Continuity of Care Requirements in the Managed Medical Assistance Program

Overview

The Statewide Medicaid Managed Care (SMMC) program consists of two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The MMA program provides medical services to infants, children and adults on Medicaid, while the LTC program provides home and community-based and nursing facility-based long-term care services to elders and adults with disabilities on Medicaid who meet nursing home level of care. A key goal of the SMMC program is ensuring that recipients experience continuity of care, meaning that recipients experience no break in services or care coordination while transitioning from one service delivery system to another, one managed care plan to another, or from one service provider to another. This document provides an overview of the continuity of care requirements for the MMA program and the expectations established by contract for managed care plans and providers. While continuity of care is a key goal during the implementation of the MMA program, this concept is a standard requirement in the core managed care contracts and will continue to apply after the initial MMA implementation.

Contract Language

Attachment II, Section VII. H., Continuity of Care in Enrollment

The Managed Care Plan shall be responsible for coordination of care for new enrollees transitioning into the Managed Care Plan. In the event a new enrollee is receiving prior authorized ongoing course of treatment with any provider, the Managed Care Plan shall be responsible for the costs of continuation of such course of treatment, without any form of authorization and without regard to whether such services are being provided by participating or non-participating providers. The Managed Care Plan shall reimburse non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of thirty (30) days, unless said provider agrees to an alternative rate.

LTC Managed Care Plans shall provide continuation of LTC services until the enrollee receives an assessment, a plan of care is developed and services are arranged and authorized as required to address the long-term care needs of the enrollee, which shall be no more than sixty (60) days after the effective date of enrollment.

MMA Managed Care Plans shall provide continuation of MMA services until the enrollee’s PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the enrollee’s treatment plan, which shall be no more than sixty (60) days after the effective date of enrollment.

Comprehensive LTC Managed Care Plans shall provide continuation of LTC services for enrollees with LTC benefits and MMA services for enrollees with MMA benefits as indicated above.

Attachment II, Exhibit II-A, Section V.D.3., New Enrollee Procedures

The Managed Care Plan shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee’s enrollment to offer to schedule the enrollee’s initial
appointment with the PCP Pursuant to s. 409.973(4)(a), F.S., for enrollees who enroll before December 31, 2015, the appointment should be scheduled within six (6) months after enrollment in the Managed Care Plan. For enrollees who enroll after December 31, 2015, the appointment should be scheduled within thirty (30) days of enrollment. This appointment is to obtain an initial health assessment including a CHCUP screening, if applicable. For this subsection “contact” is defined as mailing a notice to or telephoning an enrollee at the most recent address or telephone number available.

Within thirty (30) days of enrollment, the Managed Care Plan shall ask the enrollee to authorize release of the medical/case and behavioral health clinical records to the new PCP or other appropriate provider and shall assist by requesting those records from the enrollee’s previous provider(s).

The Managed Care Plan shall honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee’s PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee’s treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided that the services were prearranged prior to enrollment with the Managed Care Plan:

(1) Prior existing orders;

(2) Provider appointments, e.g., dental appointments, surgeries, etc.;

(3) Prescriptions (including prescriptions at non-participating pharmacies); and

(4) Behavioral health services.

The Managed Care Plan shall not delay service authorization if written documentation is not available in a timely manner. However, the Managed Care Plan is not required to approve claims for which it has received no written documentation.

Managed Medical Assistance (MMA) Plans’ Responsibilities

Continuity of Care Period

- The continuity of care period is defined as: a period of 60 days after the effective date of enrollment, or until the enrollee's primary care provider or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first. This period is in effect during both the initial implementation of the MMA program and for any new enrollments in a plan after implementation.

- For the first year of operation, MMA plans are required to use the Medicaid Preferred Drug List in order to ensure an effective transition of enrollees during implementation.
Coordination of Care

• MMA plans are responsible for the coordination of care for new enrollees transitioning into the plan.

• During the continuity of care period MMA plans are required to educate new enrollees on how to access their prescription drug benefits through their MMA plan provider network.

