DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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**MEDICARE-MEDICAID COORDINATION OFFICE**

**DATE:** August 19, 2021

**TO:** Medicare-Medicaid Plans

**FROM:** Lindsay P. Barnette
Director, Models, Demonstrations, and Analysis Group

**SUBJECT:** California MMPs: Release of Revised Chapter 1 of the Member Handbook/Evidence of Coverage for Contract Year 2022

Attached to this memorandum is a revised Contract Year 2022 Chapter 1 of the Member Handbook/Evidence of Coverage. This chapter should replace the Chapter 1 previously issued on June 10, 2021. California MMPs should ensure that this revised Chapter 1 is included in the Contract Year 2022 Member Handbook/Evidence of Coverage distributed to members and posted to the plans' websites in accordance with the California MMP Marketing Guidance.[1]

The revised Chapter 1 contains additional language in Section F.[2] The added language is underlined in the example below. No other changes to the Member Handbook have been made.

> **If <plan name> is new for you**, you can keep using the doctors you use now *for a certain amount of time.* You can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

[1] For timing requirements relating to CY 2022 materials, refer to the most current California MMP Marketing Guidance available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

[2] The purpose of this revision is to ensure that California MMPs' beneficiary communications include all of the information contained in the California Duals Plan Letter 16-002, available at: www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanLetters.aspx.

- We can establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say existing relationship, it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in <plan name>

    - We will determine an existing relationship by reviewing your health information available to us or information you give us.
    - We have 30 days to respond to your request. You may also ask us to make a faster decision and we must respond in 15 days.
    - We have 3 calendar days to respond to your request if there is a risk you will be harmed due to an interruption in your care.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

We will post the attached revised Chapter 1 of the Member Handbook to the Medicare-Medicaid Coordination Office webpage at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources, grouped alphabetically by state under the "State-Specific Information" heading.

For any questions about the contents of this memorandum, please contact your Account Manager or the Medicare-Medicaid Coordination Office at MMCOCapsModel@cms.hhs.gov.