



Continuity of Care in Medi-Cal Managed Care

Managed Care in California Series

Issue No. 6

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Introduction

Continuity of Care (“COC”) is critical to Medi-Cal beneficiaries in a variety of circumstances: moving from fee-for-service (FFS) Medi-Cal into a managed care plan for the first time, moving into Medi-Cal managed care from Covered California after a change of circumstances, or moving from one Medi-Cal health plan to another. COC protections typically allow Medi-Cal beneficiaries to continue receiving existing treatments (including medications) without having to go through additional prior authorization processes for a period of time after a transition, and in some cases also permit Medi-Cal beneficiaries to continue seeing providers who are out-of-network with their new plan for a period of time. Lack of COC can lead to significant disruptions in care, beneficiary and provider dissatisfaction, and increased medical and administrative costs for providers, for health plans and the State. Notwithstanding this fact, the lack of information about COC has made these rights difficult to enforce. The transition of seniors and persons with disabilities (“SPDs”) from fee-for-service plans to managed care plans in 2011 is one such example: more than eighty percent of SPDs did not know that they had the right to continue seeing their current provider.¹ As beneficiaries continue to transition into Medi-Cal managed care, advocates, consumers and providers must understand when COC protections apply in order to avoid dire consequences from disruptions in care.

There are a number of laws and policies that govern COC for Medi-Cal beneficiaries; some protect access to particular services or access to an existing provider for a course of treatment or for a period of time, and others protect a specific population of beneficiaries. Additionally, some of these protections are specific to Medi-Cal while others are more broadly applicable to consumers in certain types of managed care plans in California. This fact sheet provides an overview of the laws and regulations that require COC for Medi-Cal beneficiaries.

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I. COC protections allow Medi-Cal beneficiaries to continue services.

In some situations, COC protections are specifically designed to ensure that a Medi-Cal beneficiary can continue receiving an existing course of treatment without interruption or need for the plan to review or approve that course of treatment. These protections are generally aimed at ensuring continuity when a beneficiary newly enrolls in Medi-Cal managed care, or transitions to Medi-Cal from another program.

a. Prescription Drug-specific COC

All Medi-Cal beneficiaries who are newly enrolled in a managed care plan are entitled to continue use of any (single-source) prescription drug without prior authorization.² Beneficiaries are entitled to this protection whether or not the drug is covered by the plan or the prescriber contracts with the plan, as long as the prescription was in effect immediately prior to the date of the beneficiary's enrollment in the plan.³ This protection applies to those who are newly enrolled in Medi-Cal, newly enrolled in Medi-Cal managed care, or have switched from one managed care plan to another.⁴ A health plan must continue to cover and provide these prescription drugs for a new enrollee until a plan doctor makes a determination that the prescription is no longer needed.⁵

Seniors and Persons with Disabilities (SPDs) who are transitioned from FFS Medi-Cal into managed care possess additional rights to ensure that they have continued access to prescription medications. They are entitled to a 30-day authorization to continue any prescription drugs if their request for an exemption for mandatory enrollment in managed care is denied.⁶ In addition, DHCS has clarified that plans must fill any prescriptions for a new or refilled drug prescribed by a transitioning SPD's current provider if it is on the health plan's formulary.⁷ If a SPD's current provider prescribes a new drug that is not on the plan's formulary, the plan must notify the pharmacist that prior authorization is required, and it must make a decision whether to fill the prescription within 24-hours based upon medical justification provided by the prescribing doctor.⁸ If a SPD's current provider prescribes a non-formulary medication refill as part of ongoing treatment, the plan must cover the drug while it makes a determination of whether the drug is medically necessary, and until it notifies the beneficiary's doctor of its decision and develops a care plan with the beneficiary's based on her or his medical needs.⁹

b. Existing Treatment Authorizations for SPDs

In addition to the rules that ensure SPDs who move from FFS Medi-Cal into managed care may continue to receive their prescription medications, Medi-Cal plans are also required to honor any active FFS Treatment Authorization Request for newly enrolled SPDs. Plans must honor approved Treatment Authorization Requests for up to 60 days or until a new assessment is completed by the plan.¹⁰ The Medi-Cal plan must honor an active Treatment Authorization Request even without a request by the beneficiary or the provider.¹¹

c. Existing Treatment Authorizations for beneficiaries who move to Medi-Cal from Covered California

