California Medical Association

TOOLKIT

MEDI-CAL SURVIVAL GUIDE

Important Changes to Medi-Cal Fee-for-Service and Medi-Cal Managed Care:

WHAT THEY MEAN TO YOUR PRACTICE

Over the past year, there have been a number of changes for Medi-Cal patients and for the physicians who treat them. There will be more changes in 2014 as well. To help physicians understand the impact these changes will have on their practices, the California Medical Association (CMA) has published this Medi-Cal Survival Toolkit. The toolkit contains a summary on many of the changes, important dates, options for physicians and links to important resources.

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Medi-Cal Primary Care Rate Increase

The Centers for Medicare & Medicaid Services (CMS) released regulations in November 2012 implementing rate increases for primary care physicians who treat Medicaid patients. The goal of the increase is to recruit and retain more physicians to treat low-income patients who will be newly eligible for health coverage under the Affordable Care Act (ACA) begining on January 1. 2014. Under the ACA, primary care physicians will see their reimbursement rates raised to Medicare levels in 2013 and 2014 for certain CPT codes. According to CMS, states must also incorporate the increased payment rates into their contracts with managed care plans so that primary care physicians contracting with Medi-Cal managed care plans see the higher rates. The increase is financed 100 percent by the federal government.

Who Is Eligible for the Increase?

According to CMS, physicians must be practicing in an eligible specialty in order to qualify for the increase. For purposes of this regulation, primary care is defined as family medicine, general internal medicine, pediatric medicine or related subspecialties. The regulation specifies that specialists and subspecialists within those designations recognized by the American Board of Medical Specialties (ABMS), American

Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) are eligible to receive the increased fees. If a physician is not board certified in an eligible specialty, eligibility can be determined by the physician's billing history. Physicians will qualify if 60 percent of the CPT codes they bill are for the evaluation and management (E/M) codes and vaccine administration codes covered by this rule. CMS will allow physicians to self-attest to their board certification and billing history.

Q: Can I qualify for the increase based solely on the basis of meeting the 60 percent claims threshold, irrespective of specialty designation?

A: No. According to the CMS FAQ (page 1), in order to be eligible for higher payment, physicians must first self-attest to practicing in a a covered specialty or subspecialty designation. Only physicians who can legitimately self-attest to a specialty designation of (general) internal medicine, family medicine or pediatric medicine—or a subspecialty within those specialties that is recognized by ABMS, ABPS, or AOA qualify. For more information on the specialists and subspecialists that qualify, click here or see the CMS Q&A.

Eligible CPT Codes

The rate increase applies to evaluation and management codes 99201 through 99499 and vaccine administration codes 90460, 90461 and 90471 – 90474.

Self-Attesting Eligibility for the Increase

The increased payments are **not** automatic. To qualify for the increased payments, providers will first be required to self-attest eligibility. The attestation form is available on the Medi-Cal website. Physicians are required to complete the attestation online (paper copies will not be accepted).

For detailed information on the rate increase, see CMA's Medi-Cal Primary Care Physician Rate Increase FAQs.

Attest now!

According to a DHCS report, less than half of eligible providers had self-attested as of September 24, 2013. To fill out the attestation form, visit the Medi-Cal website, www.medi-cal.ca.gov and click on "Affordable Care Act (ACA)."

CMA On-Call

Throughout this document, you will find references to CMA On-Call documents. These documents are available free to members in CMA's online health law library at www.cmanet.org/cma-on-call. Nonmembers can purchase documents for $2 per page.

When Will the Increase Be Implemented?

Although the regulations implementing the pay raise were released by CMS in November 2012, DHCS did not submit its State Plan Amendment (SPA), which details California's proposed payment methodology for both fee-for-service and managed care payments for approval until late March. CMS approved the SPA on October 24, 2013. Once implemented, the increases will be retroactive to January 1, 2013, without the need to resubmit claims.

DHCS had previously indicated that it expected to implement the rate increase by February 2014, but now reports their systems won't be ready to begin paying claims at the higher rate until possibly July 2014.

DHCS announced they made an interim payment on November 4, 2013, to physicians who have attested. This payment was an estimate of what DHCS believed is owed to the physician retroactive to January 1, 2013, dates of service for fee-for-service Medi-Cal claims, however the payment will not include claim level detail.

DHCS intends on making weekly estimated payments until its systems are updated to begin processing claims at the new rate, which could be as late as July 2014.

Once its systems are updated, DHCS will issue a final settlement, which will reflect a "true up" of payment owed but not reimbursed, or possibly a refund request if overpaid. This final settlement will include claim level detail for the entire amount paid as part of this increase.

While the increase also applies to services provided by physicians to Medi-Cal managed care patients, it is unclear when or how each Medi-Cal managed care plan will implement the increase. CMA has been advised that federal money for the increase may not be released to the Medi-Cal managed care plans until the end of December.

