Anthem BlueCross

Medi-Cal Managed Care

**Provider Bulletin**
March 2023

# Important: Continuity of Care updates

On December 27, 2022, the Department of Health Care Services (DHCS) released ***All Plan Letter (APL) 22-032***,*Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal Members Who Transition into a New Medi-Cal Managed Care Health Plan on Or After January 1, 2023*.

The guidance in *APL 22-032* applies to both Medi-Cal Managed Care (Medi-Cal) only beneficiaries and those dually eligible for Medicare and Medi-Cal for their Medi-Cal providers.

## This *APL*:

- Provides guidance to managed care plans (MCPs) for Medi-Cal on Continuity of Care (COC) for beneficiaries who are mandatorily transitioning from Medi-Cal fee-for-service (FFS) to a Medi-Cal managed care plan.
- Provides guidance on COC for consumers transitioning from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023.
- Describes other types of transitions into a managed care plan for specific Medi-Cal populations for which MCPs must allow for COC.

Independent physician associations (IPAs)/capitated medical groups and network providers are required to comply with **all provisions** in *APL 22-032*, including specified decision and notification timeframes and notification language. Key points from the *APL* are noted below.

Beneficiaries who mandatorily transition from Medi-Cal for FFS to Anthem Blue Cross (Anthem), or transition from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023, have the right to request COC with providers in accordance with federal and state law and the MCP contract. These consumers may request **COC for up to 12 months after the enrollment date with Anthem** if a pre-existing relationship exists with that provider, regardless of the consumer having a condition listed in *Health and Safety Code, section 1373.96*.

## COC protections:

- Extend to **PCPs, specialists, and select ancillary providers, including physical therapy, occupational therapy, respiratory therapy, behavioral health treatment (BHT), and speech therapy providers**.
- 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.

Following a consumer's mandatory transition from Medi-Cal for FFS to Anthem, or from plans with contracts expiring or terminating to a new plan on or after January 1, 2023, **active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the consumer, authorized representative, or provider**. The plan must arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider, to provide the service with an out-of-network (OON) provider.



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## COC requirements:

- The provider is willing to accept the plan's contract rates or Medi-Cal for FFS rates.
- The provider meets the plan's applicable professional standards and has no disqualifying quality of care issues.
- The provider is a California State Plan approved provider.

## Retroactive requests

In an instance where a service has been rendered with an OON provider, and that provider satisfies the COC requirements, the consumer, authorized representative, or provider **may request COC to retroactively cover the service**. MCPs must retroactively approve a COC request and reimburse providers for services that were already provided if the request meets all COC requirements and the services that are the subject of the retroactive request meet the following requirements:

- Occurred after the consumer's enrollment into the plan.
- Have dates of service that are within 30 calendar days of the first service for which the provider requests retroactive reimbursement (for example, the first date of service is not more than 30 calendar days from the date of the reimbursement request).

## Durable medical equipment (DME) rentals and medical supplies

Continuity of DME and medical supplies must be honored without a request by the consumer, authorized representative, or provider. Plans must allow transitioning consumers 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 plan enrollment.
- Until the new plan is able to reassess and the new equipment or supplies are in possession of the consumer and ready for use.

## NEMT and NMT

MCPs must allow consumers to keep the modality of transportation under the previous prior authorization with a network provider until the new MCP is able to reassess the member's continued transportation needs.

## Other transitions

Review *APL 22-032* for details on other transitions that MCPs must allow COC, including:

- Specialty mental health services to non-specialty mental health services
- Covered California to Medi-Cal
- Pregnant and post-partum consumers and newborns
- Terminally ill consumers
- Medical exemption requests

If you have any questions, reach out to your assigned Provider Relationship Management representative.

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