

Continuity of Care in the Dual Eligible Demonstrations: A Tool for Advocates

Table of Contents

Introduction	1
1. Where in the MOUs is Care Continuity Addressed?	2
2. What is Covered?	2
3. What Is The Transition Timetable?	6
4. What Notice, Information and Practices Are Required to Make Care Continuity Work?	8
5. Conclusion	10
Care Continuity Provisions in Current MOUs	11

Introduction

A key protection for dual eligibles who are enrolling in the financial alignment demonstration projects being undertaken by states and the Medicare-Medicaid Coordination Office (MMCO) is continuity of care. Individuals joining plans participating in the financial alignment demonstrations need a smooth transition without disruption in providers or services while their new plan takes over their care. This need is particularly critical in the demonstrations because many individuals will be passively enrolled and may not know about or fully understand the change before they appear in their doctor’s office or try to access home and community-based services. Strong and specific care continuity protections that spell out rights to continue to use non-network providers and allow adequate timeframes are important to the success of the demonstrations and to the health of beneficiaries.

The five Memorandums of Understanding (MOUs) that have been approved for the financial alignment model –Massachusetts, Ohio, Illinois, California and Virginia— all discuss care continuity, but each is

significantly different. From a beneficiary point of view, each includes some important protections but all have significant gaps. Using the five MOUs as a starting point, this paper identifies important elements in a continuity of care policy that advocates should address with their states. We look at three broad questions:

- What services should be covered in a transition policy,
- How long and under what circumstances should they be covered, and
- What actions need to be taken to make sure that care continuity is actually effectuated.

In each of these broad categories, the paper looks in detail at potential problems that need to be addressed, discusses how the five MOUs deal with the issue, and makes recommendations for advocacy. Advocacy is important at every stage of the demonstration including throughout the MOU process, during the drafting of the three-way contracts, when assessing plan readiness and when implementation is underway.

1. Where in the MOUs is Care Continuity Addressed?

Each of the five MOU's contains identical language in the body of the MOU requiring that participating plans ensure that new plan members continue to have access to medically necessary items, services, and medical and long-term service and support providers for a transition period; that plans must advise new plan members and providers that the care would not otherwise be offered at an in-network level; that plans

must contact providers with information on joining the plan's network; and that Part D transition rules will be unchanged. State-specific details are set out in Appendix 7 to each MOU.

Both the standardized provisions in the body of the MOUs and the unique continuity of care provisions in the appendices of each state MOU are attached to this paper for reference.

2. What is Covered?

A starting point for talking about care continuity is the question of what services individuals will be entitled to receive during a transition period. The question is particularly important for the demonstrations because participating plans will have responsibility for all, or almost all, Medicare and Medicaid services. Our review of the current MOUs found several areas of concern.

a. Clearly Including Both Providers and Services in Transition Coverage Rights

Potential Problem: Individuals can experience dangerous gaps in care not only because they cannot see a provider with whom they have an existing relationship, but also because scheduled surgery or physical therapy gets cancelled, needed equipment that has been ordered will not be paid for, or authorized hours of care are curtailed. In such cases the basis for the transition right is not necessarily the connection with the provider but rather the preexisting need and/or the prior authorization for the ongoing or scheduled service, whether or not the provider of that service had a prior relation with the individual. If care transition policies do not specifically spell out that rights cover

ongoing and scheduled services, goods and supplies, access problems will result.

MOU Provisions: Only the Ohio MOU directly discusses care continuity rights for services in any detail, including setting specific rights for such items as chemotherapy, organ transplants and dialysis. The Ohio MOU also protects rights to, for example, Durable Medical Equipment (DME) and eyeglasses that have prior authorization but have not yet been delivered. Note, however, that Ohio's prior authorization requirement, though it may work for Medicaid-covered DME, does not offer protection for Medicare-covered DME, since Medicare, except in very limited instances, does not have a prior authorization procedure. Thus, for example, a wheelchair ordered for in-home use and covered by Medicare would not appear to fit within the Ohio transition policy. The Massachusetts MOU raises similar concerns, requiring plans to honor "prior authorizations issued by Mass Health, its contracted managed care entities, and Medicare." This formulation also creates problems for Medicare-covered services, such as scheduled surgeries, as well as Medicare-covered DME, since there is no prior authorization process for these services. The Virginia MOU similarly uses the term "preauthorized services" when setting out protections, a formulation that appears to exclude scheduled services covered by Medicare that were not subject to prior authorization. Virginia, however, also includes a requirement that plans "provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the individual/beneficiary." That provision appears to contemplate circumstances such as pre-arranged surgeries or chemotherapy

but sets no firm requirement to honor prior arrangements.