It's important to note that Medi-Cal payments are made at the lesser of the Medi-Cal fee schedule or the provider's billed charges. Therefore, CMA suggests that physicians bill their usual and customary fees for services to Medi-Cal patients. Billing at your customary fee ensures that national data reflects actual charges rather than payment rates, and ensures that Medi-Cal pays you at the highest amount possible when the claim is processed or reprocessed. Do not bill at a lower amount; you may not have the benefit of automatic reprocessing of your claims if the amount allowed is more than you charged.

Q: Is there a deadline for completing the attestation process in order to receive retroactive payment back to January 1, 2013?

A: While CMS allowed states to limit retroactive payments to the beginning of the month or quarter in which the attestation is submitted, DHCS has advised CMA that it will not be implementing any restrictions. DHCS has confirmed that physicians who complete the attestation process by December 31, 2014, will still be eligible for retroactive payment dating back to January 1, 2013. DHCS further confirmed that this also applies to Medi-Cal managed care plans as well.

Physicians are, however, encouraged to attest as soon as possible. The sooner physicians attest, the sooner they will receive the increased payments.

Q: For patients with Medicare as their primary carrier and Medi-Cal as their secondary carrier (Medi/Medis), will Medi-Cal now be paying the 20 percent coinsurance left after Medicare pays?

A: DHCS has advised CMA that for eligible physicians billing for eligible codes, Medi-Cal will begin paying as a secondary to Medicare. However, CMA is seeking clarification from DHCS on the methodology of how they will pay Medi/Medi claims and whether it will pay the full 20 percent.

Additional Information

- Medi-Cal website update
- CMS Q&As on the Increased Medicaid Payment for Primary Care CMS 2370-F (Sets I-V)
- CMS Q&As on the Increased Medicaid Payment for Primary Care CMS 2370-F – Managed Care (Sets I & II)

Medi-Cal 10 Percent Cuts

In March of 2011, the California Legislature passed and Governor Jerry Brown signed AB 97, which included a 10 percent reimbursement rate cut for physicians, dentists, pharmacists and other Medi-Cal providers.

Shortly thereafter, CMA filed a lawsuit, *CMA et al. v. Douglas et al.,* to stop the State of California from implementing the 10 percent cut included in the 2011-2012 state budget.

In January 2013, a three judge panel of the 9th Circuit Court of Appeals reversed a decision by a district court that had blocked the cuts, finding that they would irreparably harm the millions of patients who rely on Medi-Cal for health care. The Ninth Circuit also vacated the preliminary injunction clearing the way for implementation of these rate reductions. CMA requested a rehearing from the full Ninth Circuit Court of Appeals, which was denied.

CMA and the other plaintiffs in the case (the California Hospital Association, California Dental Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, AIDS Healthcare Foundation and American Medical Response), subsequently filed a request with the U.S. Supreme Court for a stay to prevent the cuts going forward. This request was denied a day later.

On September 20, 2013, CMA filed a petition asking the United States Supreme Court to review the Ninth Circuit Court of Appeals' ruling that cleared the way for the State of California to implement the cuts. For more information on this petition, click here.

When Will the Cuts go into Effect?

DHCS announced on August 14, 2013, that it would begin to implement the 10 percent Medi-Cal physician payment rate reduction on October 1, 2013, for Medi-Cal managed care and on January 9, 2014, for fee for service. DHCS also announced that it would be retroactively implementing the cuts for FFS providers to June 1, 2011, when the law authorizing the cuts went into effect.

DHCS will recoup a percentage of provider payments going forward to recover funds that were overpaid during the retroactive period. These retroactive payment recoveries will not occur until after the prospective 10 percent payment reductions are implemented. DHCS

did not indicate the specific date in which the retroactive recoupments would begin, however it did state that it will provide at least 60 days' advanced notification of the retroactive recoveries.

It is not yet known how the retroactive cuts will be reflected on the Medi-Cal Remittance Advice Detail.

The entire portion for which there would be a "clawback" cut would be June 1, 2011, until January 9, 2014, or over 29 months. This toolkit will be updated as additional details become available.

It is up to the individual Medi-Cal managed care plans how or if they pass on the cuts to physicians.

Are Any Physicians Exempt from the Cuts?

Yes. The retroactive reductions will not apply to Medi-Cal managed care plans. Additionally, specialty physician services in Medi-Cal managed care will not be subject to prospective 10 percent cut. CMA has inquired with DHCS to obtain additional clarification on this exemption, however, DHCS deferred to the managed care plans on how the specialty exemption would be implemented.

Outpatient services provided to children (defined by CMS as under age 21) by physicians and clinics are also exempt from both the prospective and retrospective cuts.

In addition, physicians who are eligible for the primary care rate increase (see page 1) will not be subject to the prospective cuts in 2013-2014 when billing for eligible codes. However, they will be subject to the cuts when billing non-eligible codes and will subject to retroactive cuts (prior to 2013) on all codes.

Q: How do I assess the impact of the Medi-Cal rate cuts on my practice?

