Disability Rights California

California's Protection & Advocacy System

Medi-Cal Managed Care: "Continuity of Care"

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If you have regular Medi-Cal[1] and you are now being told that you must enroll in a Medi-Cal managed care plan (MCP),[2] you may be able to continue to see your regular Medi-Cal health care provider. This is what is meant by "continuity of care."

1. Does this apply to any of my current health care providers?

It depends. Under Medi-Cal rules, only if your health care provider:

- Is a regular Medi-Cal physician or midwife who you have seen in the past 12 months; and
- Agrees to work with the MCP and accept the MCP's payment or the regular Medi-Cal rate whichever is higher; and
- Has no disqualifying quality of care issues.

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[1] Regular Medi-Cal is also known as Fee-For-Service (FFS) Medi-Cal. When you have regular Medi-Cal for all your medical services, you are not in a MCP. (Return To Main Document)

[2] MCPs are health plans that assume the risk of care directly through their own network of providers or as the umbrella for medical groups with their own networks or both. 42 CFR § 438.2 Members choose a primary care physician (PCP) who they generally must go to first. One exception: for family planning and related services the member may go to any Medi-Cal provider in or out of the network. 42 USC § 1396d(a)(4)(c); APL 16-003 (12-23-2016).The PCP can treat or refer members to a specialist within the network and sometimes outside of the network. (Return To Main Document)

Welf. & Inst. Code § 14182(b)(13). In addition to continuity of care protections under Medi-Cal, State law administered by the Department of Managed Health Care (DMHC) also provides continuity of care protections[3] for members of MCPs it licenses including Medi-Cal members. It does not license the MCPs in County Organized Health Systems (COHS) except for the COHS San Mateo Health Plan.[4] DMHC licenses all other MCP's serving Medi-Cal beneficiaries. The DMHC administered continuity of care state law provides members access to all licensed providers;[5] Medi-Cal continuity of care access protections apply to physicians and midwives but does not extend to related ancillary services like laboratory and imaging services such as ultra sounds, mammograms, CT scans and PET scans. That means COHS counties (except for San Mateo) can deny a continuity of care physician the benefit of comparing current test results with earlier results from the same provider.[6]

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[3] State law continuity of care protections are set out at Health & Safety Code § 1373.96 which is part of the Knox-Keene Health Care Service Plan Act. Knox-Keene covers most commercial managed care plans. (Return To Main Document)

[4] The COHS counties and plans not subject to Knox-Keene continuity of care protections: CalOptima (Orange); Central California Alliance for Health (Merced, Monterey, Santa Cruz); CenCal Health (San Luis Obispo, Santa Barbara); Partnership Health Plan (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo); Gold Coast Health Plan (Ventura). (Return To Main Document)

[5] Provider defined in Health & Safety Code 1345(i) as "any professional person, plan, health facility, or other person or institution licensed by the State to deliver or furnish health care services." Health & Safety Code § 1373.96(m)(3). (Return To Main Document)

[6] DHCS December 3, 2014, responses to Stakeholder Advisory Committee follow up questions from September 11, 2014, Committee meeting: Relying on Dual Plan Letter 14-004, ancillary services, which includes lab work and imaging, not eligible for continuity of care. http://www.dhcs.ca.gov/Documents/DHCS_SAC_9-11_Followup_Responses.pdf at page 6. (Return To Main Document)

2. What do I need to do so that I can continue to see my health care provider?

You need to contact your MCP and let it know that this is what you want to do. Give your MCP the contact information for your health care provider so that it may contact the provider. It is important to let your health care provider and the provider's front office know you have asked to continue seeing the provider as is your right under continuity of care protections. Tell the provider that the MCP will be contacting the provider, and that the pay rate will be the same as regular Medi-Cal or the MCP rate if higher. Tell the front office person that you will be checking back to see if the provider has heard from the MCP so that you can follow up with the MCP directly if the provider has not heard from the MCP. Right before you are switched over to managed care, make certain you have refilled your prescriptions.

3. How long will it take for me to hear from my MCP?

Your MCP has up to 30 calendar days from the time it gets your request to tell you if you can continue to see your health care provider. Your request can be by telephone.[7] If your need to see your continuity of care provider is urgent or you have a pending appointment, let your MCP know this. The MCP is responsible for making sure that you get medically necessary services while you wait for a decision. Write down the name and telephone number of everyone you talk with. Write down what you talked about.