Authorization Requirements

• MMA plans are required to cover any ongoing course of treatment (services that were previously authorized or prescheduled prior to the enrollee’s enrollment in the plan) with the recipient’s provider during the continuity of care period, even if that provider is not enrolled in the plan’s network.

  o The following services may extend beyond the continuity of care period, and the MMA plans are responsible for continuing the entire course of treatment with the recipient’s current provider (as described in the service-specific continuity of care period scenarios below):
    ▪ Prenatal and postpartum care
    ▪ Transplant services (through the first year post-transplant)
    ▪ Radiation and/or chemotherapy services (for the current round of treatment).

• The MMA plan must honor any written documentation of prior authorization of ongoing covered services during the continuity of care period.

  o If the services were arranged prior to enrollment with the plan, written documentation includes the following:
    ▪ Prior existing orders;
    ▪ Provider appointments, e.g., doctor or dental appointments, surgeries, etc.;
    ▪ Prescriptions (including prescriptions at non-participating pharmacies);
    ▪ Prior authorizations; and
    ▪ Treatment plan/plan of care.

• MMA plans cannot require additional authorization for any ongoing course of treatment. If a provider contacts the plan to obtain prior authorization during the continuity of care period, the MMA plan cannot delay service authorization if written documentation is not available in a timely manner. The plan must approve the service. However, the MMA plan may require the submission of written documents (as described above) before paying the claim.

Payment

• MMA plans are responsible for the costs of continuing any ongoing course of treatment without regard to whether such services are being provided by participating or non-participating providers. (Participating providers are those that have a contract with the plan and are enrolled in the plan’s provider network.)

• The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30
days, unless the provider agrees to an alternative rate (See additional information regarding pharmacy reimbursements below.)

- The Children’s Medical Services Network plan will pay providers, including non-participating providers, at the current Medicaid fee-for-service rate during and after the continuity of care period.

Other Pharmacy Continuity of Care Requirements

- For the first 60 days after implementation in a region, MMA plans or Pharmacy Benefit Managers (PBMs) are required to operate open pharmacy networks so that enrollees may continue to receive their prescriptions through their current pharmacy provider until their prescriptions are transferred to a participating pharmacy. MMA plans and/or PBMs must reimburse non-participating pharmacy providers at established open network reimbursement rates.

- For new plan enrollees (i.e., enrolled after the implementation of MMA), MMA plans must meet continuity of care requirements for prescription drug benefits, but are not required to do so through an open pharmacy network.

**Service Provider Responsibilities**

- Service providers should continue providing services to MMA enrollees during the continuity of care period for any services that were previously authorized or prescheduled prior to the MMA implementation, regardless of whether the provider is participating in the plan’s network.

- Providers should notify the enrollee’s MMA plan as soon as possible of any prior authorized ongoing course of treatment or prescheduled appointments.

- Non-participating providers will continue to be paid at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning to the MMA plan for a minimum of 30 days, unless the provider agrees to an alternative rate. (See additional information above regarding pharmacy reimbursements.) Providers will need to follow the process established by the managed care plans for getting these claims paid appropriately.

- Providers may be required to submit written documentation (as described above) of any prior authorized ongoing care, along with their claim(s) in order to receive payment from the plan.

**Continuity of Care Scenarios – General**

1. Do the MMA plans have to continue to provide services if an enrollee has already started treatment with a provider (e.g., physician, dentist, etc.) who does not participate in their network at the time of enrollment and the treatment is not completed?

   *Yes. The MMA plan must continue to pay for ongoing treatment during the continuity of care period. However, after the continuity of care period, if the provider is still not a part of the plan’s network, the enrollee may have to change providers in order for the plan to continue to pay for services. If the enrollee must change to a new provider,*
the plan must ensure that any needed medical records information is transferred and that services continue uninterrupted until treatment resumes with the new provider.