A: It is important that physicians understand how the cuts will affect their practices' bottom line so that they can make informed decisions about participation in the Medi-Cal program. CMA has developed a simple financial impact worksheet to help physicians analyze proposed fee schedules and assess the impact any fee schedule change may have on physician practices based on the practices' commonly billed CPT codes. This worksheet is available free to members at CMA's members' only website at www.cmanet.org/ces.

What Are My Options?

Physicians have the following options:

1. Limit or close your practice to new Medi-Cal patients.

For some physicians, abruptly terminating your participation in the Medi-Cal program may not be financially feasible. Another option may be to limit the number of, or close their practice to, new Medi-Cal patients.

The DHCS has rendered conflicting answers to the question of whether physicians must accept all Medi-Cal patients who come through their doors if they agree to take one Medi-Cal patient. However, DHCS recently, in response to CMA advocacy, advised that:

> *There are no regulations that require a fee-for-service physician to see a set amount of [Medi-Cal] patients. They can see one beneficiary or many. Therefore there is no minimum requirement of Medi-Cal patients that must be assigned to a participating Medi-Cal provider.*

For more information, see CMA On-Call document #7204, "Side Agreements with Medi-Cal Patients."

2. Terminate your participation in the Medi-Cal program.

Physicians who wish to terminate their participation in the Medi-Cal program may request to be deactivated by submitting a Medi-Cal Supplemental Changes (DHCS 6209) form along with a cover letter explaining the action requested and the effective date of the termination. There is no official advance notice of a request to deactivate required when terminating enrollment in the Medi-Cal program. For this reason, CMA suggests the physician simply indicate the requested termination effective date in their cover letter. Ultimately, the Medi-Cal Provider Enrollment Division has the final say on the effective date, but they try to honor the requested date.

While physicians who terminate their participation in the Medi-Cal program will not have to deal with the prospective cuts, they will still be subject to the retrospective cuts. CMA has inquired with DHCS about how it will pursue monies due from physicians who have left the program, but at the time of publication it was still unclear.

3. Agree to the cuts.

If a physician agrees to the 10 percent cuts, no action is required. The revised reimbursement rates will become effective for dates of service beginning October 1, 2013, for Medi-Cal managed care and on January 9, 2014, for fee-for-service Medi-Cal.

Q: I have decided to terminate my Medi-Cal participation. Will I be able to continue to see Medi-Cal patients?

A: To be reimbursed by the Medi-Cal program, the provider must have been enrolled as a Medi-Cal provider on the date of service. Furthermore, both the courts and DHCS have made it clear that they believe that any side agreements with Medi-Cal beneficiaries are unlawful, even if the beneficiary does not seek Medi-Cal reimbursement.

State law also contains a specific prohibition against beneficiary billing (Welfare & Institutions Code §14019.4(a).). State regulation clarifies and interprets this provision (22 C.C.R. §51002.).

Failing to comply with the law can subject a physician to sanctions as well as penalties, payable to DHCS, not to exceed three times the amount payable by the Medi-Cal program.

Physicians are encouraged to communicate their decisions to terminate their participation in the Medi-Cal program with their patients. More information on terminating the physician-patient relationship can be found in CMA On-Call document #3503, "Termination of the Physician-Patient Relationship." Also included in this On-Call document is a sample letter physicians may wish to use to notify patients.

Additional information can also be found in CMA On-Call document #7204, "Side Agreements with Medi-Cal Patients."

Q: What steps can I take to bring awareness to the impact these cuts have on my patients and my practice?

A: Physicians may wish to consider the following options:

- Get your legislators involved by calling or writing them with your concerns regarding the effects the cuts have on your ability to continue to provide care to Medi-Cal patients, as well as concerns you may have about adequate patient access to medical care. To look up your legislators' contact information, click here.
- Get your patients involved by encouraging them to contact their legislators to communicate their concerns regarding adequate access to medical care.

Additional Information:

- DHCS Implementation of AB97 Reductions
- DHCS Medi-Cal Payment Reduction Update

California's Dual Demonstration Project

In an effort to save money and better coordinate care for the state's low-income seniors and persons with disabilities, the 2012 state budget authorized a three-year demonstration project, the Coordinated Care Initiative (CCI).

CMS approved the Memorandun of Understanding (MOU) between the State of California and CMS on March 27, 2013.

CCI contains two main components (1) Cal MediConnect, which transitions individuals who are eligible for both Medicare and Medi-Cal (duals) away from fee for service and into managed care and (2) integration of long term supports and services (LTSS) into managed care.

The Cal MediConnect Program, begins with a three-year demonstration project that will transition more than 450,000 of the state's dual eligible beneficiaries into managed care plans.

Enrollment begins no sooner than April 2014 in eight counties (Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino).

For more information on LTSS, visit www.calduals.org.

Scope and Timeline

Enrollment in the program, which was originally scheduled to begin September 1, 2013, has now been scheduled to begin no sooner than April 1, 2014. The length of the enrollment period depends on the county of residence (shown in the chart on the next page).