When a person who was previously enrolled in Covered California moves into Medi-Cal managed care coverage, the Medi-Cal plan must make a good faith effort to obtain information from the beneficiary about any active and ongoing treatments or medications.¹² To facilitate these efforts, the Medi-Cal plans must attempt to contact the new enrollee within 15 days of enrollment.¹³ The Medi-Cal plan must honor any active treatment authorizations for up to 60 days or until a new assessment is completed by the plan.¹⁴ The plan must honor these active treatment authorizations even without a request for COC by the enrollee or the provider.¹⁵

II. COC protections allow Medi-Cal beneficiaries to continue seeing their existing out-of-network providers.

There are also situations where Medi-Cal beneficiaries are entitled to see an existing provider, even though that provider does not contract with the beneficiary's managed care plan. The goal of COC in these cases is to reduce gaps in care that can result when a beneficiary must suddenly change from their experienced provider who is familiar with the beneficiary's health history to a new plan doctor. These kinds of COC protections may arise both when a beneficiary newly joins a plan, and also in situations where a provider and plan end their relationship.

a. Beneficiaries who move into Medi-Cal managed care from FFS

Whenever a Medi-Cal beneficiary moves from FFS into mandatory Medi-Cal managed care, that beneficiary has a right to continuing seeing an out-of-network provider for up to 12 months.¹⁶ This option is available for provider types who are covered in California's state Medicaid plan, which includes Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals, along with the providers defined in Health and Safety Code Section 1373.96(m)(1)—i.e., a physician, surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant, or chiropractor.¹⁷ COC is not available for providers who provide carved out Medi-Cal services (e.g. Specialty Mental Health Services through a Mental Health Plan), or services not covered by Medi-Cal.¹⁸ The availability of carved out services is not impacted by an enrollee's mandatory enrollment into a managed care health plan.¹⁹

The beneficiary must request continuity from their new managed care plan, which must approve such continued care when: 1) the health plan finds, using FFS utilization data, that the enrollee has seen the provider any time in the last 12 months; 2) the provider is willing to accept the higher of either the plan's contracted rate or the Medi-Cal FFS rate; 3) the provider meets the plan's professional standards

and has no disqualifying quality-of-care issues; and 4) the provider provides the plan with the enrollee's treatment information to the extent permitted by law.²⁰ A quality-of-care issue means the health plan can document concerns with the provider's quality-of-care such that the provider would not be eligible to provide services to any other health plan members.²¹ The plan must notify enrollees whether continuity of care will be provided within 30 days of their request unless an exception applies; plans must provide continuity of care within 15 days of request if the enrollee has upcoming appointments, and within three days of request where there is a risk of harm to the enrollee if treatment is discontinued.²² If the plan is unable to reach an agreement with an enrollee's out-of-network provider, and the enrollee does not select an in-network provider, the plan will assign the enrollee to an in-network provider, instead.²³ Out-of-network providers may be reimbursed for services provided to enrollees up to 30 days before the enrollee requested COC, if the request is ultimately granted.²⁴ Enrollees may appeal COC decisions using the grievance and appeal processes available in Medi-Cal.²⁵

b. Beneficiaries who move to Medi-Cal from Covered California

When a person who was previously enrolled in Covered California moves into Medi-Cal managed care coverage, beneficiary has a right to continuing seeing an out-of-network provider for up to 12 months.²⁶ The beneficiary must request continuity from their new managed care plan, which must approve such continued care when: 1) it determines that the enrollee has seen the provider any time in the last 12 months; 2) the provider is willing to accept the higher of either the plan's contracted rate or the Medi-Cal FFS rate; and 3) the provider meets the plan's professional standards and has no disqualifying quality-of-care issues.²⁷ Plans must process these COC requests within 30 days.²⁸

c. Dual Eligibles who enroll in a combined Medicare and Medi-Cal managed care plan in one of the seven demonstration counties

