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Continuity of Care in the Transition from the Low Income Health Program to Medi-Cal

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Introduction

Continuity of Care ("COC") is critical to the successful transition of Low Income Health Program (LIHP) enrollees into Medi-Cal managed care. The LIHPs were created in California in 2010 pursuant to a Medicaid Waiver that was executed under Section 1115 of the Social Security Act. The waiver allowed California counties to begin expanding health care coverage to certain low-income individuals not otherwise eligible for Medi-Cal in 2011, as allowed under the Affordable Care Act, three years before the state implemented a statewide Medi-Cal Expansion program. The LIHPs are governed by the Special Terms and Conditions (STCs) of the waiver, a contract between the state and federal government, which provides fifty-percent of the funding for the program.[1] Pursuant to the waiver, counties that implemented LIHPs must seamlessly transition their Medicaid Coverage Expansion (MCE) enrollees—i.e., those with income below 133% of the Federal Poverty Level—into Medi-Cal on January 1, 2014.[2] By state law, this population will receive Medi-Cal through a managed care delivery system.[3]

Today, nearly 650,000 LIHP enrollees are preparing to move into Medi-Cal managed care in January, 2014.[4] Many will be enrolled into plans with significantly different provider networks that those they used in the LIHPs, creating a risk of significant and harmful disruptions in care, and increased medical and administrative costs for providers, health plans and the State.[5] Notwithstanding this risk, the lack of information about COC has made these rights difficult to enforce in prior transitions. The transition of seniors and persons with disabilities from fee-for-service Medi-Cal to managed care plans in 2011 is one such example: more than eighty percent of of these individuals did not know that they had the right to continue seeing their current provider.[6] As California prepares to enroll hundreds of thousands of LIHP enrollees into Medi-Cal managed care for the first time, advocates, consumers and providers must be made aware of the availability of COC protections that apply to transitioning LIHP enrollees in order to avoid disruptions in care. This fact sheet provides an overview of the laws, regulations, and other guidance that require COC for those transitioning from LIHPs to Medi-Cal.

A. COC for Primary Care

Washington, DC
(202) 289-7661

Los Angeles, CA
(310) 204-6010
www.healthlaw.org

Carrboro, NC
(919) 968-6308

As required by state law, DHCS sent notices to MCE enrollees in early November, 2013, informing them which Medi-Cal plan(s) their primary care providers contract with.[7] During the first week of December, 2013, DHCS sent a reminder notice with FAQs to enrollees who did not choose a plan or provider; these materials included some basic information about continuing primary care services.[8] Under state law, DHCS must place LIHP enrollees into a plan that contains their primary care provider, when possible, unless a LIHP enrollee chooses a different plan.[9] When more than one plan contains an enrollee's primary care provider and the enrollee does not choose a plan, DHCS will enroll the person into a plan that contains the enrollee's primary care provider according to a formula aimed at targeting enrollment in plans that include public hospitals.[10]

If an enrollee's primary care provider does not contract with any of the Medi-Cal plans in the area and the person does not choose a plan, DHCS will enroll the person into a plan according to its usual default formula.[11] In addition, DHCS has worked with the plans to ensure that in cases where an enrollee's primary care provider is not part of any of the enrollee's plan options, the enrollee may request to continue seeing that provider for up to 12 months.[12] Where an enrollee enters a plan that does not include her existing primary care provider, the enrollee's new plan primary care provider must perform a health assessment within 120 days of enrollment to identify the enrollee's health needs, including where COC will be required.[13]

B. COC for Specialty Care

In addition, DHCS will permit transitioning LIHP enrollees to request to continue seeing their existing LIHP specialists for up to 12 months when those specialists are not in their new plan's network.[14] Enrollees may only request this option for providers of plan-covered physician services, but not for providers other types of care such as DME or ancillary services, services not covered by Medi-Cal, or carved-out services such as specialty mental health.[15] When a LIHP enrollee requests such COC from his new managed care plan, the plan must approve COC as long as: 1) it finds evidence of an existing relationship between the enrollee and the provider; 2) the provider is willing to accept the payment based on the current Medi-Cal fee schedule; and 3) the plan would not exclude the provider from its network due to quality-of-care issues.[16]