4. What if I change to a different MCP before the continuity of care period is over?

When you switch to a new MCP plan, "the 12-month continuity of care period may start over one time. But if you switch again, no new 12-month period.[8]

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[7] DHCS APL 15-019 at p. 2: "must accept requests for continuity of care over the telephone … an must not require the requester to complete and submit a paper or computer form…." (Return To Main Document)

[8] APL 15-019, page 2; DPL 15-003, p. 3; An earlier 2014 DHCS FAQ and Q&A 4 indicates only one 12-month period. (Return To Main Document)

5. Will the doctor I saw in regular Medi-Cal be paid for services provided after I was transferred to the MCP but before I asked the MCP to continue seeing her? What about if I see that doctor after I asked but before I get the O.K. from the MCP?

The answer is yes to services provided before you ask the MCP to qualify your regular Medi-Cal doctor as your continuity of care doctor and yes to services provided before you get the MCP's O.K.[9] There can be no payment for services until the doctor and any other providers are signed up as your continuity of care doctor. Continuity of care is a right and can be denied only if there are quality of care issues that would prevent the doctor from serving other MCP members.[10] You can have multiple continuity of care providers.

6. What about continuity of care if I am required to transition into Medi-Cal managed care from a Covered California plan?

Your continuity of care rights are the same as your rights transitioning from regular Medi-Cal into managed care.[11]

7. What if the specialist I want to continue seeing is in my MCP but not in the network of my primary care physician's medical group or has signed up with the health plan for only a certain number of slots and those are filled up?

Your continuity of care rights apply because for you that specialist is out of network. For long-term access to a particular specialist, find out if there is another primary care physician you can move to so that the specialist will then become "in network." If you are in a two-plan county where there is a

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[9] DHCS APL No. 15-019, pages 2-3 under heading "MCP Processes" (Return To Main Document)

[10] DHCS APL No. 15-019, p. 2, 3. (Return To Main Document)

[11] DHCS APL 15-019 at p. 5. (Return To Main Document)

local plan in addition to a commercial plan,[12] ask if you can receive services directly from the local initiative plan rather than through a medical group if that means you will have in network access to your specialist.

8. What are my continuity of care rights if I am transitioning to a Medi-Cal MCP after aging out from my parents' health plan?

You do not have any *Medi-Cal* continuity of care rights but may have rights under the Knox-Keene Act. In addition, under State law protections, you may continue to be eligible for benefits under your parents' health plan past age 26 (or whatever becomes the limiting age) based on continued disability.[13]

9. What are my continuity of care rights if I change from one MCP to another and I want to continue services with the provider from the first MCP?

Continuity of Care rules apply so that you can continue to see the provider from the first MCP.

10. What if I am currently receiving services authorized under regular Medi-Cal when I am switched to a MCP?

The MCP is required to honor any current approved treatment authorization request for up to 60 days or until there is a new assessment.[14] In addition, Medi-Cal regulations provide that either the continuity of care provider or the new MCP provider may request authorization through the MCP for

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[12] The two-plan counties with a local initiative are Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare. (Return to Main Document)

[13] Under Knox-Keene, Health & Safety Code § 1373(d); under CalPERS, https://www.calpers.ca.gov/docs/forms-publications/state-health-guide.pdf; Ins. Code §§ 10277 and 10278. (Return to Main Document)

[14] DHCS APL 15-019 at p. 6. (Return to Main Document)

continuation of services previously authorized under regular Medi-Cal. This is called a reauthorization request. If the MCP denies or reduces the reauthorization request, timely appeal qualifies the Medi-Cal beneficiary to continuation of the service as aid paid pending a fair hearing.[15]

11. How do I get my current medications covered under continuity of care?

State law helps you to continue getting prescribed drugs. Welf. & Inst. Code Section 14185:

(1) No problem with continued authorization of drugs or a new prescription for drugs on the MCP formulary.[16]

(2) If prescribed a brand name drug that has no generics[17] and "which is part of a prescribed therapy in effect ... immediately prior to …enrollment," will continue until no longer prescribed by continuity of care or plan physician.[18]

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[15] DHCS regulations at 22 CCR §§ 51003(c)(1) (requesting reauthorization of previously approved Treatment Authorization Request or TAR), 51014.1(e) (denial or reduction of reauthorization request treated as a termination of services), 51014.2(a) (when entitled to a continued medical assistance pending a hearing), 51014.2(d) (authorization of continued medical assistance pending hearing) (Return to Main Document)