Starting in April, 2014, DHCS implemented a demonstration project in seven counties that allowed those dually eligible for Medicare and Medi-Cal to enroll in integrated managed Medicare and Medi-Cal managed care plans – called Cal MediConnect plans – if they chose to.²⁹ The seven demonstration counties are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.³⁰ DHCS has worked to include as many Medicare and Medi-Cal providers as possible in Cal MediConnect to ensure a smooth transition. Cal MediConnect plans are also tasked with reaching out to non-participating providers to attempt to include them in their networks.³¹ In addition, Cal MediConnect plans are required to contract with all willing and licensed Multi-Purpose Senior Services Programs (MSSPs) and Community-Based Adult Services (CBAS) programs, which should ensure that enrollees may continue services with existing providers of those services.³² Cal MediConnect plans are also encouraged to contract with licensed nursing facilities that serve the dual eligible population.³³ Dual eligible enrollees in the demonstration counties who choose to enroll in Cal MediConnect may request to continue treatment with their out-of-network Medicare and Medi-Cal providers.³⁴ Enrollees

may request up to six months of continued care with Medicare providers of specialty and primary care.³⁵ Enrollees must request COC in situations where they enroll in a plan's delegated entity (like an Independent Practice Association) and their existing provider is not included in that delegated entity, even if the provider contracts with the prime plan.³⁶ The Cal MediConnect plan must approve such continued care when: 1) the enrollee demonstrates that she or he has seen the PCP at least once or the specialty provider at least twice in during the 12 months prior to the date of the beneficiary's initial enrollment in the Cal MediConnect plan for a non-emergency visit, 2) the provider is willing to accept payment based on the current Medicare or Medi-Cal fee schedule, as applicable and 3) the plan would not exclude the provider from its network due to a documented quality-of-care issue.³⁷ The enrollee may request continued care from Medi-Cal PCPs, specialty care providers, and nursing facilities (but not providers of ancillary services) for up to 12 months.³⁸ If the enrollee requests continuity of care, the plan must determine whether the enrollee has seen a provider at least twice in the past 12 months, by reviewing claims or encounter data from the state, documentation from the provider, or the enrollee's attestation.³⁹ Dual eligibles are also afforded specific continuity protections for prescription medications by Medicare Part D.⁴⁰

Cal MediConnect Plans are not required to provide COC with an out-of-network provider if 1) the services are not covered by Medi-Cal or Medicare, 2) the provider is a provider of DME, transportation, other ancillary services, or carved-out services and/or 3) the provider does not agree to abide by the Cal MediConnect plan's utilization management policies.⁴¹

d. Certain enrollees in Knox-Keene-licensed plans receiving select treatment

Most—but not all—Medi-Cal managed care plans are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the California Knox-Keene Act.⁴² Enrollees in Knox-Keene licensed plans are entitled to additional protections that allow them to continue seeing out-of-network providers, either when their existing providers leave their plan, or when they join a new plan whose network does not include their out-of-network provider.⁴³ To be eligible to continue seeing a provider who is not in the network of an enrollee's new plan, the enrollee must not have had any option to choose a plan that included that provider.⁴⁴ Enrollees are eligible for these additional COC protections in three scenarios:

- **Pregnancy:** A health plan must provide COC for the full duration of a pregnancy. "Pregnancy" is not only limited to the three trimesters of pregnancy, but also the immediate postpartum period.⁴⁵
- **Terminal Illness:** A health plan is required to provide COC for a terminal illness for the duration of the illness. "Terminal illness" is defined as "an incurable or irreversible condition that has a high probability of causing death within one year or less."⁴⁶

- Care of baby or toddler: A health plan must provide up to 12 months of COC for care of a child between birth and age thirty-six months.⁴⁷

III. COC protections allow Medi-Cal beneficiaries to continue receiving services and see existing out-of-network providers.