The Illinois MOU allows an individual to "maintain a current course of treatment" with a non-network provider but does not address scheduled procedures, DME or other services that are not "treatment." The California MOU raises similar concerns. It talks about service authorizations only in the context of "existing relationships" with the service providers, which are precisely defined (see below) and does not appear to contemplate services such as scheduled surgeries or scheduled chemotherapy with a new provider.

Recommendations:

- Clarify that care continuity rights apply to services and treatments, not just providers. The Ohio MOU provides the best current model by laying out specific services and the criteria for each.
- Ensure that protection for continuity of services exists independently from protections for access to current providers. For example, a scheduled surgery should be covered because it was already scheduled; it should not matter whether the individual has yet been to the surgeon's office. Similarly, continuity protections for a continuing course of treatment should not be affected if there is a change in provider during the transition period.
- Avoid provisions that require prior authorization as a basis for care continuity rights, particularly for Medicare-covered services. Services that would have been covered if the individual were in fee-for-service Medicare or Medicaid, are part of a current care plan and have been

“scheduled,” “ordered,” “prescribed” or “initiated” should all be protected.

b. Including All Types of Providers and Services

Potential Problem: Care continuity is not effective if it is not comprehensive. Excluding certain categories of providers and services from care continuity protections leads to transition issues. There should be no carve-outs of any types of services needed by new plan members during a transition.

MOU Provisions: California is the only state to date with an MOU that specifically denies continuity of care protections for a category of services. California excludes what the state describes as “ancillary” services such as DME, medical supplies and transportation. The provision mirrors an exclusion California had instituted earlier when moving non-dual seniors and persons with disabilities into Medicaid managed care. California advocates reported significant transition issues for individuals who had long-established relationships with DME suppliers who understood their conditions and frequently adjusted their DME.

A sub-issue of DME coverage is an issue with all of the MOUs. Although Medicare’s managed care rules require a 90 day transition period in which plans must continue to supply and, if required, repair non-preferred brands of DME, prosthetics, orthotics and supplies (DMEPOS) furnished in the previous year,¹ none of the MOUs discuss or acknowledge this Medicare right.

Recommendations:

¹ Medicare Managed Care Manual, Ch. 4 at 10.13, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

- Do not exclude any categories of covered services from care continuity rights.
- Specifically incorporate the Medicare right to non-preferred brands of DMEPOS.

c. Including Newly Covered Services

Potential Problem: The demonstrations have, in most states, proposed to add new services or expand the scope of existing services. In California, for example, previously uncovered dental and vision services are part of the benefit package. If a demonstration includes such new services, and the care continuity protection does not extend to those services, individuals may be forced to pay from their own pocket for services that should be covered by the plan. For example, an individual might be in the midst of dental work with a non-network dentist. Without transition coverage, the individual would face the prospect of either disruption in care or paying out-of-pocket for a service that should be part of the demonstration plan’s benefit package.

MOU Provisions: None of the MOUs clearly offer transition coverage for newly-covered services. The Illinois definition specifically limits care continuity to services “existing in Medicare or Medicaid at the time of enrollment.” Ohio’s approach, which specifically identifies all included services and provider types, may offer better protection but it is important that any list be comprehensive and cover all providers and services included in the demonstration.

Recommendation:

- Define covered services to specifically include providers of new services not previously covered by Medicare or Medicaid.

d. Defining “Current Providers”

Potential Problem: The MOUs all make reference to a right to see current providers during the transition. How the term “current provider” is defined will determine how robust this protection is.