[16] Drugs not on the formulary and requiring prior authorization include those where the manufacturer has not agreed to rebates to reduce the cost, drugs that are expensive, drugs that present risks that need to be evaluated by a prior authorization or authorized as part as a step therapy program, and drugs where there are concerns about effectiveness or safety. (Return To Main Document)

[17] This is the definition of a single source drug. (Return To Main Document)

[18] Welf. & Inst Code § 14185(b). *See, also,* DHCS 2014 "Continuity of Care FAQ" Q&A 15 #2. (Return to Main Document)

(3) For prescriptions involving name-brand drugs with generics[19] not on the MCP's formulary, it is DHCS' position that prior authorization with medical justification must be provided.[20]

When a prescription requires prior authorization, MCP determination must be made within 24 hours or one business day; when the pharmacists determines there is an emergency need, 72 hours worth of medication must be given to the Medi-Cal beneficiary.[21]

In addition, under the Medi-Cal regulations referenced in Q&A 10 above, a denial of a reauthorization request for continuation of drugs previously authorized by Medi-Cal triggers a right to continued access to the medications pending a fair hearing decision if the denial is timely appealed.

12. What if my Medical Exemption Request (MER) to remain in regular Medi-Cal is denied and now I am in managed care. What about my continuity of care rights?

The Medi-Cal Managed Care Division (MMCD) of DHCS in All-Plan Letter 15-001 (Jan. 13, 2015) directs the MCP to treat the MER as also a continuity of care request and to contact you. However, we recommend that you not wait for the MCP to contact you but that you contact the MCP as explained above.

13. If my MCP says "yes" – how long can I continue to see my healthcare provider?

Generally for up to 12 months. This is called the "extended continuity of care period." It is possible for your MCP to agree to allow you to go to your health care provider for more than 12 months. You will need to ask your MCP. Ask your primary care physician to support you in your request. See Q&A 14 below.

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[19] This is the definition of a "multiple source drug." (Return To Main Document)

[20] DHCS 2014 "Continuity of Care FAQ" #3. (Return To Main Document)

[21] Welf. & Inst. Code § 14185(a); 42 1396r-8(d)(5). (Return To Main Document)

14. What if my MCP says "no" to my continuity of care request or ignores my request?

File a grievance

You can file a grievance with your MCP at any time. Ask your MCP how to do this. If your problem is urgent (a serious threat to your health), your MCP must give you a decision within 3 days. If your problem is not urgent, your MCP has 30 days to give you a decision.

Ask the Department of Managed Health Care for help.

Under most MCP plans, you can file a complaint with the Department of Managed Health Care (DMHC) at (888) 466-2219 or TDD: (877) 688-9891 if you are unhappy with your MCP's decision or if you have not received a decision within 3 days for an urgent problem or 15 or 30 days for a non-urgent problem. Tell the DMHC when you filed a grievance request with the MCP because filing a grievance or complaint with the MCP is required before you can file a complaint with the DMHC. The above telephone number is where you call if you have any questions about your rights protected by DMHC. Also see: *https://www.dmhc.ca.gov/FileaComplaint.aspx#.WBJ8JY3FA3E*

However, going to DMHC is not an option in COHS counties except for the County of San Mateo because COHS MCPs have not elected and have not been required to be licensed by DMHC

Other options

You may also want to look at other options such as requesting a Medical Exemption which you can do before being enrolled in managed care or within the first 90 days of enrollment. For more information on Medical Exemption Requests (MERs) see our publication found at https://www.disabilityrightsca.org/publications/medi-cal-managed-care-health-plans-what-are-they-what-do-i-need-to-know-about-them or call us

at 1 800 776-5746 to send you this publication. A Medical Exemption Request is not an option in COHS counties. [22]

Another option for those not in a COHS county is to disenroll from Medi-Cal Managed Care if you are in a category authorized to do so such as being dual eligible (that is, eligible for both Medi-Cal and Medicare) or having other health insurance or a Medi-Cal share of cost. With the termination of the IHSS Medi-Cal Personal Care services part of the CCI program expected as of July 1, 2017, dual eligibles will not be required to enroll in managed care in CCI counties as a condition for receiving Medi-Cal Personal Care services (IHSS). However, in the CCI counties but not in other counties. Medi-Cal beneficiaries including dual eligibles in long term care (i.e. in a nursing facility) would be required to enroll in Medi-Cal Managed Care. In all counties enrollment in Medi-Cal managed care is required in order to receive Community-Based Adult Services (CBAS), which used to be called Adult Day Health Care. If you are receiving services through a home-and-community based waiver administered by