COC protections may also arise in a hybrid scenario—where an enrollee wishes to finish a particularly course of treatment or care with an existing provider. Unlike the situations described above where a beneficiary may have continued access to a particular provider for any reason, COC in these situations is limited to a specified course of treatment.

a. People moving to Managed Care from FFS after being denied a MER

Note that when Medi-Cal beneficiaries are required to move from FFS into a managed care plan, they may submit a Medical Exemption Request (MER) to remain in managed care for up to 12 months.⁴⁸ Beneficiaries can qualify for a MER if they are receiving treatment for a complex medical condition from a Medi-Cal FFS physician, certified nurse midwife, or licensed midwife who is not contracted with any of their plan choices.⁴⁹ If a beneficiary's MER is denied, it must be treated by the plan as an automatic request for COC to allow the beneficiary to continue treatment with the beneficiary's FFS providers under the Knox-Keene rules or any other applicable COC rules.⁵⁰

b. Persons under 21 Receiving Behavioral Health Treatment Services for Autism Spectrum Disorder

Medi-Cal enrollees under age 21 with a diagnosis of Autism Spectrum Disorder (ASD) who are receiving Behavioral Health Treatment (BHT) services, such as Applied Behavioral Analysis therapy, outside of a Regional Center or the MCP's network are entitled to continue receiving BHT with their existing providers for up to 12 months upon request.⁵¹ In this scenario, the beneficiary must affirmatively request continuity from their new managed care plan, which must approve such continued care when: 1) it determines that the enrollee has seen the provider any time in the last six months or, for beneficiaries who enrolled in a plan after September 15, 2014, the enrollee saw the provider within six months of enrollment; 2) the provider is willing to accept payment based on the current Medi-Cal fee schedule; 3) the provider meets the plan's professional standards and has no disqualifying quality-of-care issues; and 4) the provider is a Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals.⁵² Enrollees may request COC for BHT services retroactively for services that were provided after September 15, 2014, or retroactive to the date of the beneficiary's enrollment into the plan if the enrollment occurred after September 15, 2014.⁵³

The plan must cover BHT provided by the out-of-network provider until it has performed a comprehensive diagnostic evaluation and assessment, and a new treatment plan is submitted by the plan provider.⁵⁴ BHT services must not be discontinued during a COC evaluation.⁵⁵

California will transition BHT services for enrollees under 21 who are receiving BHT services through a Regional Center to their Medi-Cal managed care plans in phases starting in February, 2016.⁵⁶ These enrollees are also entitled to continue receiving BHT from their current providers, even if those providers are not contracted with their Medi-Cal plan. Medi-Cal plans must automatically consider every beneficiary transitioning BHT services from a Regional Center as making a COC request.⁵⁷ Plans must use DHCS-supplied utilization data to identify each enrollee's BHT provider and proactively contact the provider to begin COC even if the enrollee does not affirmatively request COC.⁵⁸ If the plan is unable to identify an enrollee's existing BHT provider, it must contact the enrollee's parent or guardian and make a good faith effort to obtain information that will facilitate COC.⁵⁹ Plans must continue to pay enrollees' existing BHT providers the rates paid by the Regional Centers, or if the plan is unable to determine that rate, at least the minimum FFS rate.⁶⁰ If the plan and provider are not able to reach a COC agreement, the plan must ensure that the enrollee is able to continue receiving BHT services without reduction from one of the plan's in-network providers, until the plan is able to conduct a comprehensive diagnostic evaluation, assessment, and established a treatment plan.⁶¹

c. Persons Receiving Long Term Services and Supports in seven demonstration counties