In all six counties where the transition is occurring over 12 months, patients will be transitioned into managed care based on their birth month.

Individuals Excluded from Cal MediConnect

Certain dual-eligible populations will be excluded from Cal MediConnect, including:

- Individuals under age 21
- Individuals with other private or public health insurance
- Individuals receiving services through a regional center, state developmental center or intermediate care facility for the developmentally disabled
- Most individuals with a share of cost
- Individuals residing in a Veterans Home

Cal MediConnect Implementation Timeline

County	Participating Plan(s)	Timeline
Alameda	Alameda Alliance for Health and Anthem Blue Cross	12 mo
Los Angeles*	LA Care and Health Net	Currently in development
Orange	CalOptima	12 mo
Riverside	Inland Empire Health Plan and Molina	12 mo
San Bernardino	Inland Empire Health Plan and Molina	12 mo
San Diego	Care 1st, Community Health Group, Health Net and Molina	12 mo
San Mateo	Health Plan of San Mateo	In the first month
Santa Clara	Anthem Blue Cross and Santa Clara Family Health Plan	12 mo

*Enrollment in Los Angeles County will be capped at 200,000.

- Individuals in some rural zip codes
  - San Bernardino: 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93592, and 93558.
  - Los Angeles: 90704
  - Riverside: 92225, 92226, 92239
- Individuals with a diagnosis of end state renal disease at the time of enrollment, except in San Mateo and Orange Counties.

Enrollment Process and Opt Out

Dual eligibles should begin receiving notices regarding the Cal MediConnect program in January 2014, 90 days before enrollment is set to begin. There will be subsequent notices (60 days and 30 days before enrollment begins, respectively). Patients who do not select a health plan after all three notices will be "passively enrolled" into a plan selected by DHCS.

The State of California had proposed that, once a patient had selected or been assigned to a plan, they would be "locked-in" for six months. CMS, however, rejected that proposal completely. Patients will have the ability to opt out of the demonstration into fee-for-service Medicare at any time.

While the dual eligible patients in affected areas have the option of opting out of a Medicare managed care plan and staying in fee-for-service Medicare, there is **no** ability to opt out of enrollment in a Medi-Cal managed care plan.

Patients who choose to opt out of the demonstration into fee-for-service Medicare, can do so at any time and their coverage will be effective the first of each month. Those who wish to opt out or switch to another plan can contact Health Care Options at (800) 430-4263.

Covered Benefits and Services

Cal MediConnect plans will be required to cover all services currently covered by Medicare Parts A, B or D (physicians, hospitals and prescription drugs, respectively), and any services currently covered by Medi-Cal. In addition, plans will be required to cover some services that are currently not covered by either Medicare or Medi-Cal, including vision and medical transportation. For more information on additional covered benefits, click here (see Appendix 7).

Continuity of Care

There are a couple of very important protections for physicians and their patients regarding continuity of care.

Once patients are enrolled in a Medi-Cal managed care plan, they can continue to see a physician with whom they have an existing relationship, even if the physician is not contracted with the plan, for up to 6 months for Medicare and up to 12 months for Medi-Cal services if certain criteria are met.

Medicare Services

- Patient demonstrates they've seen the out-of-network physician at least twice in the previous 12 months
- Provider must be willing to accept payment from the plan at Medicare rates
- The plan would not have otherwise excluded that provider from its network due to quality or other concerns

Medi-Cal Services*

- Patient demonstrates they've seen the out-of-network physician at least twice in the previous 12 months
- Provider must be willing to accept payment from the plan based on the plan's reimbursement rate or Medi-Cal rate (whichever is higher)
- The plan would not have otherwise excluded that provider from its network due to quality or other concerns

A pre-existing relationship with the out-of-network physician may be established by the plan using Medicare data or by documentation from the provider or enrollee. The process by which the provider or enrollee would submit documentation is not yet clear, however.

For more information on the laws on continuity of care, see CMA On-Call document #7051, "Contract Termination by Physicians and Continuity of Care Provisions."

Q: Where can patients and physicians report continuity of care or other access problems?

A: Patients who have concerns with continuity of care or access to care can call the number on the back of their ID cards to talk with the Medi-Cal managed care plan. Additionally, patients with questions or concerns about continuity of care or access problems specific to their Medi-Cal managed care plan can also contact the Medi-Cal Managed Care Office of the Ombudsman by phone at (888) 452-8609 or by email at MMCDOmbudsmanOffice@dhcs.ca.gov. While the Ombudsman Office was created to assist patients, CMA has confirmed that physicians can report concerns to the Ombudsman as well.

Patients also have the ability to appeal a plan's continuity of care decision by contacting DHCS for a State Fair hearing or the Department of Managed Health Care (DMHC) for an Independent Medical Review.