MOU Provisions: Massachusetts, Ohio, and Virginia refer to the right to see current providers without further elaboration. California is much more specific, saying that the provider must have seen the individual twice within a year of a request for coverage. Evidence of provider visits may be shown through Medicare and Medicaid records or by the beneficiary or physician. Illinois, as already discussed above, conflates the requirement that a provider be current with a requirement that there be a “current course of treatment.” The Illinois language raises the concern of whether, for example, an individual would have the right to continue to see a primary care physician during the transition if the reason for the visit were a new condition, such as the flu or a broken leg.

Recommendations:

- Weigh the benefits and risks of bright line criteria for defining “current providers,” such as California’s requirement of two documented visits. Considering the wide range of circumstances that can be expected to arise, establishing a safe harbor would be preferable to setting strict cut-offs.
- If proposing a bright line test, set the standard as one visit within a year of joining the plan. Individuals may have longstanding relationships with providers whom they see only annually.
- For any designated timeframe, count from the date of enrollment rather than the

date of request for services. Establishing a one-year look back from the date of enrollment is clearer, fairer and easier to administer than determining rights based on the date a service was requested.

- As already discussed, provide continuity rights both for current providers and for ongoing and scheduled services, without conflating the two protections.

e. Protecting HCBS Hours and Providers

Potential Problem: Disruption in personal care and other home and community based services can be catastrophic to individuals needing these services. Care continuity for such services has been among the highest priorities for advocates.

MOU Provisions: The Ohio MOU specifically requires that plans at least maintain current service levels for all direct care waiver services (including personal care, waiver nursing, home care, respite care, community living, adult day health, social work counseling, and independent living assistance) for a year unless a significant change occurs. California has taken a different approach. Plans, though responsible for payment for personal care services (called In-Home Supportive Services—IHSS), do not assess hours; assessments will continue to be performed by county workers. For the first year of the demonstration, plans may add but not reduce personal care hours. Greater plan control is projected for the second year, though the details remain to be worked out.² Plans will have the authority to reduce provision of other HCBS. The Illinois

² California MOU at 93, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.

and Massachusetts MOUs have no special provisions for HCBS.

Recommendation:

- Build on the Ohio MOU as a model of HCBS protections.

3. What Is The Transition Timetable?

The current MOUs vary widely both in the length of transition rights and in how they structure transition timetables. Advocacy concerns include:

a. Identifying a Reasonable Transition Period

Potential Problem: If the transition period is not long enough to ensure smooth transitions and avoid gaps in service, beneficiaries' access to needed care will be jeopardized and their health will be at risk.

MOU Provisions: Massachusetts has the shortest transition period-- 90 days for all services. In Illinois, the transition period is set at 180 days but the MOU requires that, when out-of-network PCPs and specialists are providing an ongoing course of treatment, they must be offered single case agreements to continue to care for individuals beyond the care continuity period if they remain outside the network. Virginia's transition period is 180 days from enrollment or the duration of a prior authorization, whichever is shorter. Virginia also provides that "under certain defined circumstances" plans must offer single case agreements to out-of-network providers. California set a six-month transition for Medicare services but a one-year transition for Medicaid services. The

state did not address the issue of overlapping services. Ohio chose a more complex route with different requirements depending on the service. For physician services, the state set a 90 day transition period for individuals identified for high risk case management and a 365 day transition period for all others. For DME, surgeries, chemotherapy, transplants, and vision and dental, Ohio sets no time period but instead simply requires that previous scheduling, authorizations and orders be honored and that plans allow courses of treatment to be completed.

Recommendations:

- Consider the value of different timelines for different services versus one transition period for all services.
- If setting different transition timelines, ensure that the differences are based on rational distinctions. The question of whether a service is covered by Medicare or Medicaid should not be dispositive. Higher needs individuals may need longer transitions rather than Ohio's approach of giving them a shorter timeframe.
- Carefully define transition rights for an ongoing course of treatment to ensure that a treatment regime is not interrupted and to minimize the need for a burdensome exceptions process.
- If one transition period is set for all or most services, ensure that it is adequate in length. NSCLC has proposed a 12 month period as appropriate.
- Require single case agreements beyond the designated period when circumstances warrant.

b. Linking Transition Periods to Care Planning

Potential Problem: All the MOUs require that care continuity be provided at least until a plan has conducted an assessment. Assessment, however, does not necessarily equate with having a care plan in place and having access to appropriate in-network providers and services.