Starting in April, 2014, DHCS implemented a second demonstration project in the same seven counties described above that required most adults, including dual eligibles, to receive their Medi-Cal services, including long term services and supports, through managed care.⁶² Multipurpose Senior Services Program (MSSP) services, In-Home Support Services (IHSS) and nursing facility services are now only available through managed care plans in those counties.⁶³ Dual eligibles who do not enroll in a Cal MediConnect plan are still required to enroll in a Medi-Cal managed care plan to receive long term services and supports.⁶⁴

Medi-Cal managed care enrollees in the seven demonstration counties will be able to continue MSSP, IHSS, and nursing facility services with their current providers through their MCPs. MCPs are required to contract with all licensed MSSP sites to ensure that enrollees will be able to continue receiving services from their current providers.⁶⁵ Authorization of IHSS will continue to be administered by the county, and enrollees who receive IHSS will retain their right to hire and fire their providers, ensuring continuity of IHSS providers.⁶⁶ For those enrollees who reside in an out-of-network nursing facility, plans are required to provide at least six months of COC before moving enrollees to a new in-network facility.⁶⁷

d. Certain enrollees in Knox-Keene-licensed plans can continue ongoing course of treatment

Enrollees in Knox-Keene licensed plans are entitled to additional protections that allow them to continue a course of treatment with their out-of-network providers, either when their existing providers leave their plan, or when they join a new plan whose network does not include their out-of-network provider.⁶⁸ To be eligible to continue seeing a provider who is not in the network of an enrollee's new plan, the enrollee must not have had any option to choose a plan that included that provider.⁶⁹ Enrollees are eligible for these additional COC protections in three scenarios:

- **Acute Condition:** A health plan must provide COC for the full duration of an acute condition, such as pneumonia. "Acute condition" is defined as "a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration."⁷⁰
- **Serious Chronic Condition:** A health plan is required to continue services for a serious chronic condition, such as diabetes or heart disease, for a maximum of twelve months from the contract termination date or twelve months from the effective date of coverage for a newly covered enrollee. "Serious chronic condition" is defined as "a medical condition due to a disease, illness, or other medical problem or medical disorder 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."⁷¹ Unless twelve months have passed, the health plan must ensure the coverage of services for "a period of time necessary" to complete treatment and arrange for a safe transfer of the enrollee to another plan or nonparticipating provider.⁷²
- **Scheduled or Recommended Procedure:** A health plan must provide COC when a procedure, such as surgery, 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.⁷³

Conclusion

As Medi-Cal populations transition into mandatory managed care for a variety of reasons, COC is critical to ensure that these enrollees do not suffer substantial disruptions in care. Since the responsibility of requesting COC lies with the enrollee, DHCS must ensure that enrollees have sufficient information about their COC rights to make them effective. Those who are providing direct services to transition populations should also inform these populations about their COC rights and assisting them in contacting their respective health plans.

ENDNOTES

¹ CARRIE GRAHAM ET AL., CAL. HEALTHCARE FOUND., THE EXPERIENCES OF SENIORS AND PERSONS WITH DISABILITIES WHO TRANSITIONED TO MEDI-CAL MANAGED CARE 17 (2013), <http://www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20%20Sact003282013SPDsTransitionMediCalManagedCare.pdf>.

² CAL. WELF. & INST. CODE § 14185(b).

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.* § 14182(b)(22).

⁷ CAL. HEALTH & HUMAN SERVS. AGENCY, DEPT. HEALTH CARE SERVS., EXTENDED CONTINUITY OF CARE FOR SENIORS AND PERSONS WITH DISABILITIES FREQUENTLY ASKED QUESTIONS 5 (2011),

http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ContinuityCare/SPD%20FAQ_ENG_1011.pdf.

⁸ *Id.*

⁹ *Id.*

¹⁰ Letter from Sarah Brooks, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans 5 (Aug. 25, 2015) [hereinafter APL 15-019],

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-019.pdf>.