Reimbursement

DHCS and CMS have not completed their contracts with the managed care plans, which will specify the capitation rates that the plans receive. It will then be left to the plans to negotiate with their provider networks. We don't expect the contracts with the managed care plans to be completed until December 2013.

In an urgent or emergent situation, the plans will be required to pay out-of-network physicians at the Medicare fee-for-service rate for Medicare services, and the Medi-Cal fee schedule for Medi-Cal services. This is an important protection for physicians covered by federal EMTALA law, including emergency physicians.

CMA will continue to work with DHCS and other stakeholders in an effort to minimize the impact of the transition on physicians and their patients. CMA has also established a resource center at www.cmanet.org/duals with additional information to help physicians and their patients understand what is being implemented.

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

Network Adequacy

For Medicare services, health plans will be required to meet Medicare Advantage standards for network adequacy, unless the Medi-Cal standards are more stringent. Networks will be subject to an initial assessment and ongoing monitoring by the Department of Managed Health Care.

Physicians should also be aware that plans will be required to ensure that their providers comply with all requirements of the Americans with Disabilities Act.

Q: Does CMA have any resources to assist me in communicating with my patients about how their choice in the Cal MediConnect program may affect my ability to continue to provide services?

A: Yes. CMA has created sample letters physicians can use to communicate with their patients about their options in the Cal MediConnect program. The sample letters are available **free** for CMA members on our website at www.cmanet.org/duals.

Q: In order to make decisions about which Medi-Cal managed care plans I may wish to explore a contract with, I'd like some information on the number of enrollees in each plan in my county. Where can I find that?

A: For information on the number of dual eligible enrollees by county, visit the Cal Duals website (under "Cal MediConnect Counties," click the county). For information on the number of individuals enrolled in each Medi-Cal managed care plan by county see the DHCS Medi-Cal Managed Care Expansion website (under "For Health Plans," click "Enrollment Reports (MMCD)," then click the most recent report).

Additional Information

- CMA webinar, "California's New Coordinated Care Initiative (CCI) for Dual Eligibles"
- Full text of CMS MOU
- Cal Duals website
- DHCS Coordinated Care Initiative Overview
- Draft Cal MediConnect beneficiary notices

Healthy Families Transition to Medi-Cal Managed Care

On December 31, 2012, DHCS received federal approval to begin transitioning approximately 860,000 low income children from the Healthy Families program into Medi-Cal Managed Care. Phase 1A of the transition (see schedule below) began on January 1, 2013.

The transition, proposed by Governor Brown and passed by the Legislature last summer as part of a larger plan to close the budget deficit, is expected to save the state about $64 million in 2013. CMA opposed the plan since it was first proposed, expressing concern that the move will likely have a negative impact on those who rely on the Healthy Families program for health care coverage.

Four-phase transition

The first two phases affected children who are covered by health plans that participate in both the Healthy Families and Medi-Cal managed care programs in their counties of residence. These children will continue to be covered by their current plans.

Phase 1 – More than 403,000 children were transitioned in the first phase. This phase was divided into three parts. Part A began on January 1, 2013, and affected Alameda, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo and Santa Clara counties. Part B began on March 1, 2013, and impacted Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Monterey, Napa, Sacramento, San Diego (Health Net), San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Tulare and Yolo counties. Part C began on April 1, 2013, and affected Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin and Stanislaus counties.

Phase 2 – Approximately 269,000 children were transitioned in Phase 2, which began on April 1, 2013.

Phase 3 – This phase impacted approximately 107,000 children who were covered by health plans that did not participate in Medi-Cal managed care or subcontract with a Medi-Cal managed care plan. These children were enrolled in a Medi-Cal managed care health plan in their county of residence. Enrollment included consideration of the child's primary care providers. This was the first phase of the Healthy Families transition where patients may have been required to change physicians. Phase 3 began on August 1, 2013.

Phase 4 – This phase, which began on September 1, 2013, affected 8,000 in the eight County Organized Health System counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity).

Phase 4b – On November 1, 2013, approximately 27,000 children will be transitioned in the remaining 20 counties (Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, San Benito, Sutter, Tehama, Tuolumne and Yuba).

Because patients in phases 4 and 4b were required to switch plans and physicians, practices are highly encouraged to ask patients for their **new** insurance cards, to make copies and then to verify eligibility to prevent payment delays and denials due to incorrect insurance information or out-of-network status.

CMA continues to actively participate in the Healthy Families transition process and stakeholder meetings in an effort to minimize any potential confusion caused by such a large scale transition.

Continuity of Care

Plans will be required to follow continuity of care laws, which require plans, at the enrollee's request, to provide for the completion of covered services for new enrollees as follows:

- **For the duration of an acute condition.** An acute condition is a condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has limited duration;
- **For serious chronic conditions.** For the period of time, not to exceed 12 months, necessary to complete a course of treatment and arrange for a safe transfer in consultation with the enrollee and treating provider and consistent with good professional practice. A serious chronic condition is a condition 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;
- **For the duration of a pregnancy.** Pregnancy is the three trimesters of pregnancy and the immediate post-partum period;
- **For the duration of a terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Nonetheless, completion of covered services must be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months after the effective date of coverage for a new enrollee;
- **For the care of children between birth and 36 months,** not to exceed 12 months; and
- **For the performance of a surgery or other procedure** that has been authorized by the plan as part of a recommended and documented course of treatment to occur within 180 days of the termination or new enrollment.

