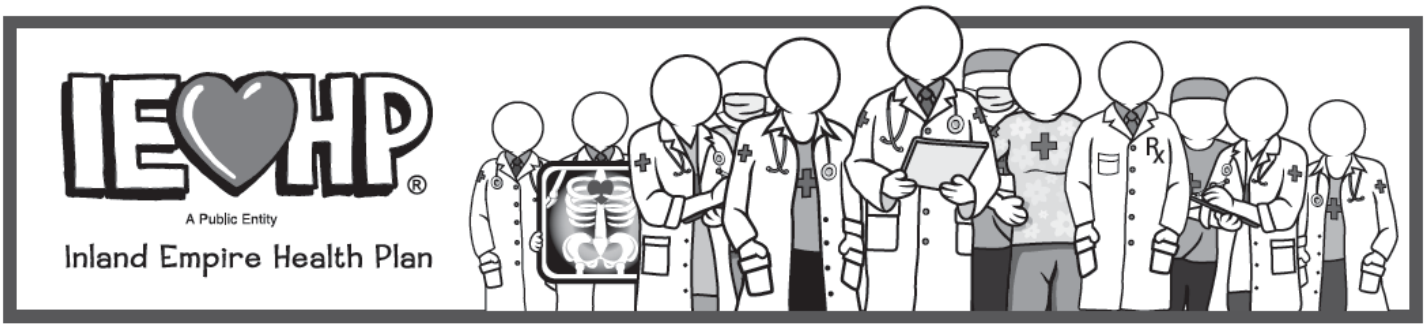

To: IEHP IPAs

From: IEHP – Provider Relations

Date: October 16, 2017

Subject: Continuity of Care for IEHP Medi-Cal and Medicare Members

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The Department of Health Care Services (DHCS) has issued several All Plan Letters (APLs) and Duals Plan Letters (DPLs) to clarify and provide guidance about continuity of care requirements for Medi-Cal managed care plans (MCPs) and Medicare-Medicaid plans (MMPs) such as IEHP.

Continuity of Care (COC) for services and medicines means that Members in the middle of care or treatment may continue to receive these services and medicines for up to 12 months after they are mandatorily enrolled in IEHP. IEHP is required to review each request for COC against a set of criteria established by DHCS in order to allow the Member to continue receiving services from their Fee-For-Service (FFS) provider during the COC period or until they can be safely transitioned to a network Provider. IEHP is also expected to meet State reporting requirements for COC.

IEHP has historically coordinated the completion of these COC requests for IEHP-Direct and delegated Members and will continue to do so until further notice. IEHP's coordination currently involves contacting the delegated Members, inquiring about their COC needs and passing the Member on to the delegate to arrange the COC services. IEHP documents and tracks the outcome for reporting to the State. Please be aware that we are streamlining our internal process with the intent to delegate these responsibilities to our Delegates for their assigned Members. We will be informing you of changes to the Delegation Agreement, policies and procedures, and reporting requirements, as soon as details are defined. Meanwhile, please review the attached comparative information on COC regulations for Medi-Cal and Medicare beneficiaries.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at the following address: https://ww3.iehp.org/en/providers/correspondence/.

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

Enclosure: Continuity of Care (COC) Regulations for Medi-Cal and Medicare Beneficiaries

Continuity of Care (COC) Regulations for Medi-Cal and Medicare Beneficiaries

Line of Business	Medi-Cal	IEHP DualChoice Cal MediConnect
DHCS Letters	**APL 13-023 and APL 17-007**	**DPL 16-002**
Identification Avenues through which a COC request may be identified	• Member may call in to request COC (i.e. "I have an appointment with my Specialist next week. Am I going to be able to see my Specialist?); **or** • Provider may send in a Specialist referral for continued services or a prescription to continue medication regimen; **or** • DHCS sends IEHP a weekly list of Members that were mandatorily enrolled to IEHP after being denied their Medical Exemption Request (MER).	• Member may call in to request COC (i.e. "I have an appointment with my Specialist next week. Am I going to be able to see my Specialist?); **or** • Provider may send in a Specialist referral for continued services or a prescription to continue medication regimen; **or** • Care Management (CM) may identify the need for COC during the Member's completion of the Health Risk Assessment (HRA).
Review of Request Criteria that must be met in order to provide services and/or medication under the COC requirements	• Member must have seen the provider once in the 12 months prior to plan enrollment for a non-emergency; **and** • The Provider does not have any documented quality of care concerns that would cause the plan to exclude the Provider from our network; **and** • The Provider is willing to contract with the plan or accept, at a minimum, payment from the plan based on current Medi-Cal rates.	• Member must have seen the Provider once in the 12 months prior to IEHP enrollment for a non-emergency; **and** • The Provider does not have any documented quality of care concerns that would cause the plan to exclude the Provider from our network; **and** • The Provider is willing to contract with the plan or accept at a minimum payment from the plan based on current Medicare or Medi-Cal rates, as applicable.
COC Period Length of time by which a Member may receive services and/or medication under the COC requirements	• **Medi-Cal medical or behavioral health services** - Up to 12 months • **For Prescriptions** – Until the prescribed therapy is no longer prescribed by the Provider. • COC period may start over one time if the Member transfers to a different managed care plan.	• **Medi-Cal services** - Up to 12 months • **Medicare services** - Up to 12 months • **For Prescriptions** – Until the prescribed therapy is no longer prescribed by the provider. • COC period may start over one time if the Member transfers to a different managed care plan.

Continuity of Care (COC) Regulations for Medi-Cal and Medicare Beneficiaries

Line of Business	Medi-Cal	IEHP DualChoice Cal MediConnect
DHCS Letters	**APL 13-023 and APL 17-007**	**DPL 16-002**
Processing Turnaround time requirements for resolving a COC request	• The plan must begin the COC process within five (5) working days and complete it within 30 calendar days or faster if the condition requires immediate handling. • If the Member's MER was denied and the Member's medical condition requires more immediate attention, the plan has 15 calendar days to resolve the COC request. If there is risk of harm to the Member, the COC request must be resolved within three (3) days.	The plan must begin the COC process within five (5) working days and complete it within 30 calendar days or 15 calendar days, if the condition requires immediate handling. If there is risk of harm to the Member, the request must be completed within three (3) days.
Resolution When a COC request is considered as complete	A COC request is considered complete when the Member is informed of: 1. Continued access; or 2. Inability to continue care due to one of the following: a. A rate cannot be agreed upon; or b. IEHP has documented a quality-of-care issue; or c. The Provider is non-responsive for 30 calendar days to the plan's attempt to contact. 3. Member is connected to an in-network Provider if the COC Provider is non-responsive.	A COC request is considered complete when the Member is informed of: 1. Continued access; or 2. Inability to continue care due to one of the following: a. A rate cannot be agreed upon; or b. IEHP has documented a quality-of-care issue; or c. The Provider is non-responsive for 30 calendar days to the plan's attempt to contact. 3. Member is connected to an in-network Provider if the COC Provider is non-responsive.
Exclusions Where COC requirements do not apply	Continuity of care does not extend to the following: • Services not covered by Medi-Cal and/or Medicare; • Durable Medical Equipment (DME); • Transportation; • Other ancillary services; and • Carved-out services.	Continuity of care does not extend to the following: • Services not covered by Medi-Cal and/or Medicare; • Durable Medical Equipment (DME); • Transportation; • Other ancillary services; and • Carved-out services.