MOU Provisions: Only one state, Illinois, includes MOU provisions that directly address this issue. Illinois allows the transition of an enrollee to a network primary care provider (PCP) earlier than the end of the care continuity period only if all of the following conditions are met: the individual has been assigned to a medical home capable of serving his needs appropriately; the appropriate assessment has been completed; the plan has determined that the medical home is “accessible, competent and can appropriately meet the Enrollee’s needs;” a transition care plan is in place; and the individual agrees to the early transition. Illinois has similar, though slightly less rigorous requirements for any shortening of the transition period for access to a specialist.

Recommendation:

- The care continuity period should last either until the transition timeframe runs out or until the beneficiary both has agreed to a care plan and has access to needed providers, whichever comes later.

c. Protecting Nursing Home Residents from Forced Moves

Potential Problem: Requiring individuals living in nursing homes, particularly long-time residents, to move because their facility is

not part of a plan’s network can be traumatic and negatively affect health. Advocates have reported many instances in Medicaid managed care when nursing home residents were uprooted because the nursing home where they lived for years was not part of a plan’s network. Avoiding similar outcomes in the demonstrations should be a high priority.

MOU Provisions: The Ohio and Virginia MOUs offers the strongest protections for individuals who, at the time of enrollment, reside in long-term care facilities that are not part of a demonstration plan’s network. Ohio requires that plans must pay nursing home providers that are serving those individuals and that remain out of network at the current Medicaid rate for the life of the demonstration. It similarly requires that providers of assisted living waiver services be maintained at their current payment rate for the life of the demonstration. Virginia provides that current residents of a nursing home may stay in the facility as long as they meet state criteria for nursing home care, unless the individuals or their families prefer to move to another facility or return to the community.³

Recommendations:

- Allow individuals currently in nursing facilities and assisted living facilities that have Medicaid contracts to remain in those facilities.

³ In the network adequacy portion of the Virginia MOU, the state also requires plans to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the plan’s rates and requirements. Virginia MOU at 68., available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VAMOU.pdf.

- Establish provider payment requirements that make resident retention practicable.

4. What Notice, Information and Practices Are Required to Make Care Continuity Work?

The current MOUs say very little about the mechanics of informing individuals and their providers about care continuity rights and about how they will be effectuated. Advocacy will be needed to flesh out those details.

a. Ensuring Beneficiaries Are Told Their Care Continuity Rights

Potential Problem: Care continuity protections will have little meaning if individuals do not know their rights. Communicating such information is critical. In a recent evaluation of California’s transition of seniors and persons with disabilities who only have Medicaid into managed care, fully 83 percent of respondents reported that they did not know about continuity of care rights.⁴ States and demonstration plans need to do a better job in informing beneficiaries about what their transition rights are and how they can exercise those rights.

MOU Provisions: Standardized language in all of the MOUs provides that “Participating Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level.” This provision, in the most general

⁴ See Briefing—Transitioning the SPD Population to Medi-Cal Managed Care, Slide 17, available at www.chcf.org/events/2013/briefing-spd-transition-managed-care. The evaluation was conducted by California HealthCare Foundation at the request of the California Department Health Care Services.

terms, addresses notices to plan members after they receive services from an out-of-network provider. It does not address how individuals are informed at the start that they have a right to those services and the extent of those rights. The only more detailed reference to beneficiary transition notices is in the California MOU, which requires that “descriptions of continuity of care rights will be developed in all threshold languages and distributed to enrollees in their enrollment choice packet, distributed 60 days before they are enrolled in a Participating Plan.”

Recommendations:

- Insist on notices that effectively highlight care continuity rights. Transition rights should not be buried in long communications covering multiple subjects or restricted to member handbooks.
- Ensure that individuals receive care continuity notices at the time they are likely to need transition protections, that is, at the start of enrollment. The California approach of describing care continuity rights in the 60 day passive enrollment notice is helpful for individuals making enrollment decisions but rights should be reiterated at the point when they are likely to be exercised.
- Ensure that notices about care continuity rights are sent to all enrollees, not just those receiving passive enrollment notices. Voluntary enrollees have the same rights and the same need to understand those rights.
- Set deadlines and content requirements for the required individualized notices that are sent to a plan member and the member’s provider after the individual

has exercised his right to see an out-of-network provider. Further, if the provider has not joined the network prior to the close of the transition period, the plan member should receive a second letter warning that the continuity period is ending and explaining the individual's alternatives.⁵ Telephone outreach may also be appropriate.