2. Do the MMA plans have to cover services that were prescheduled prior the Medicaid recipient enrolling in their plan?

   If the appointment occurs during the continuity of care period, the plan should pay for services without requiring any additional authorization. If the appointment was scheduled to occur after the continuity of care period ends the MMA plan should ensure that the enrollee’s PCP or behavioral health provider (whichever is applicable) reviews the enrollee’s treatment plan no more than 60 days after enrollment in the plan to ensure that any needed services continue to be authorized.

3. Do the managed care plans have to honor prior authorizations that were issued (either through the Agency or one of its contracted prior authorization vendors or a managed care plan) prior to the recipient’s enrollment in the MMA plan? Examples include:

   - Home health
   - Dental
   - Behavioral Health
   - Durable medical equipment (rent-to-purchase equipment, ongoing rentals, etc.)
   - Prescribed drugs

   Yes, during the continuity of care period, the MMA plan must continue to pay for any prior approved services, regardless of whether the provider is in the plan’s network. During this timeframe, the plan should be working with the enrollee and his or her treating provider to obtain any information needed to continue authorization after the continuity of care period (if the service is still medically necessary). After the continuity of care period, if the provider is not a part of the plan’s network, the enrollee may be required to switch to a participating provider.

**Continuity of Care Scenarios – Service Specific**

**Pregnancy Care**

If a pregnant Medicaid recipient enrolls in an MMA plan and her OB/GYN is not a part of the plan’s network, does the plan have to continue to pay for the services?

Yes. The MMA plan must continue to pay for services provided by her current provider for the entire course of her pregnancy including the completion of her postpartum care (six weeks after birth), regardless of whether the provider is in the plan’s network. The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate.

**Oncology (Radiation and/or Chemotherapy)**

Will the MMA plans be required to continue to cover radiation and/or chemotherapy services for a new enrollee who is being treated by an out-of-network provider?
Yes. The MMA plan must continue to pay for services provided by the current provider for the duration of the current round of treatment, regardless of whether the provider is in the plan’s network. Once the current round of treatment is completed, the recipient may be transitioned to a network provider. The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate.

Transplant Services

Will the MMA plans be required to continue to cover transplant-related services for a new enrollee who is being treated by out-of-network provider?

Yes. The MMA plan must continue to pay for services provided by the current provider for one year post-transplant, regardless of whether the provider is in the plan’s network. The MMA plan must pay non-participating providers at the rate they received for services rendered to the enrollee immediately prior to the enrollee transitioning for a minimum of 30 days, unless the provider agrees to an alternative rate.

Orthodontics

Will the MMA plan be required to continue to cover orthodontic treatment that has already begun (regardless of whether it was previously approved through the fee-for-service system or through another managed care plan)?

Yes. The MMA plan must continue to pay for ongoing treatment during the continuity of care period. After the continuity of care period, the plan must ensure that services continue uninterrupted. If the enrollee’s current provider is still not in the plan’s network, the plan must:

- Transfer the enrollee to a participating provider, ensuring that care is not interrupted and any needed medical records information is transferred to the new provider; or
- Continue to authorize and reimburse for services with the non-participating provider until treatment can continue with a participating provider or until the conclusion of care.

Pharmacy Services:

1. If a prescription refill request is denied during the continuity of care period (e.g., for “PA Required”, “Non-matched Prescriber ID”, “Non-Preferred Drug – Prior Authorization Required”, or “Therapeutic Duplication”), how will this issue be resolved by the MMA plan so that the enrollee receives their medication?

The MMA plan should cover the refill prescription. The plan should work with its Pharmacy Benefit Manager to prevent these conflicts from arising during the continuity of care period and/or ensure protocols are in place for educating pharmacies on how to resolve these issues in real-time (e.g., the pharmacy receives a message from the MMA plan with a phone number and/or directive on how to obtain an immediate override).
2. Can a pharmacy refill a prescription for a controlled substance (C-II drug) during the continuity of care period?

No. The pharmacy will not be able to refill or transfer this prescription, per Florida Statutes. All laws related to pharmacy services remain in effect, and MMA plans must operate in compliance with any such laws. The MMA plan should assist the recipient in scheduling an appointment with their provider to obtain a new prescription.