Fact Sheet

NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS.

Cal MediConnect: Continuity of Care

Dual eligible beneficiaries who enroll in a Cal MediConnect plan have the right to continue to see providers who are not in the health plan's network when certain criteria are met.[1]

What Are The Requirements For Continuity Of Care Protections?

Relationship – the beneficiary must have a relationship with the provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

Specialists: The beneficiary must have seen the specialist ***twice*** within the twelve months prior to enrollment into a Cal MediConnect plan for a non-emergency visit.

Primary Care Provider: The beneficiary must have seen the primary care provider ***once*** within the twelve months prior to enrollment into a Cal MediConnect plan for a non-emergency visit.

Quality – the provider does not have documented quality of care concerns that would cause the health plan to exclude the provider.

How does a beneficiary prove a prior relationship with a provider?

The Cal MediConnect plan is required to first review Medicare and Medi-Cal utilization data supplied by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) to determine if a relationship exists. If the health plan cannot determine if a relationship exists based on the data, the health plan can then ask the provider and beneficiary to provide proof of the relationship. An attestation that a relationship exists is not sufficient.

Provider Agreement – the provider must agree to accept payment from the health plan. The health plan must reimburse the provider at the fee-for-service Medicare or Medi-Cal rates (whichever is applicable). A continuity of care arrangement is generally a one-page agreement between the provider and the health plan. The provider does not have to enter into a contract with the health plan or become an in-network provider to be reimbursed under continuity of care.

How Long Do Continuity Of Care Protections Apply?

If the above criteria are met, a beneficiary can continue to see an out-of-network Medicare

1 The Cal MediConnect continuity of care protections are outlined in the Dual Plan Letter (DPL 14-004) available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2014/DPL14-004.pdf.

1444 Eye St., NW, Suite 1100 | Washington, DC 20005 | (202) 289-6976 | (202) 289-7224 Fax
3701 Wilshire Blvd., Suite 750 | Los Angeles, CA 90010 | (213) 639-0930 | (213) 639-0934 Fax
1330 Broadway, Suite 525 | Oakland, CA 94612 | (510) 663-1055 | (510) 663-1051 Fax

provider for at least **six** months and a Medi-Cal provider for at least **twelve** months from plan enrollment. Cal MediConnect plans have the option to extend these periods at their discretion.

What Providers Are Covered By Continuity Of Care Protections?

A beneficiary's primary care physician, specialists, hospitals, and clinics are covered by continuity of care. Continuity of care does not extend to durable medical equipment providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to certain types of providers, the health plan must still provide continuity of care for services – the health plan is responsible for finding an in-network provider to deliver services without disruption.

Example: Ms. Smith has been receiving transportation services through Provider A to her weekly chemotherapy appointments. Her Cal MediConnect plan is not contracted with Provider A for transportation services but is contracted with Provider B. The Cal MediConnect plan must arrange for Provider B to provide Ms. Smith with her needed transportation services.

Who Can Request Continuity Of Care?

The beneficiary, his or her appointed representative, power of attorney, or conservator may request continuity of care. The beneficiary's out-of-network provider may also request continuity of care on behalf of the beneficiary. Requests for continuity of care should be made by contacting the Cal MediConnect plan's member services department. Requests can be made verbally or in writing.

How Long Do Cal Mediconnect Plans Have To Process A Continuity Of Care Request?

Generally, Cal MediConnect plans must start processing a request for continuity of care within five working days after the request is received. The plan has a maximum of 30 days to complete the request. However, if the beneficiary's medical condition requires more immediate attention (e.g., an upcoming appointment), the plan must complete the request within 15 days. If there is a risk of harm to the beneficiary, the request must be completed within 3 days of the request.

What If A Beneficiary Receives Services From An Out-Of-Network Provider But Did Not Request Continuity Of Care First?

If the criteria for continuity of care as outlined above are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care

request as long as the provider submits the request for payment within 30 calendar days of the first date of service.

Nursing Facilities

Beneficiaries residing in an out-of-network nursing facility at the time of enrollment into a Cal MediConnect plan will not have to move from the facility. As long as the nursing facility meets quality standards (see above) and will accept payment, the Cal MediConnect plan must enter into an agreement with the nursing facility and reimburse the facility at Medicare and Medi-Cal fee-for-service rates. This continuity of care protection is available as long as the dual eligible beneficiary resides in the nursing facility. Continuity of care in a nursing facility is automatic – a beneficiary does not have to make a request for continuity of care.

If a beneficiary opts out of Cal MediConnect and is enrolled in managed care only for Medi-Cal services, will he have to move out of the nursing facility if the plan does not contract with the facility?

No. Continuity of care protections for nursing facility residents are the same for Medi-Cal plans as for Cal MediConnect plans.

Prescription Drugs

If a beneficiary's prescription drug is not on the Cal MediConnect plan's formulary, she has the right to a one time fill of a 30-day supply (unless a lesser amount is prescribed) of any ongoing medication within the first 90 days of plan membership.
If the beneficiary resides in a nursing facility, she has the right to a 31 day supply and the plans must honor multiple 31 day fills during the first 90 days of plan enrollment.

Beneficiaries who experience any difficulty establishing continuity of care should contact the Coordinated Care Initiative Ombudsman at 1-855-501-3077.