For more information on continuity of care requirements, see CMA On-Call document, #7051, "Contract Termination By Physicians and Continuity of Care Provisions."

Q: Where can patients and physicians report continuity of care or other access problems?

A: Patients who have concerns with continuity of care or access to care can call the number on the back of their ID cards to talk with the Medi-Cal managed care plan or can contact the Medi-Cal Managed Care Office of the Ombudsman by phone at (888) 452-8609 or by email at MMCDOmbudsmanOffice@dhcs.ca.gov. While the Ombudsman Office was created to assist patients, CMA has confirmed that physicians can report concerns to the Ombudsman as well.

For more information on the role of the Office of the Ombudsman, visit the DHCS website.

Patients also have the ability to appeal a plan's continuity of care decision by contacting DHCS for a State Fair hearing or DMHC for an Independent Medical Review (IMR).

Q: In order to make decisions about which Medi-Cal managed care plans I may wish to explore a contract with, I'd like some information on the number of enrollees in each Medi-Cal managed care plan in my count. Where can I find that?

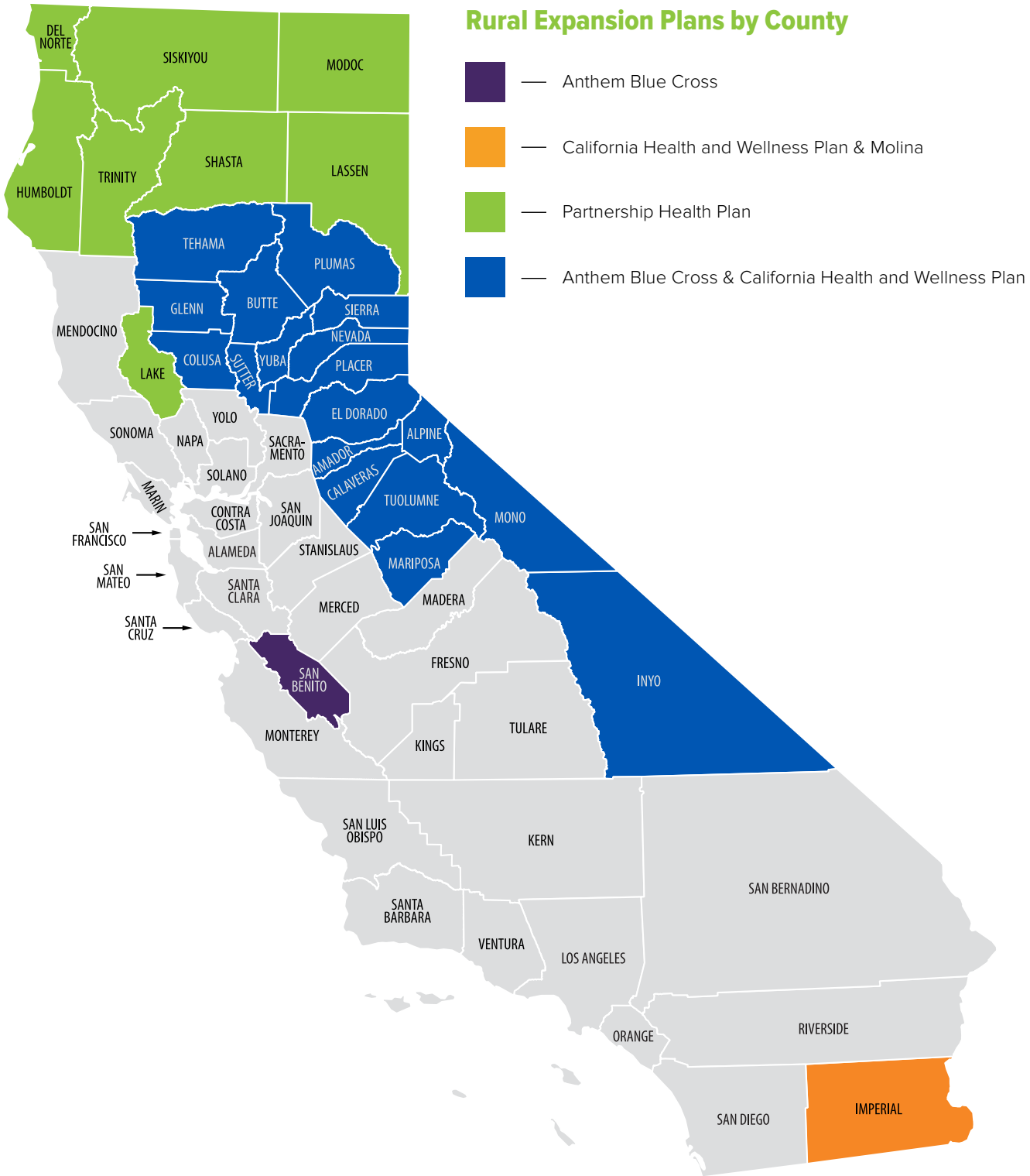
A: For information on the number of individuals enrolled in each Medi-Cal managed care plan by county, see the DHCS Medi-Cal Managed Care Expansion website (under "For Health Plans" click "Enrollment Reports (MMCD)," then click the most recent report).

