Medi-Cal Continuity of Care

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Roadmap

- What is Continuity of Care (COC) in Medi-Cal?
- Overview of how COC works in various situations:
  - COC for mandatory managed care plans changes
  - COC for mandatory moves from Medi-Cal Fee-For-Service (FFS) to managed care
  - COC for mandatory moves from Covered Cal to Medi-Cal
  - COC for people receiving specialty mental health services
  - COC in Knox-Keene licensed plans

Goals

- Identify cases where a Medi-Cal beneficiary is (and is not) eligible for continuity of care protections.
- Know where to get more information to determine whether someone:
  - Is eligible for COC?
  - If so, with what provider / service?
  - And for how long?
  - And what, if anything, do they need to do to ensure that COC?

What is COC in Medi-Cal?

COC in Medi-Cal

- Mainly comes up in the managed care context.
  - Generally, no COC for FFS – though there are a few limited situations where people may still be receiving certain Rx through COC protections after the 2022 transition to FFS Medi-Cal Rx.
- Available in situations where a beneficiary is required to make a change to try to ensure continued access to providers and services as much as possible:
  - Providers that are out-of-network with the plan; or
  - Services that would not be authorized in the same way by the plan.

Types of COC

- COC is mainly used to talk about ensuring a beneficiary has continued access to a particular provider – even if that provider does not participate in their managed care plan's network.
  - Generally arises when someone enrolls in a new managed care plan.
  - Sometimes can also be used to ensure continued access when a provider leaves a plan's network.
  - Usually only ensures access to that provider for care that is already underway, not any service that provider may provide.

Types of COC

- COC may also refer to continued access to a particular authorized service without a gap, even if the person has to change providers.
  - E.g., durable medical equipment or laboratory services.

- Sometimes, COC refers to continued access to a particular facility (especially a residential facility) without having to change.
  - E.g., skilled nursing facilities (SNFs) or intermediate care facilities (ICFs).

When does a beneficiary have a right to COC

- When a beneficiary must switch from one Medi-Cal managed care plan to another in the same county.
- When a beneficiary must move from Medi-Cal FFS to Medi-Cal managed care.
- When a beneficiary must move from Covered California to Medi-Cal.
- When a beneficiary's provider leaves their managed care plan's network.
- When the mental health condition of a beneficiary receiving certain mental health services changes and their provider can continue providing their mental health care.

Note: Provider must qualify and agree to COC.

When does a beneficiary NOT have a right to COC

- When a beneficiary chooses to switch from one Medi-Cal managed care plan to another in the same county.
- When a beneficiary chooses to move from Medi-Cal FFS to Medi-Cal managed care.
- When the beneficiary's provider participates in the network of one of the beneficiary's plan options.
- When a beneficiary moves to a different county.
- When a beneficiary's provider dies, leaves the geographic area, stops providing the service a person needs, is disqualified from participating in the plan, stops participating in Medi-Cal, or is unwilling to continue treating the person.

Overview of various COC rights

COC when a beneficiary was required to change plans in 2024

- COC for providers*
  - 12 months of COC (from enrollment date)
  - Provider:
    - Has pre-existing relationship (seen at least once in last 12 months);
    - Is providing covered services;
    - Agrees to accept plan's rate or FFS rate;
    - State plan approved; AND
    - Is qualified.
  - Beneficiary, authorized representative, or provider must request.

* See Table A for eligible provider types

COC when a beneficiary was required to change plans in 2024

- Enhanced COC for providers*
  - Automatic 12 months of COC (from enrollment date)
  - For beneficiaries in special populations**
  - Provider:
    - Has pre-existing relationship (seen at least once in last 12 months);
    - Is providing covered services;
    - Agrees to accept plan's rate or FFS rate;
    - State plan approved; AND
    - Is qualified.
  - Plan must initiate CoC requests for all OON providers on behalf of beneficiary automatically.
  - Plan must monitor utilization for first 6 months of enrollment for this purpose.

* See Table A for eligible provider types

** See Table B for special populations

COC when a beneficiary must change plans

- COC for authorized services, including Durable Medical Equipment (DME) and medical supplies
  - Plan must honor any active prior authorizations and active courses of treatment, not covered by an authorization, for 6 months following the transition date and until reassessment for Medical Necessity of ongoing services;
  - Plan should initiate automatically.
- New specialist appointments
  - Plan should make a good faith effort to either schedule a comparable appointment on or before the appointment date, or allow the beneficiary to keep the appointment.

COC when a beneficiary must move from FFS to managed care

- COC for providers*
  - 12 months of COC (from enrollment date)
  - Provider:
    - Has pre-existing relationship (seen at least once in last 12 months);
    - Is providing covered services;
    - Agrees to accept plan's rate or FFS rate;
    - State plan approved; AND
    - Is qualified.
  - Beneficiary, authorized representative or provider must request, EXCEPT a Medical Exemption Request (MER) denial will be treated automatically as a request for COC.