- Because of their importance to the beneficiary, communications about care continuity rights should be among those translated into all required non-English languages. Use of plain language is also critical. Make an explanation of care continuity a required part of the care planning process.

b. Ensuring Provider Participation in The Transition

Potential Problem: For care continuity protections to be effective, out-of-network providers must be willing to continue to serve individuals during a transition. This means that they must have information available to them about transition coverage rules, they must understand when and how they will be paid, they must find procedures easily navigable, and they must be confident that payment will be forthcoming. If out-of-network providers do not understand the system, if it is difficult to file claims, or if they do not receive timely payment, providers will refuse to serve plan members. Further, payment difficulties during the transition will create strong disincentives for providers to

consider joining a plan's network.

MOU Provisions: The standardized provision in all the MOUs states: "On an ongoing basis, Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers." The MOUs also contain general requirements for plans to have systems in place for payment to non-network providers.

Recommendations:

- Ensure that three way contracts and plan readiness reviews address transition payment issues with specificity.
- Require participating plans to have mechanisms in place to fulfill the general MOU requirement for outreach to non-network providers.
- Seek specific requirements for plan outreach to providers. Three-way contracts should require specific outreach to those providers that Medicare and Medicaid data show as serving plan members and not allow plans to wait until they are billed by an individual's provider.
- Require that plans detail how they will communicate billing requirements and payment rates to providers and what telephone and on-line assistance will be available to respond to questions from non-network providers.
- Ensure that billing systems are set up to promptly process non-network claims and to override prior authorization restrictions.

⁵ See National Health Law Program, "Hold Harmless" Passive Enrollment, available at www.healthlaw.org/images/stories/2012_04_NHeLP_Hold_Harmless_Passive_Enrollment.pdf. The NHeLP paper also contains other very useful recommendations for care continuity protections.

5. Conclusion

Advocacy on care continuity protections is needed around the remaining MOUs, the three-way contracts, plan readiness, and state and federal oversight during implementation. Comprehensive and careful definitions of care continuity rights are necessary to ensure that individuals experience a smooth and safe transition into managed care. Further, beneficiaries and providers need notices and education so they understand these rights and take the steps needed to get care. The five current MOUs offer both helpful formulations of care continuity rights and examples of omissions and areas of imprecision that should be avoided.

For more information on dual eligibles demonstration projects, visit NSCLC's dual demonstration website, www.dualsdemoadvocacy.org. The site contains information and tools to help state and national advocates be more effective in representing consumers through the planning and implementation of the demonstrations.

Care Continuity Provisions in Current MOUs

Provision Common to All MOUs

E. 2. Continuity of Care: CMS and California will require Participating Plans to ensure that individuals continue to have access to medically necessary items, services, and medical and long-term service and support providers, and plans will be required to authorize payment to providers at Medicare rates for Medicare services or Medi-Cal rates for Medi-Cal services, for the transition period, as described in Appendix 7. Participating Plans will inform beneficiaries of their new service providers. In addition, Participating Plans will advise beneficiaries and providers that they have received care that would not otherwise be covered at an in-network level. On an ongoing basis, and as appropriate, Participating Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers. Part D transition rules and rights will continue as provided for in current law and regulation.

MASSACHUSETTS MOU at pp. 82-83.

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

f. Continuity of Care

- i. The ICO must perform an initial assessment within 90 days of an individual's enrollment in the ICO.
- ii. ICOs must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:
 - i. a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or
 - ii. until the ICO completes an initial assessment of service needs, whichever is longer.
 - iii. During the time period set forth in Appendix 7, Section V.d.ii., the ICO will maintain the Enrollee's current providers at their current provider rates and honor prior authorizations issued by MassHealth, its contracted managed care entities, and Medicare.
 - iv. If, as a result of the initial assessment, the ICO proposes modifications to the Enrollee's prior authorized services, the ICO must provide written notification about and an opportunity to appeal the proposed modifications no less than 10 days prior to implementation of the Enrollee's ICP. The Enrollee shall be entitled to all appeal rights, including aid pending appeal, if applicable.