Additional Information

- CMA webinar, "Preparing for Phases 3 and 4 of the Healthy Families Program Transition to Medi-Cal"
- CMA's webinar, "Healthy Families: Important Program Changes Practices Need to Know"
- DHCS Healthy Families Program Transition to Medi-Cal website
- Healthy Families Program Transition FAQ website, which includes a provider specific FAQ.
- Questions or comments for DHCS can be sent via email to DHCSHealthyFamiliesTransition@dhcs.ca.gov.

Medi-Cal Managed Care Rural Expansion

The California Legislature authorized, as part of the 2012 budget, the expansion of Medi-Cal managed care into 28 rural fee-for-service counties, which expands the Medi-Cal managed care program into all of California's 58 counties. This expansion is part of the governor's plan to reduce costs in the Medi-Cal program. Under the expansion program, eligible Medi-Cal enrollees will be required to enroll in a Medi-Cal managed care program in order to receive services.



DHCS announced that for purposes of consistency and to ensure the readiness of the plans, the rural expansion transition would be split into two phases to coincide with Healthy Families transition phases 4a and 4b (see page 8). The rural expansion transition will occur as follows:

September 1, 2013: Approximately 103,000 Medi-Cal fee-for-service enrollees in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity counties will transition to Medi-Cal managed care.

November 1, 2013: Approximately 173,000 Medi-Cal fee-for-service enrollees in Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito Sierra, Sutter, Tehama, Tuolumne and Yuba counties will transition to Medi-Cal managed care.

The plans selected by DHCS include Anthem Blue Cross and California Health and Wellness Plan in the counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. The state entered into an exclusive Medi-Cal managed care contract with Partnership HealthPlan of California for expansion in Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity counties. DHCS selected Molina and California Health and Wellness Plan to provide services in Imperial County.

The transition from fee-for-service Medi-Cal to managed care in San Benito County is voluntary. Anthem Blue Cross was the plan selected in this county.

Practices are encouraged to verify eligibility of Medi-Cal patients on or after the above effective dates to ensure eligibility, that the correct payor is billed and to prevent denials of claims.

Continuity of Care

Health plans will be required to follow continuity of care laws, which require plans, at the enrollee's request, to provide for the completion of covered services for new enrollees as follows:

- **For the duration of an acute condition.** An acute condition is a condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has limited duration;
- **For serious chronic conditions.** For the period of time, not to exceed 12 months, necessary to complete a course of treatment and arrange for a safe transfer in consultation with the enrollee and treating provider and consistent with good professional practice. A serious chronic condition is a condition 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;
- **For the duration of a pregnancy.** Pregnancy is the three trimesters of pregnancy and the immediate post-partum period;
- **For the duration of a terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Nonetheless, completion of covered services must be provided for the duration of a terminal illness which may exceed 12 months from the contract termination date or 12 months after the effective date of coverage for a new enrollee;
- **For the care of children between birth and 36 months,** not to exceed 12 months; and
- **For the performance of a surgery or other procedure** that has been authorized by the plan as part of a recommended and documented course of treatment to occur within 180-days of the termination or new enrollment.

For more information on continuity of care requirements, see CMA On-Call document #7051, "Contract Termination By Physicians and Continuity of Care Provisions."

Q: I do not practice in a rural expansion county, but received a contract from a Medi-Cal managed care plan for rural expansion. Why?

A: DHCS has advised CMA that it anticipates some overlap in contracting to cover patients who may live in a rural expansion county, but work or receive their medical care in a neighboring county.

Q: If I provide emergency services to a Medi-Cal managed care patient, but I am out-of-network with the patient's plan, will I be paid?

A: Federal law requires all Medi-Cal managed care organizations to "protect rights of beneficiaries

to access emergency services (as defined under "prudent layperson" standards) without regard to prior authorization or provider network status, under the same standards that apply to emergency and post-stabilization care under the Medicare Advantage program." (SSA §1932(b)(1) & (2))

Payment for emergency services may be denied only a) if the plan reasonably determines that the emergency services were never performed; or b) for a medical screening examination, in cases when the plan enrollee did not require emergency services, and the enrollee should have reasonably known that an emergency did not exist.