C. COC for Open Treatment Authorizations

Where LIHP enrollees have been authorized to receive a course of treatment or health care services for a period that extends beyond December 31, 2013, their LIHPs must work with their new Medi-Cal Managed Care plans to share data as needed to prevent any gaps in coverage.[17] The LIHPs and Medi-Cal managed care plans developed protocols to transfer information about open treatment authorizations and scheduled services in December, 2013.[18] These files were transferred after the LIHP enrollees enrolled in a Medi-Cal managed care plan, or earlier in COHS counties.[19] In addition,

DHCS facilitated the transfer of enrollment data in batches starting in early December, 2013, and of utilization data in late December, 2013.[20] Medi-Cal plans are required to pay for treatment and services provided on or after January 1, 2014 pursuant to an open authorization from a LIHP unless it has information that indicates that the service or treatment is not medically necessary.[21] DHCS also clarified that the LIHPs must share data for any authorizations scheduled to expire on December 31, 2013, and the Medi-Cal managed care plans must review those expiring authorization and follow-up to ensure continuity of care as needed.[22]

D. COC for Prescription Drugs

All Medi-Cal beneficiaries who are newly enrolled in a managed care plan, including those who are transitioning from the LIHPs, are entitled to continue use of any (single-source) prescription drug, whether or not the drug is covered by the plan, as long as the prescription was in effect immediately prior to the date of their enrollment in the plan.[23] A health plan must continue to cover and provide these prescription drugs for a new enrollee until a plan doctor makes a determination that the prescription is no longer needed.[24] Transitioning LIHP enrollees may also be provided an emergency 72-hour supply of a prescription at the pharmacists' discretion, if it has not yet been authorized by the new Medi-Cal managed care plan.[25] Where a pharmacist fills a prescription on an emergency basis, the Medi-Cal managed care plan must reimburse the provider for the supply, unless that drug is carved out of the plan's responsibility. [26] Certain mental health and substance use disorder drugs are carved out of the Medi-Cal plans' responsibilities.[27] The state will provide automatic authorization to transitioning LIHP enrollees for any of those drugs when they were prescribed by the LIHP immediately prior to the transition, and there is evidence that the LIHP enrollee's condition was stabilized on that medication.[28]

E. Additional Knox-Keene COC Protections

While the Medi-Cal managed care plans are not specifically Knox-Keene licensed (though plans that participate in Medi-Cal may be licensed for other lines of business), DHCS requires all but County Organized Health System (COHS) plans to comply with Knox Keene COC requirements through the contracting process.[29] DHCS has indicated that the following COC provisions from the Knox-Keene Act will apply to all LIHP enrollees who are transitioning into Medi-Cal.[30] LIHP enrollees are entitled to complete their course of treatment with a provider who does not participate in any of their Medi-Cal managed care plan options for the following conditions:

- Acute Condition: managed care plans must provide COC for the full duration of an acute condition, such as pneumonia. "Acute condition" is defined as "a medical condition that involves a sudden onset of symptoms due to an illness,

injury, or other medical problem that requires prompt medical attention and that has a limited duration."[31]

- Serious Chronic Condition: A health plan is required to continue services for a serious chronic condition, such as diabetes or heart disease, for a maximum of twelve months from the contract termination date or twelve months from the effective date of coverage for a newly covered enrollee. "Serious chronic condition" is defined as "a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration."[32] Unless twelve months have passed, the health plan must ensure the coverage of services for "a period of time necessary" to complete treatment and arrange for a safe transfer of the enrollee to another plan or nonparticipating provider.[33]

- 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.[34]

- Terminal Illness: A health plan is required to continue services for a terminal illness for the duration of the illness. "Terminal illness" is defined as "an incurable or irreversible condition that has a high probability of causing death within one year or less."[35]

- Care of baby or toddler: A health plan must provide up to twelve months of COC for care of a child between birth and age thirty-six months.[36]

- Scheduled or recommended procedure: A health plan must provide COC when a procedure, such as surgery, has been scheduled or recommended within 180 days of the effective date of coverage for a newly covered enrollee.[37]

Conclusion

As DHCS moves almost 650,000 LIHP enrollees into mandatory managed care, COC is critical to ensure that these enrollees do not suffer significant and harmful disruptions in care. Since the responsibility of requesting COC lies with the enrollee, DHCS must ensure that these enrollees have sufficient information about their COC rights to make them effective. Those who are providing direct services to transitioning LIHP enrollees should also focus on informing enrollees about their COC rights and assisting them in accessing the care that they need.