OHIO MOU at pp. 60-64.

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/OHMOU.pdf

f. Continuity of Care

i. ICDS Plans must allow Enrollees to maintain current providers and service levels at the time of enrollment as described in Table 7-B.

ii. ICDS Plans are required to provide or arrange for all medically necessary services provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the individual/beneficiary.

Table 7-B: ICDS Plan Transition Requirements at Enrollment

Transition Requirements¹	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (NH and PDN use)	NF Enrollees A AL Enrollees	Enrollees not identified for LTC Services²
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider	Must honor specified provider	Must honor specified provider	Must honor specified provider
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider

¹ Requirements for all Medicare and Medicaid pharmacy transition will adhere to Medicare Part D pharmacy transition requirements.

² Individuals who do not fall into any of the other categories depicted on this table (e.g., HCBS waiver enrollees) would be included in the "community well" rate cell.

TOOL FOR ADVOCATES

Transition Requirements¹	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (NH and PDN use)	NF Enrollees A AL Enrollees	Enrollees not identified for LTC Services²
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider	Must honor specified provider	Must honor specified provide	Must honor specified provide
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
Assisted Living Waiver Service			Provider maintained at current rate for the life of Demonstration.	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of Demonstration.	

TOOL FOR ADVOCATES

Transition Requirements ¹	HCBS Waiver Enrollees	Non-Waiver Enrollees with LTC Needs (NH and PDN use)	NF Enrollees A AL Enrollees	Enrollees not identified for LTC Services ²
Waiver Services-Direct Care <ul style="list-style-type: none"> • Personal Care • Waiver Nursing • Home Care Attendant • Choice Home Care Attendant • Out of Home Respite • Enhanced Community Living • Adult Day Health Services • Social Work Counseling • Independent Living Assistance 	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	N/A	N/A	N/A
Waiver Services-All other	<p>Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.</p>	N/A	N/A	N/A
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	<p>Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.</p>	<p>Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.</p>	<p>Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.</p>	<p>Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.</p>

During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Enrollee requests a change;
- 2) The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid; or
- 3) The ICDS Plan, CMS, or the State identify provider performance issues that affect an Enrollee's health and welfare.

ILLINOIS MOU at pp. 72-73.

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/ILMOU.pdf

d. Continuity of Care – Demonstration Plans will be required to offer a 180-day transition period in which Enrollees may maintain a current course of treatment with a provider who is currently out of the Demonstration Plan's network. The 180-day transition period is applicable to all providers, including behavioral health providers and providers of LTSS. Out-of-network PCPs and specialists providing an ongoing course of treatment will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network.

i. Demonstration Plans may choose to transition Enrollees to a network PCP earlier than 180 days only if:

1. The Enrollee is assigned to a medical home that is capable of serving his/her needs appropriately;
2. A health screening and/or a comprehensive assessment, if necessary, is complete;
3. The Plan consulted with the new medical home and determined that the medical home is accessible, competent, and can appropriately meet the Enrollee's needs;
4. A transition care plan is in place (to be updated and agreed to with the new PCP, as necessary); and
5. The Enrollee agrees to the transition prior to the expiration of the 180-day transition period.

ii. Demonstration Plans may choose to transition Enrollees to a network specialist or LTSS provider earlier than 180 days only if:

1. A health screening and/or a comprehensive assessment, if necessary, is complete;

2. A transition care plan is in place (to be updated and agreed to with the new provider, as necessary); and
 3. The Enrollee agrees to the transition prior to the expiration of the 180-day transition period.
- e. With the exception of Part D drugs, which are required to follow all Part D transition requirements, all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 180 days after enrollment and will not be terminated at the end of 180 days without advance notice to the Enrollee and transition to other services, if needed.

CALIFORNIA MOU at pp. 94-96.