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[22] The 22 counties where managed care is delivered through a County Operated Health System (COHS) plan are CalOptima (Orange); CenCal Heralth (San Luis Obispo, Santa Barbara); Central California Alliance for Health (Merced, Monterey, Santa Cruz); Gold Coast Health Plan (Ventura); Partnership Health Plan (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo); San Mateo Health Plan (San Mateo). (Return To Main Document)

DHCS' In-Home Operations, your enrollment in managed care is voluntary even if the Medi-Cal beneficiary needs Medi-Cal Personal Care.[23]

For more information go to the DHCS Medi-Cal Managed Care website http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx And then click on "aid code chart" under "Resources and Information If you are dual eligible, you would be able to continue seeing your Medicare paid doctor through Medicare even if in Medi-Cal Managed Care.

15. What if the MCP denies my request to continue seeing my continuity of care provider after the continuity of care period has run out?

To continue seeing an out-of-network provider beyond the continuity of care period usually requires showing that there is no in-network provider with the experience and expertise to address your health care needs.

Federal managed care regulations give a right to disenroll from managed care for cause at any time. 42 C.F.R. § 438.56. This right to disenroll applies to all Medi-Cal Managed Care plans including COHS MCPs. "Cause" includes "lack of access to providers experienced in dealing with the enrollee's care needs" which may apply to persons with very complex

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[23] If you were a dual eligible in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo or Santa Clara Counties, the counties participating in the California Coordinated Care Initiative (CCI), there was an argument that the requirement to enroll in Medi-Cal managed care as the only way to access personal care services (IHSS) authorized by the county also meant enrollment in managed care was no longer voluntary but mandatory for Medi-Cal beneficiaries receiving services under the NF/AH waiver who also needed county authorized IHSS/Medi-Cal personal care services. However the IHSS part of the CCI program is being terminated as of July 1, 2017. To the contrary of the interpretation that enrollment in Medi-Cal Managed Care was mandatory for waiver beneficiaries needing IHSS are (i) language in provisions of the nursing facility/acute hospital home and community based services waiver and (ii) the state two-plan regulation at 22 CCR § 53887(a)(2)(A).8. exempting waiver participants from mandatory enrollment. In the pending HCBS waiver, see application at 1.G. at p. 3 and Appendix I.3.iii. at p. 268; in the current extended waiver at application 1.G. at page 6, indicating no 1115 waiver funds would be counted against the waiver budget. (Return To Main Document)

or rare diseases and medical conditions. 42 C.F.R. § 438.56(c)(2)(v).[24] MCP authorization of medically necessary out-of-network care is an alternative to disenrollment.

Or contact Health Care Options at 1-800-430-4263.

16. Other information

See Department of Health Care Services (DHCS) - ALL PLAN LETTER 15-019 at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-019.pdf

Go here for:

Information hosted by the Medi-Cal Managed Care Division, MMCD:
http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Copies of All Plan Letters (APL), Duals Plan Letters (DPL) and Policy Letters (PL):
http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx

"Continuity of Care in Medi-Cal Managed Care, National Health Law Program, https://healthlaw.org/resource/continuity-of-care-in-medi-cal/

Frequently Asked Questions (FAQs) re continuity of care (Medi-Cal, 2014) http://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx.

For continuity of care when your doctor, medical group, or hospital leaves the MCP see:

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[24] One reason for asking the MCP to authorize continued access to your continuity of care provider may be that there is no in-network provider with clinical experience dealing with your care needs. If the MCP denies your request to continue with your out-of-network provider you can file a grievance. If the grievance is denied, you can file a disenrollment request with both the MCP and the Department of Health Care Services' Medi-Cal Managed Care Division. Other grounds for seeking disenrollment include "poor quality of care, lack of access to services covered under the contract which would include unreasonable delays in getting an appointment or accessing services. 42 CFR § 438.56(d)(2)(v). (Return to Main Document)

https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/ContinuityofCare.aspx#.WBOqaY3FA3E

To view a state statute, go here: http://leginfo.legislature.ca.gov/faces/codes.xhtml

To view a state regulation, go here and click on the box that reads "California Code of Regulations": http://www.oal.ca.gov/

If you do not have access to the information found by going to any of the links, call Disability Rights California at 1 800 776-5746 to get what you need.

We want to hear from you! Please complete the following survey about our publications and let us know how we are doing! [Take the Survey]

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