Extended Continuity of Care for Seniors and Persons with Disabilities Frequently Asked Questions

September 2011

Question #1: If a beneficiary's current regular Medi-Cal (Fee-For-Service, FFS) doctor does not accept any health plans how does the beneficiary continue to see this doctor after they have enrolled in a health plan?

Answer: If the beneficiary was seeing a regular Medi-Cal (FFS) doctor before enrolling in a health plan, the beneficiary may be able to continue to see that doctor for 12 months while they are enrolled in the health plan, as long as the doctor agrees to work with the health plan, accepts payment from the health plan, and has no quality of care issues. This is called the "extended continuity of care period." If the beneficiary still wants to see their current regular Medi-Cal (FFS) doctor, these steps must be followed:

1. The beneficiary must call their new health plan.
2. The beneficiary must tell their health plan that they want to continue seeing their regular Medi-Cal (FFS) doctor.
3. The beneficiary must tell their health plan the name of their regular Medi-Cal (FFS) doctor and ask the health plan to contact the doctor on their behalf. The regular Medi-Cal (FFS) doctor may continue to see the beneficiary if the health plan determines that the beneficiary has seen that doctor in the past 12 months, that there are no quality of care issues, and the doctor and health plan agree on a payment amount.
4. Within 30 days of receiving the beneficiary's request, the health plan will tell the beneficiary if they can still see their regular Medi-Cal (FFS) doctor or if they will be assigned to a health plan doctor.
5. If the regular Medi-Cal (FFS) doctor is willing to continue to see the beneficiary, but their health plan says no, the beneficiary may ask the health plan how to file a grievance.

Question #2: Which doctors may a beneficiary continue to see out-of-network?

Answer: Access to an out-of-network regular Medi-Cal (FFS) doctor for the extended continuity of care period (12 months) applies to physicians, surgeons, and specialists, and does not apply to durable medical equipment, transportation, or other ancillary services. It also does not include carved out services as the mandatory enrollment of Seniors and Persons with Disabilities (SPDs) into managed care does not impact the way they access carved out services.

Question #3: Does this apply to any Medi-Cal beneficiary in managed care?

Answer: No. This only applies to a beneficiary that was previously seeing a regular Medi-Cal (FFS) doctor and is now required to enroll in a managed care health plan.

This does not apply to beneficiaries already in a managed care health plan or beneficiaries that have become eligible for Medi-Cal or recently regained Medi-Cal eligibility and must enroll in a health plan, in which case the beneficiary will have to see doctors that are part of the health plan network.

Question #4: If the beneficiary changes health plans, does the beneficiary get another 12 month period to see their out-of-network regular Medi-Cal (FFS) doctor?

Answer: No. The beneficiary only gets 12 months from the date of their initial enrollment in managed care.

Question #5: When will the beneficiary be notified whether or not they can continue to see their current regular Medi-Cal (FFS) doctor?

Answer: The health plan shall process each request and provide notice to each beneficiary as quickly as the beneficiary's health condition requires, and within 30 calendar days from the date the health plan receives the request.

Question #6: Can the beneficiary's approved out-of-network regular Medi-Cal (FFS) doctor refer the beneficiary to another out-of network doctor?

Answer: No. An out-of-network regular Medi-Cal (FFS) doctor can not refer the beneficiary to another doctor. An out-of-network doctor, approved by the health plan under the extended continuity of care period, must work with the health plan and its contracted network. If the health plan does not have the type of specialist that the beneficiary needs in their network, the health plan must provide the medically necessary specialist referral out-of-network.

Question #7: What if the beneficiary's regular Medi-Cal (FFS) doctor will not or cannot work with the health plan?

Answer: If the health plan and the regular Medi-Cal (FFS) doctor are unable to reach an agreement; meaning the doctor will not accept payment from the health plan or that the health plan has quality of care issues with that doctor, the beneficiary will need to work with their health plan to transition to an in-network doctor. The beneficiary and their doctor may also file a Medical Exemption Request (MER). (See Question #9)

Question #8: What happens if the beneficiary becomes eligible for Medicare after being enrolled in managed care?

Answer: Once the beneficiary has enrolled in Medicare, Medi-Cal will send a letter telling the beneficiary that they are no longer required to be in a health plan. However, the beneficiary may stay in their health plan if they want to.

Question #9: Does the extended continuity of care period have any impact on the existing Medical Exemption Request process?

Answer: No. The extended continuity of care requirements are new requirements only for SPDs newly transitioning from regular Medi-Cal (FFS) into mandatory Medi-Cal Managed Care. To ensure a smooth transition into mandatory managed care, an SPD beneficiary may continue to see their regular Medi-Cal (FFS) doctor for 12 months if the member has a current relationship with their regular Medi-Cal (FFS) doctor, if the health plan does not have quality of care issues with that doctor, and if the doctor will accept the health plan's contracted rates or regular Medi-Cal (FFS) rates; whichever is higher, in accordance with Welfare and Institutions Code Section 14182(b) (13).