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf

b. Continuity of Care – The State will require Participating Plans to follow continuity of care requirements established in current law.

i. As part of a process to ensure that continuity of care and coordination of care requirements are met, Participating Plans must perform an assessment process within 90 days of an individual's enrollment in the Participating Plan as described in section IV of Appendix 7.

ii. Participating Plans must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for:

1. A period up to 6 months for Medicare services if all of the following criteria are met under Welfare and Institutions Code section 14132.275(k)(2)(A):

a. Beneficiary demonstrates an existing relationship with the provider prior to enrollment. This will be established by the Participating Plan by identifying whether the beneficiary has seen the requested out-of-network provider at least twice within the previous 12 months from the date of the request. The link between the newly enrolled beneficiary and the out-of-network provider may be established by the Participating Plan using Medicare data provided by California or by documentation by the provider or enrollee.

b. Provider is willing to accept payment from the Participating Plan based on the current Medicare fee schedule; and

c. Participating Plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns or State or Federal exclusion requirements.

2. A period of up to 12 months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

a. Beneficiary demonstrates an existing relationship with the provider prior to enrollment. This will be established by the Participating Plan by identifying whether the beneficiary has seen the requested out-of-network provider at least twice within the previous 12 months from the date of the request. The link between the newly enrolled beneficiary and the out-of-network provider may be established by the Participating Plan using Medi-Cal Fee-For-Service claims data or Medi-Cal managed care encounter data provided by the state or by documentation from the provider or enrollee.

b. Provider is willing to accept payment from the Participating Plan based on the Participating Plan's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

c. Participating Plan would not otherwise exclude the provider from their provider network due to documented quality of care concerns or State or Federal exclusion requirements.

d. This does not apply to IHSS providers, durable medical equipment, medical supplies, transportation, or other ancillary services.

iii. Descriptions of continuity of care rights will be developed in all threshold languages and distributed to enrollees in their enrollment choice packet, distributed 60 days before they are enrolled in a Participating Plan.

iv. As part of a process to ensure that continuity of care requirements are met, Participating Plans must perform an assessment process within 90 days of an individual's enrollment in the Participating Plan, to identify existing providers and establish a care plan that addresses how continuity of care and coordination of care provisions will be carried out. This is further described in section IV.A.III.

VIRGINIA MOU at pp. 73-74.

www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VAMOU.pdf

G. Continuity of Care

1. Participating Plans must allow Enrollees to maintain their current providers (including out of network providers) for 180 days from enrollment. Participating Plans must also allow Enrollees to maintain their preauthorized services for the duration of the prior authorization or for 180 days from enrollment, whichever is sooner, except for individuals residing in a nursing facility at the date of Demonstration implementation. Individuals in nursing facilities at the time of program implementation may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

2. Participating Plans are required to provide or arrange for all medically necessary services

provided by the three-way contract, whether by sub-contract or by single-case agreement in order to meet the needs of the individual/beneficiary.

During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Enrollee requests a change;
- 2) The provider chooses to discontinue providing services to an Enrollee as currently allowed by Medicare or Medicaid;
- 3) The Participating Plan, CMS, or DMAS identify provider performance issues that affect an Enrollee's health and welfare; or
- 4) The provider is excluded under State or Federal exclusion requirements.

3. During the time period set forth in Appendix 7, Section V.G.1. the Participating Plan will maintain the Enrollee's current providers at the Medicare or Medicaid FFS rate and honor prior authorizations issued by DMAS, its contracted managed care entities, and Medicare.

H. Out of Network Reimbursement Rules

1. In an urgent or emergency situation, Participating Plans must reimburse an out-of-network provider of emergent or urgent care at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services. For example, where this service would traditionally be covered under Medicare FFS, the Participating Plan will pay out of network providers the lesser of providers' charges or the Medicare FFS.

2. During the six month transition period (described in Appendix 7, Section V.G.1.), the Participating Plan must honor existing service authorization timeframes and continue to provide access to the same services and providers at the same levels and rates of Medicare or Medicaid FFS payment (not to exceed six months) as individuals were receiving prior to entering the Participating Plan.

3. Beyond this six (6) month period, under certain defined circumstances, Participating Plans will be required to offer single-case out-of-network agreements to providers who are currently serving Enrollees and are willing to continue serving them at the Participating Plan's in-network payment rate, but who are not willing to accept new patients or enroll in the Participating Plan's network.