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Coordinated Care Initiative (CCI) Continuity of Care

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Cal MediConnect: Continuity of Care

If certain criteria is met, a Cal MediConnect plan must allow a beneficiary the right to maintain his or her current out-of-network providers and service authorizations at the time of enrollment for a period of

Six (6) months for Medicare

Twelve (12) months for Medi-Cal services

Plans can provide extended continuity of care

http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf

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Criteria

1. Must have an existing relationship with the Provider

-Must see **PCP provider** at least **once** in 12 months proceeding enrollment in plan for non-emergency visit

-Must see **specialist** at least **twice** in 12 months proceeding enrollment in plan for a non-emergency visit

The plan must first use data provided by CMS and DHCS to determine pre-existing relationship. If relationship cannot be established through data, then plan can ask beneficiary to provide documentation of the relationship.

Cal MediConnect: Continuity of Care

Criteria

2. Provider must accept payment and enter into agreement with plan.

3. Provider does not have documented quality of care concerns

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Exceptions

Nursing Facilities – a beneficiary residing in a nursing facility prior to enrollment will not be required to change the nursing facility during the demonstration.

Durable Medical Equipment providers – no continuity of care for providers

Ancillary Services – no continuity of care for providers

Carved-out services – no continuity of care

IHSS – an individual does not need to make any request to continue to see an IHSS provider

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Prescription Drugs

Part D rules apply – 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, even if the drug is not on the plan's formulary or is subject to utilization controls.

-Residents in institutions get further protections

-Part D rules apply to both Medi-Cal and Medicare-covered drugs

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Other Protections

Health plan must complete services for the following conditions:

- -Acute
- -Serious chronic
- -Pregnancy
- -Terminal illness
- -Surgeries or other procedures previously authorized as part of documented course of treatment

CAL. HEALTH & SAFETY CODE § 1373.96(c)(1)

Cal MediConnect: Continuity of Care

Continuity of Care Periods

If a beneficiary changes plans, the continuity of care period can start over one time.

- Continuity of care does not start over if beneficiary returns to FFS Medicare and later reenrolls in Cal MediConnect.
-When a beneficiary changes a plan, continuity of care does not extend to the previous plan's in-network providers.

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Continuity of Care Requests

-Plan must perform an assessment process within 90 days of enrollment to identify continuity of care issues

-A beneficiary may make a direct request for continuity of care

-MMP must begin to process request within 5 working days of request.

-Request must be completed within 30 calendar days of request or within 15 if medical condition requires immediate attention

Consumer Protections: Continuity of Care

DISENROLL

-A beneficiary can disenroll from Cal MediConnect at any time for any reason.
-Disenrollment is effective the first day of the following month
-Must stay in Medi-Cal managed care

Continuity of Care: Medi-Cal managed care

- 12 months - keep seeing current providers and maintain service authorizations and receive services that are set to occur within 180 days of enrollment.
- Must have an "existing relationship"
  - Seen the provider at least once within 12 months (from date of plan enrollment)
- Provider must accept plan reimbursement rate or Medi-Cal rate
- Provider must meet quality of care standards
- Continuity of care does not extend to durable medical equipment, medical supplies, transportation, or other ancillary services
- Nursing facility and CBAS providers are 12 months or until a service plan is completed and agreed upon by beneficiary or resolved through an appeal.

Continuity of Care: Medi-Cal managed care

- Medical Exemption Request (MER) for SPDs
  - Available in two-plan or GMC Counties
  - Acts to avoid enrollment in managed care entirely for a certain amount of time
  - Available to individuals with complex medical conditions (e.g., cancer)
  - Administered by Health Care Options (enrollment broker)

Want to know more?

- NSCLC Duals Website
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