* See Table A for eligible provider types

COC when a beneficiary must move from FFS to managed care

- Note on Medical Exemption Requests (MERs)
  - MERs are available to people in FFS Medi-Cal who are required to enroll in a managed care plan in a Two-Plan or Geographic Managed Care (GMC) county who have a complex condition (including third trimester of pregnancy);
  - Allow people to remain in FFS for up to 12 months to continue care with FFS providers who do not participate in any of their plan options;
  - Denial of a MER must be treated automatically as a request for COC with the FFS providers.

COC when a beneficiary must move from FFS to managed care

- Residential facility transitions in non-COHS (County Organized Health System) counties:
  - SNFs (6/1/23 transition), ICFs (1/1/24 transition), Sub-Acute Care (1/1/24 transition).
  - Up to 24 months of COC (from enrollment date).
  - Available when:
    - Beneficiary was residing in the facility on the transition date;
    - State plan approved facility; AND
    - Qualified facility.
  - Plan must initiate 12 months of COC automatically, beneficiary may request an additional 12 months.

COC when a beneficiary must move from FFS to managed care

- COC for authorized services, including DME, medical supplies, and non-emergency & non-medical transportation:
  - Plan must allow beneficiary to keep their existing DME and medical supplies for a minimum of 90 days following the Plan enrollment (enrollment date).
  - Plan must allow beneficiaries to keep their modality of transportation under the previous prior authorization with a Network Provider until the new Plan is able to reassess.
- New specialist appointments
  - Plan should make a good faith effort to either schedule a comparable appointment on or before the appointment date, or allow the beneficiary to keep the appointment

COC when someone must move from Covered California to Medi-Cal

- COC for providers*
  - 12 months of COC (from enrollment date)
  - Provider:
    - Has pre-existing relationship (seen at least once in last 12 months);
    - Is providing covered services;
    - Agrees to accept plan's rate or FFS rate;
    - State plan approved; AND
    - Is qualified.
  - Beneficiary, authorized representative, or provider must request.

- COC for authorized services and active treatment plans
  - Up to 90 days of COC (from enrollment date).
  - Plan should initiate by contacting the beneficiary within 15 days of enrollment.

* See Table A for eligible provider types

COC for beneficiaries receiving Specialty Mental Health Services

- COC for providers of overlapping mental health services
  - 12 months of COC (from enrollment date).
  - Provider:
    - Was providing the beneficiary with SMHS until beneficiary's condition changed such that SMHS are no longer needed; AND
    - Is capable of providing covered non-specialty mental health services.
  - Beneficiary, authorized representative, or provider must request.

COC under the Knox-Keene Act

- The Knox-Keene Act allows a managed care enrollee newly enrolling in a plan or whose provider leaves the plan to continue seeing an out-of-network provider in these scenarios:
  - **Pregnancy:** beneficiaries are entitled to receive care from out-of-network providers relating to pregnancy, during pregnancy and for the post-partum period (12 months after birth). Beneficiaries who have written documentation of being diagnosed with a maternal mental health condition may also receive COC for 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
  - **Care of baby or toddler:** beneficiaries are entitled to receive care from out-of-network providers who is providing care to a child between birth and age thirty-six months for up to 12 months.
  - **Scheduled or Recommended Procedure:** beneficiaries are entitled to receive care from out-of-network providers related to a procedure that has been scheduled or recommended within 180 days of the date that the previously in-network provider's contract was terminated or within 180 days of the effective date of coverage for a newly covered enrollee.

COC under the Knox-Keene Act (cont'd)

- The Knox-Keene Act allows a managed care enrollee newly enrolling in a plan or whose provider leaves the plan to continue seeing an out-of-network provider in these scenarios:
  - **Terminal Illness:** beneficiaries are entitled to receive care from out-of-network providers for a terminal illness for the duration of the illness.
  - **Acute Condition:** beneficiaries are entitled to receive care from out-of-network providers for an acute condition for the duration of an acute condition.
  - **Serious Chronic Condition:** beneficiaries are entitled to receive care from out-of-network providers for a serious chronic condition for up to 12 months or time necessarily to safely transition to an in-network provider.

COC: Spotlight on ECM and CS

- People receiving Enhaced Care Management (ECM) and Community Supports (CS) were considered a "special population" for COC purposes during the 2024 MCP Transition.
- When someone receiving ECM or CS was required to transition to another plan, their new plan was required to take affirmative steps to allow the person to continue receiving ECM / CS from their existing provider for 12 months if possible.
  - However, no COC required where the new plan does not offer the specific CS a person was receiving.
- The new plan must monitor the provision of ECM / CS for the first 6 months to ensure the person is getting the service.