The extended continuity of care period requirements for health plans does not eliminate the rights of SPD beneficiaries to file a MER or a disenrollment request at any time.

The existing MER process as stated in Title 22, Section 53887 and the completion of covered services requirements in Health and Safety Code, Section 1373.96, remain in place, for all Medi-Cal managed care enrollees; including SPDs.

Question #10: Must the health plan grant the beneficiaries request for continuing care with their existing doctor?

Answer: The health plan is required to grant all requests by a transitioning mandatory SPD for extended continuity of care as long as the doctor requested is identified on Fee-For-Service Medi-Cal utilization data as having provided services to the beneficiary during the most recent 12 months, the doctor agrees to accept the health plan's contracted rates or Medi-Cal (FFS) rates, whichever is higher, in accordance with Welfare and Institutions Code Section 14182(b)(13), and the doctor has no quality of care issues which, otherwise, would make them ineligible to provide services to any health plan members. Additionally, health plans must comply with the Health and Safety Code Section 1373.96 requirements which outline specific circumstances in which access to out-of-network doctors must be provided to all members; including SPDs.

Question #11: What does quality of care issues mean?

Answer: A quality of care issue means that a health plan can document that they would not contract with this doctor because of concerns with the quality of care that they provide, and which would make them ineligible to provide services to any health plan members.

Question #12: How have mandatory SPDs and doctors been notified of the extended continuity of care requirements?

Answer: Prior to mandatory managed care enrollment, the beneficiary received a 90-day and 60-day notice, explaining that they may be able to stay with their current regular Medi-Cal (FFS) doctor even if the doctor is not in the health plan's network and that they should contact the health plan to initiate this process. All regular Medi-Cal (FFS) doctors will be notified by means of a Medi-Cal Provider Bulletin.

Question #13: How long does the beneficiary have to file a grievance if the health plan denies their request for the extended continuity of care period with their existing regular Medi-Cal (FFS) doctor?

Answer: A health plan beneficiary may file a grievance with the health plan at any-time. The health plan must resolve each grievance and provide written notice to the beneficiary as quickly as the beneficiary's health condition requires, and within 30 calendar days from the date the health plan receives notice of the grievance.

Question #14: What should the beneficiary do if they have a serious, acute or ongoing medical or health condition that requires treatment or monitoring before the health plan makes a decision about the beneficiary's out-of-network doctor or during the grievance process?

Answer: If the beneficiary has urgent medical needs, they must call their health plan primary care doctor and their health plan. The health plan is required to ensure that the beneficiary obtains all medically necessary Medi-Cal covered services and provides the beneficiary with continuity of care for the completion of covered services in compliance with Health and Safety Code, Section 1373.96. The health plan primary care doctor will assist the beneficiary in obtaining all medically necessary services.

Question #15: What if the beneficiary wishes to continue with their out-of-network doctor for more than the allowed 12 months?

Answer: Each health plan may choose to work with the beneficiary's out-of-network doctor past the 12 month extended continuity of care period, but they are not required to do so. Alternatively, the beneficiary and their doctor may file a MER to be removed from managed care as described on the Health Care Options (HCO) website. In this case, the doctor must provide documentation that the beneficiary's medical condition is unstable to the point that they cannot safely transfer to a doctor in the health plan's network.

Question #16: Will the beneficiary be allowed to keep a scheduled appointment with a regular Medi-Cal (FFS) doctor after enrollment in a managed care health plan?

Answer: A managed care health plan is required to allow SPD beneficiaries access during the extended continuity of care period if the appointment is with a doctor the SPD beneficiary has seen in the past 12 months, as verified by Fee-For-Service utilization data; if the doctor is willing to accept payment from the health plan; and if there are no quality of care issues with that doctor. If the appointment is with a doctor that the beneficiary has never seen, but because of a serious medical condition it is medically necessary that they keep the appointment, then the health plan must allow access in accordance with the completion of covered services requirements in Health and Safety Code Section 1373.96.

Question #17: How can the beneficiary get new medications or refill current medications after they are enrolled in a managed care health plan?

Answer: A prescription for a new or refilled drug prescribed by the beneficiary's current, regular Medi-Cal (FFS) doctor will be filled if it is on the health plan's formulary list of approved drugs. For a new prescription that is not on the formulary, the pharmacist will be notified by the health plan that prior authorization is required and the health plan must make a decision within 24-hours based upon medical justification requested from the prescribing doctor. A non-formulary medication refill that is part of ongoing treatment may be subject to concurrent review by the health plan during which time the medication must be covered until the beneficiary's doctor has been notified of the plan's decision and a care plan has been agreed upon by the beneficiary's doctor that is appropriate for their medical needs, as required by Health and Safety Code 1367.01.

For further information please see the general SPD website:

http://dhcs.ca.gov/SPDinfo.