCPs by choice following the initial enrollment with MHC or if a Member loses and then later regains MCP eligibility during the 12-month COC period, the 12-month COC period for a pre-existing Provider may start over one time.

B. Scheduled Specialist Appointments

At the Member, authorized representative, or Provider's request, MHC will allow transitioning Members to keep authorized and scheduled Specialist appointments with OON Providers when COC has been established and the appointments occur during the 12-month COC period.

II. Additional Continuity of Care Protections in HSC section 1373.96

HSC section 1373.96 offers additional protections for Members to continue seeing a terminated or nonparticipating Provider, at a Member, authorized representative, or Provider's request, to complete Covered Services for specific conditions.

III. Continuity of Medi-Cal Covered Services and Prior Treatment Authorizations

All Members have the right to continue receiving Medi-Cal services covered under MHC's Contract when transitioning to an MCP, even in circumstances in which the Member does not continue receiving services from their pre-existing Provider.

A. Durable Medical Equipment Rentals and Medical Supplies

MHC will allow transitioning Members to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing Provider under the previous Prior Authorization for a minimum of 90 days following MHC enrollment and until MHC is able to reassess the new equipment or supplies are in possession of the Member, and ready for use.

B. Non-Emergency Medical Transportation and Non-Medical Transportation

For NEMT and NMT, MHC will allow Members to keep the modality of transportation under the previous Prior Authorization with a Network Provider until MHC is able to reassess the Member's continued transportation needs.

IV. Member and Provider Outreach and Education

MHC will inform Members of their COC protections and include information about these protections in Member information packets, handbooks, and on the MHC's website.

V. Specific Contexts

There are other transitions for specific Member populations that MHC will allow COC for:

A. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity Of Care For Approved Provider Types:

MHC will provide COC with an OON SMHS Provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive NSMHS from MHC. MHC will allow, at the request of the Member, authorized representative, or Provider, up to 12 months COC with the OON MHP Provider.

B. Covered California To Medi-Cal Transition

To ensure that care coordination requirements are met, the MHC will ask these Members if there are upcoming healthcare appointments or treatments scheduled and assist them. If the Member requests COC, MHC will help initiate the process at that time. MHC will, at the Member, authorized representative, or Provider's request, offer up to 12 months of COC.

C. Pregnant and Post-Partum Members and Newborns

MHC, at the request of a Member, authorized representative, or Provider, provide for the completion of Covered Services relating to pregnancy, during pregnancy, and immediately after the delivery (the post-partum period, which is 12 months), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan Provider.

D. Terminally Ill Members

MHC, at the request of a Member, authorized representative, or Provider, provide for the completion of Covered Services of a Member with a terminal illness.

E. Medical Exemption Requests

A Medical Exemption Request (MER) should only be used to preserve COC with a Medi-Cal FFS Provider. MHC is required to consider MERs that have been denied as automatic COC requests to allow Members to complete courses of treatment with OON Providers.

WHAT IF YOU NEED ASSISTANCE?

If you have any questions regarding the notification, please contact your Molina Provider Relations Representative below:

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