Endnotes

[1] CENTERS FOR MEDICARE & MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, AMENDED JUNE 28, 2012, CALIFORNIA BRIDGE TO REFORM DEMONSTRATION [hereinafter STC], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/CA%201115%20Amendment%20Approval%2006.28.2012.pdf.
[2] *Id.* ¶ 23.
[3] CAL. WELF. & INST. CODE § 14005.60(c)(1)
[4] CAL. DEPT. OF HEALTH CARE SERVS., LIHP SEPTEMBER 2013 MONTHLY ENROLLMENT 1 (2013) (643,577 MCE enrollees as of September, 2013), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/September%20Enrollment.pdf.
[5] *See, e.g.,* THE HENRY J. KAISER FAMILY FOUND., TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: INSIGHTS FROM CALIFORNIA 9 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs2.pdf.
[6] CARRIE GRAHAM ET AL., CAL. HEALTHCARE FOUND., THE EXPERIENCES OF SENIORS AND PERSONS WITH DISABILITIES WHO TRANSITIONED TO MEDI-CAL MANAGED CARE 17 (2013), *available at* http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20Sacto03282013SPDsTransitionMediCalManagedCare.pdf.
[7] *See* CAL. DEPT. OF HEALTH CARE SERVS., IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE (2013) (model 60 day notice for non-COHS counties), http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP_TRANSITION/LIHPPlanChoiceNotice-COHSManagedCare7-19.pdf; CAL. DEPT. OF HEALTH CARE SERVS., IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE (2013) (model 60 day notice for COHS counties), http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP_TRANSITION/LIHPPlanChoiceNotice-combinedManagedCare7-19.pdf; *see also* CAL. WELF. & INST. CODE § 14005.61(c)(1); CAL. DEPT. HEALTH CARE SERVS., LIHP TRANSITION PLANNING: CONTINUITY OF CARE DRAFT PLAN 1 (2013), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Meetings/LIHPTransition-ContinuityofCareFrameworkDRAFT.pdf. 246,023 of the 483,800 notices DHCS sent out on November 1, 2013 incorrectly informed LIHP enrollees that their primary care provider did not participate in any of the Medi-Cal managed care plans in their county. CAL. DEPT. HEALTH CARE SERVS., MEDI-CAL EXPANSION: LIHP TRANSITION PROJECT 4 (2013), http://www.dhcs.ca.gov/Documents/SACLIHPTransitionPresentation1120.pdf. DHCS sent corrected notices to individuals who received erroneous notices on November 12, 2013. *Id.*
[8] *See, e.g.,* CAL. DEPT. OF HEALTH CARE SERVS., IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE! (2013) (30 day notice for LA County), http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/LIHP_TRANSITION/30DayNotices/LACO30DayNoticeEng.pdf.
[9] CAL. WELF. & INST. CODE § 14005.61(c)(2); *see also* Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Continuity of Care for Medi-Cal Beneficiaries Who Transition From Fee-For-Service Medi-Cal into Medi-Cal Managed Care 4 (Dec. 24, 2013) [hereinafter APL 13-023], *available at* http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-023.pdf.
[10] CAL. WELF. & INST. CODE §§ 14005.61(c)(3)-(4); *id.* § 14199.1(c).
[11] *Id.* § 14005.61(c)(5).
[12] *See, e.g.,* CAL. DEPT. HEALTH CARE SERVS., LOW INCOME HEALTH PROGRAM (LIHP) TRANSITION TO MEDI-CAL MANAGED CARE - CONTINUITY OF CARE 1 (2013) [hereinafter REVISED DRAFT COC PLAN] ("Beneficiaries have the right to request from the MCP 12 months of continuity of care with a specialist or primary care provider (without regard to the condition

criteria of H&S 1373.96) if an existing relationship can be demonstrated between the member and the provider.") (emphasis removed), *available at* http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPContinuity.pdf. DHCS published general guidance on how plans are to determine whether a relationship exists between an enrollee and a provider in December, 2013. APL 13-023 at 2-3.