Special Considerations for Foster Youth

- Foster Youth may frequently move
  - Continuity of Care can be disrupted by placement changes
    - DHCS deployed enhanced COC protections to Foster Youth transitioning in 2024 and 2025
  - Change in County
    - MCPs: Welf. & Instit. Code § 14093.09(d) - Plans must pay out-of-network providers while child is in out-of-county placement
    - BHPs: Presumptive Transfer [ACL 17-77/18-60; MHSUDS 17-032; 18-027; BHIN 24-025]
  - Intra-county placement changes
    - Delegated networks may change
    - Providers may be far away

Special Considerations for Foster Youth (cont'd)

- Foster Youth enrollment in managed care versus FFS
  - Varies by county - mandatory versus optional
- Help Navigating access:
  - MCP: Required Child Welfare Liaison [All Plan Letter 24-013] [MOU with CW Agency]
  - MCP: ECM Lead Care Manager [See ECM Policy Guide]
  - Child Welfare: Health Care Program for Children in Foster Care (HCPCFC) PHNs
  - DHCS: Medi-Cal Managed Care Ombudsman [Urgent disenrollments]
  - MCPs/BHPs: Community Health Workers (CHWs)/Enhanced CHWs [BHIN 25-@]

Case Examples

Case Example

- Selena enrolled in Medi-Cal in Imperial County on November 15, 2024 after losing her job (and employer-sponsored insurance). Selena receives regular dialysis. After enrolling in FFS Medi-Cal starting in November, Selena begins receiving dialysis from Raisa Dialysis Center. Then, effective January 1, 2025, she enrolls in Community Health Plan of Imperial Valley, which does not contract with Raisa. Is Selena entitled to COC to continue her care at Raisa?
  - Selena has appointments scheduled for 1/5, 1/12, and 1/19. Will she be able to keep those appointments?

Case Example

- Blake is 16 and lives in Fresno; she is on Medi-Cal and is enrolled in CalViva. She has generalized anxiety disorder. For the last nine months, after several severe anxiety attacks, she has been receiving intensive day treatment lead by Dr. Ferrera through the Fresno County Department of Behavioral Health. The treatment has helped reduce the severity of her symptoms and the County has determined that she no longer meets the criteria for Specialty Mental Health Services. Blake would like to transition to weekly therapy with Dr. Ferrera, which Dr. Ferrera is willing to provide, but Dr. Ferrera does not contract with CalViva. What are Blake's options?

Case Example

- Gigi is a 13 year-old who was placed in foster care in San Bernardino County in 2023, and enrolled in IEHP. for several months, she has been seeing an Enhanced Care Manager to help coordinate her services and care. In February, 2025, she was placed in Los Angeles County, and she was enrolled in LA Care as of April 1, 2025.
  - Can Gigi continue to receive Enhanced Care Management services with LA Care?
  - Can Gigi continue seeing her Enhanced Care Manager now that she’s enrolled in LA Care?

Additional Resources

Table A:
Comparison of Providers subject to 12 month COC

	Managed Care to Managed Care	Fee for Service OR Covered California to Managed Care
primary care providers	√	√
specialists	√	√
ECM providers	√	
CS providers	√	
SNFs	√	√
Intermediate Care Facilities	√	√
CBAS providers	√	
dialysis centers	√	
physical therapists	√	√
occupational therapists	√	√
respiratory therapists	√	√
mental health providers	√	
BHT providers	√	√
speech therapy providers	√	√
Doulas	√	
CHWs	√	
Sub-Acute Care Facilities		√

Table B:
Special Populations entitled to Enhanced COC

- with authorizations to receive Community Supports
- receiving Complex Care Management
- enrolled in 1915(c) waiver programs
- receiving in-home supportive services (IHSS)
- enrolled in California Children's Services (CCS)/CCS Whole Child Model
- receiving foster care, and former foster youth through age 25
- in active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- taking immunosuppressive medications, immunomodulators, and biologics
- receiving treatment for end-stage renal disease (ESRD)
- living with an intellectual or developmental disability (I/DD) diagnosis
- living with a dementia diagnosis
- in the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
- pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- receiving specialty mental health services (adults, youth, and children)
- receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- receiving hospice care
- receiving home health
- residing in Skilled Nursing Facilities (SNF)
- with authorizations to receive Community Supports
- receiving Complex Care Management
- residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- receiving hospital inpatient care
- post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- newly prescribed DME (within 30 days of January 1, 2024)
- receiving Community-Based Adult Services

Additional Resources

- NHeLP Updated Fact Sheet on Continuity of Care
- NHeLP Fact Sheet on Medi-Cal Delivery System Changes in 2023 and 2024
- Disability Rights California Fact Sheet on Medical Exemption Requests
- DHCS COC Landing Page
- DHCS COC FAQ

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