Payment for emergency services, however, is limited to the lower of the provider's usual charges or the fee-for-service rates for similar services under the Medi-Cal program. (22 C.C.R. §53698)

Q: I treated a Medi-Cal managed care patient in my office for a non-emergent issue, but I am not contracted with the plan. The plan is denying payment stating I am out-of-network. Can I collect from the patient?

A: Physicians may not seek reimbursement from Medi-Cal beneficiaries for any covered services provided by a Medi-Cal managed care health plan (Welfare & Institutions Code §14452.6).

Q: I am not contracted with the Medi-Cal managed care plan(s) in my county, but am interested in exploring the possibility of becoming a participating physician. How can I contact the plan(s)?

A: DHCS, on its Medi-Cal Managed Care Rural Expansion webpage, provides detailed contact information on the Medi-Cal managed care plans selected for rural expansion. Physicians who are interested in exploring a contract with one of the plans selected are encouraged to reach out to the plan directly. Click here to access the plan contact information.

Q: Where can patients and physicians report continuity of care or other access problems?

A: Patients who have concerns with continuity of care or access to care can call the number on the back of their ID cards to talk with the Medi-Cal managed care plan or can contact the Medi-Cal Managed Care Office of the Ombudsman by phone at (888) 452-8609 or by email at MMCDOmbudsmanOffice@dhcs.ca.gov. While the Ombudsman Office was created to assist patients, CMA has confirmed that physicians can report concerns to the Ombudsman as well.

Patients also have the ability to appeal a plan's continuity of care decision by contacting DHCS for a State Fair hearing or DMHC to request an Independent Medical Review (IMR).

Q: In order to make decisions about which Medi-Cal managed care plans I may wish to explore a contract with, I'd like some information on the number of enrollees in each Medi-Cal managed care plan in my count. Where can I find that?

A: For information on the number of dual eligibles by county, see the DHCS Medi-Cal Managed Care Expansion website (under "For Health Plans" click "Enrollment Reports (MMCD)," then click the most recent report).

Additional Information

- DHCS Medi-Cal Managed Care Expansion page at www.dhcs.ca.gov.
- DHCS Medi-Cal Managed Care Rural Expansion page
- Carved Out Managed Care Service Paid For by Fee-For-Service

Low Income Health Program Transition

DHCS received approval on August 29, 2013, from CMS of the Section 1115 Medicaid Demonstration ("1115 Waiver"), entitled "California's Bridge to Reform," effective November 1, 2010 through October 31, 2015. Low Income Health Plans (LIHP) provide a basic level of coverage for medically indigent adults between 19 – 64 years of age who don't qualify for Medi-Cal, the Children's Health Insurance Program, are not pregnant, meet county residency and income requirements, and meet federal citizenship requirements.

DHCS will be eliminating the LIHP and transitioning approximately 600,000 individuals eligible for LIHPs to Medi-Cal managed care plans effective January 1, 2014. Another 24,000 individuals eligible for LIHPs will be referred to Covered CA for determinations of their eligibility for Advanced Premium Tax Credits and subsidies to purchase insurance through the exchange for coverage effective January 1, 2014.

CMA and DHCS will work together to get additional information out to doctors via the DHCS LIHP website and upcoming webinars.

Additional Information

- DHCS Low Income Health Plan webpage

ACA Medi-Cal Expansion

Not to be confused with Medi-Cal Rural Expansion (see page 10), the Medi-Cal expansion called for under the ACA will expand Medi-Cal coverage to many low-income individuals who were previously ineligible for coverage.

Under the ACA, states have the option of expanding coverage to include childless adults, ages 19-64. The expansion also raises the income eligibility limit from 100 percent of federal poverty level (FPL) to 138 percent of FPL ($15,856 for an individual in 2013) for individuals who are citizens or legal immigrants.

DHCS must submit a State Plan Amendment to CMS and obtain approval before the expansion becomes effective.

Open enrollment for Medi-Cal expansion coverage began October 1, 2013, with coverage to be effective on January 1, 2014.

The costs of expanding the Medi-Cal program are federally financed for three years. After that, states gradually, year-by-year assume up to 10 percent of the financial responsibility for offering expanded Medi-Cal coverage.

Physicians should note that the majority of Medi-Cal enrollees receive services through Medi-cal managed care plans. Patients who have questions about how to enroll can be directed to the DHCS website at www.dhcs.ca.gov.

Q: In order to make decisions about which Medi-Cal managed care plans I may wish to explore a contract with, I'd like some information on the number of enrollees in each Medi-Cal managed care plan in my count. Where can I find that?

A: For information on the number of individuals enrolled in each Medi-Cal managed care plan by county, see the DHCS Medi-Cal Managed Care Expansion website (under "For Health Plans" click "Enrollment Reports (MMCD)," then click the most recent report).

Additional Information

- DHCS Medi-Cal Expansion webpage

CMA hopes that this information is helpful. For more information or assistance, physician members can call CMA's reimbursement helpline at (888) 401-5911 or email CMA's Center for Economic Services at economicservices@cmanet.org.