[13] *See* CAL. DEPT. HEALTH CARE SERVS., LOW INCOME HEALTH PROGRAM TRANSITION PLAN (REVISED) 15 (2013) [hereinafter REVISED LIHP TRANSITION PLAN], http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Meetings/DRAFT-RevisedLIHPTransitionPlan.pdf; Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Staying Healthy Assessment / Individual Health Education Behavioral Assessment for Enrollees from Low-Income Health Program (Nov. 18, 2013) (APL 13-017), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-017.pdf.

[14] *See* CAL. DEPT. HEALTH CARE SERVS., DRAFT JUNE 28, 2013: LIHP TRANSITION PLANNING: CONTINUITY OF CARE 2 (2013) [hereinafter DRAFT COC PLAN], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Meetings/LIHPTransition-ContinuityofCareFrameworkDRAFT.pdf; APL 13-023 at 4.

[15] DRAFT COC PLAN at 2; APL 13-023 at 4.

[16] DRAFT COC PLAN at 2; *see also* REVISED DRAFT COC PLAN at 1-2.

[17] CAL. WELF. & INST. CODE § 14005.61(i); *see also* Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Open Authorization and Scheduled Service Information for New Beneficiaries Transitioning from the Low-Income Health Program (Dec. 4, 2013) [hereinafter APL 13-020], http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-020.pdf.

[18] APL 13-020 at 1.

[19] *Id.* at 3.

[20] *See id.;* Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Utilization Data File to be Provided to Medi-Cal Managed Care Health Plans for Transitioning Low-Income Health Program Beneficiaries (Nov. 27, 2013) (APL 13-019), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-019.pdf.

[21] APL 13-020 at 2.

[22] *Id.* at 1-2.

[23] CAL. WELF. & INST. CODE § 14185(b); *see also* APL 13-023 at 4-5.

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

[25] REVISED DRAFT COC PLAN at 2.

[26] *Id.*

[27] Cal. Dep't of Health Care Servs., *MCP: Geographic Managed Care (GMC), MCP: Imperial, San Benito and Regional Models, MCP: Two-Plan Model*, *in* MEDI-CAL PROGRAM AND ELIGIBILITY MANUAL (2013), http://tinyurl.com/kf6uhk8; *see also, e.g.,* Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Medi-Cal Manged Care Plan Responsibilities for Outpatient Mental Health Services at Att. 2 (Dec. 13, 2013) (list of mental health drugs carved out from Medi-Cal managed care), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf; Letter from Margaret Tatar, Assist. Deputy Dir., Health Care Delivery Systems, Cal. Dept. Health Care Servs., to Medi-Cal Manged Care Plans, Re: Memorandoum of Understanding Requirements for Medi-Cal Managed Care Plans at Att. 1 § 1810.370(A)(4)(A). (Nov. 27, 2013) (describing which mental health medications must be covered by Medi-Cal

managed care plans), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf.

[28] REVISED DRAFT COC PLAN at 2.

[29] *See, e.g.,* CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 9 § 16.B (2011) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96) [hereinafter TWO-PLAN CONTRACT], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/ MMCD_TwoPlanBoilerplate-Web.6-1-11.pdf; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 9 § 16.B (2011) [hereinafter GMC CONTRACT] (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_GMCBoilerplate-Web.6-1-11.pdf. COHS plans are not subject to Knox-Keene COC requirements by contract. Instead they are simply exhorted to describe their activities "designed to assure the provision of . . . coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management." CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 4 § 7.I (2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_COHS_Boilerplate.pdf. DHCS has indicated that COHS plans will be held to the same Knox-Keene requirements for transitioning LIHP enrollees, however. *See* REVISED LIHP TRANSITION PLAN at 14.

[30] *See* REVISED LIHP TRANSITION PLAN at 14; DRAFT COC PLAN at 2; CAL. HEALTH & SAFETY CODE § 1373.96(b)(2); s*ee also* TWO-PLAN CONTRACT at Ex. A, Att. 9 § 16.B (2011) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96); GMC CONTRACT at Ex. A, Att. 9 § 16.B (2011) (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96). DHCS has not yet explicated how it will apply these requirements to COHS plans.

[31] CAL. HEALTH & SAFETY CODE § 1373.96(c)(1).

[32] *Id.* § 1373.96(c)(2).

[33] *Id.*

[34] *Id.* § 1373.96(c)(3).

[35] *Id.* § 1373.96(c)(4).

[36] *Id.* § 1373.96(c)(5).

[37] *Id.* § 1373.96(c)(6).