¹¹ *Id.*

¹² *Id.* Such transitions will typically arise either due to the Covered California yearly coverage renewal determination or changes in a beneficiary's eligibility circumstances that may occur at any time throughout the year. *See id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *See id.* at 1 ("All MCP beneficiaries with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.").

¹⁷ *Id.* at 2.

¹⁸ *Id.*; *see also* Letter from Jane Ogle, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans 2 (Sep. 21, 2011) [hereinafter APL 11-019] ("Therefore, out-of-network FFS providers can include physicians, surgeons and specialists, but do not include providers of durable medical equipment, transportation, other ancillary services, or carved out services."),

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-019.pdf>; *see also* CAL. HEALTH & HUMAN SERVS. AGENCY, *supra* note 7.

¹⁹ *See* APL 11-019 at 2.

²⁰ *See* CAL. WELF. & INST. CODE § 14182(b)(13); *see also* APL 15-019 at 2.

²¹ APL 15-019 at 2.

²² *Id.* at 2-3.

²³ *Id.* at 4.

²⁴ *Id.* at 3.

²⁵ *Id.* at 4. For a detailed explanation of the grievance and appeals processes available to Medi-Cal managed care enrollees, *see* ABBI COURSOLE, NAT'L HEALTH LAW PROG., INTERNAL GRIEVANCES AND EXTERNAL REVIEW FOR SERVICE DENIALS IN MEDI-CAL MANAGED CARE PLANS (2015), <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/CA-MC-4>.

²⁶ *See* APL 15-019 at 5-6.

²⁷ *See id.* (incorporating by reference Letter from Margaret Tatar, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans (Dec. 24, 2013) [hereinafter APL 13-023],

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-023.pdf>.

²⁸ *See* APL 13-023 at 3.

²⁹ See generally MEMORANDUM OF UNDERSTANDING (MOU) BETWEEN THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) AND THE STATE OF CALIFORNIA REGARDING A FEDERAL-STATE PARTNERSHIP TO TEST A CAPITATED FINANCIAL ALIGNMENT MODEL FOR MEDICARE-MEDICAID ENROLLEE: CALIFORNIA DEMONSTRATION TO INTEGRATE CARE FOR DUAL ELIGIBLE BENEFICIARIES (2013) [hereinafter MOU], <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>.

³⁰ *Id.* § III(C)(1) (page 8).

³¹ See, e.g., *id.* § III(E)(2) (page 14).

³² *Id.* at Appx. 7 §§ IV(c)(iv), (v) (page 85).

³³ *Id.* at Appx. 7 § IV(c)(iii) (page 85).

³⁴ CAL. WELF. & INST. CODE §§ 14132.275(l)(2)(A) (Medicare), 14182.17(d)(5)(G) (Medi-Cal).

³⁵ *Id.* § 14132.275(l)(2)(A).

³⁶ Letter from Sarah Brooks, Chief, Medi-Cal Managed Care Quality and Monitoring Division, Cal. Dept. Health Care Servs., to All Cal MediConnect Medicare-Medicaid Plans (Mar. 27, 2015) [hereinafter DPL 15-003], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-003.pdf>.

³⁷ *Id.*; see also MOU at Appx. 7 § V(b)(ii)(1) (page 95).

³⁸ CAL. WELF. & INST. CODE § 14182.17(d)(5)(G); MOU at Appx. 7 § V(b)(ii)(2) (page 95).

³⁹ MOU at Appx. 7 §§ V(b)(ii)(1)(a), V(b)(ii)(2)(a) (page 95).

⁴⁰ See DPL 15-003 at 2; CENTERS FOR MEDICAID & MEDICARE SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, Ch. 6 at 30.4.3 (2010), available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf. Medicare generally provides that if a beneficiary presents a newly written non-formulary prescription at the pharmacy during the COC period, and the pharmacy cannot determine at the point of service whether the prescription is for ongoing drug therapy, the pharmacy must fill the prescription and the plan must cover the fill. See *id.*

⁴¹ *Id.*

⁴² See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

⁴³ *Id.* § 1373.96(b); see also CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR TWO-PLAN COUNTIES, Ex. A, Att. 9 § 16.B (2014) (requiring plans in two-plan counties to comply with Health & Safety Code § 1373.96), <http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GEOGRAPHIC MANAGED CARE, Ex. A, Att. 9 § 16.B (2014) (requiring plans in GMC counties to comply with Health & Safety Code § 1373.96), <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>. Most COHS plans are not Knox-Keene licensed, and unlicensed plans are not subject to Knox-Keene COC requirements by contract. Instead they are simply exhorted to describe their activities "designed to assure the provision of . . . coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management." CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COUNTY ORGANIZED HEALTH SYSTEMS, Ex. A, Att. 4 § 7.I (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.

⁴⁴ CAL. HEALTH & SAFETY CODE § 1373.96(j).

⁴⁵ *Id.* § 1373.96(c)(3).

⁴⁶ *Id.* § 1373.96(c)(4).

⁴⁷ *Id.* § 1373.96(c)(5).

⁴⁸ See CAL. CODE REGS., tit. 22, §§ 53887, 53923.5; Letter from Sarah Brooks, Chief, Medi-Cal Managed Care Quality and Monitoring Division, Cal. Dept. Health Care Servs., to All Non-County Organized Health System Medi-Cal Managed Care Health Plans (Jan. 14, 2015) [hereinafter APL 15-001], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-001.pdf>.

⁴⁹ See CAL. CODE REGS., tit. 22, §§ 53887, 53923.5; APL 15-001 at 2.

⁵⁰ APL 15-001 at 1-2; APL 15-019 at 8.

⁵¹ APL 15-019 at 6; see also Letter from Nathan Nau, Chief, Medi-Cal Managed Care Division, Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans 3-4 (Dec. 3, 2015) [hereinafter APL 15-025],

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-025.pdf>;

Letter from Sarah Brooks, Chief, Medi-Cal Managed Care Division, Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans (Sep. 15, 2014) [hereinafter APL 14-011],

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-011.pdf>.

⁵² See APL 15-019 at 6; APL 14-011 at 3.

⁵³ APL 15-019 at 6.

⁵⁴ *Id.*; see also APL 14-011 at 3.

⁵⁵ APL 14-011 at 3.

⁵⁶ APL 15-025 at 2; see also CAL. HEALTH & HUM. SERVS. AGENCY, BEHAVIORAL HEALTH TREATMENT TRANSITION PLAN (2015), http://www.dhcs.ca.gov/services/medi-cal/Documents/BHT_Transition_Plan_Final.pdf.

⁵⁷ CAL. HEALTH & HUM. SERVS. AGENCY, *supra* note 52 at 12; see also APL 15-019 at 7.

⁵⁸ APL 15-019 at 7.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² CAL. WELF. & INST. CODE § 14186.2.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.* §§ 14186.3(b)(2)(B), (3)(B).

⁶⁶ *Id.* §§ 14186(b)(3), (b)(5)(E), (b)(6)(A); *id.* §§ 14186.35(a)(9), (b); see also CAL. DEPT. HEALTH CARE SERVS., IN-HOME SUPPORTIVE SERVICES AND THE COORDINATED CARE INITIATIVE FREQUENTLY ASKED QUESTIONS (2012), available at <http://www.calduals.org/wp-content/uploads/2012/09/FAQIHSS090512.pdf>.

⁶⁷ CAL. WELF. & INST. CODE § 14186.3(c)(3).

⁶⁸ CAL. HEALTH & SAFETY CODE § 1373.96(b); see also sources cited at *supra* note 43.

⁶⁹ CAL. HEALTH & SAFETY CODE § 1373.96(j).

⁷⁰ *Id.* § 1373.96(c)(1).

⁷¹ *Id.* § 1373.96(c)(2).

⁷² *Id.*

⁷³ *Id.* § 1373.96(c)(6).