State of California

Department of Health Care Services

Provider Bulletin: Continuity of Physician Care for Beneficiaries Who Are Enrolled in Cal MediConnect Managed Care Plans

July 2016

The purpose of this bulletin is to explain the process for current out-of-network physicians to continue to see Cal MediConnect beneficiaries and for those physicians to bill the correct entity for payment. These provisions are referred to as **continuity of care**.

Most individuals who have both Medicare and Medi-Cal, known as "dual eligible" or "Medi-Medis," and reside Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties are eligible to enroll in a new type of coordinated care plan, called a Cal MediConnect health plan.

Through Cal MediConnect plans, beneficiaries receive streamlined services and care coordination that may help them better manage all aspects of their health, in-home, and social needs.

Each Cal MediConnect plan is responsible for administering both the beneficiaries' Medicare and Medi-Cal benefits.

Participation in Cal MediConnect is voluntary. A beneficiary who chooses to enroll in a Cal MediConnect plan or who has been passively enrolled in a Cal MediConnect plan has the right to disenroll or switch to a different Cal MediConnect plan at any time.

If beneficiaries who are dual eligibles choose not to join a Cal MediConnect plan or disenroll from their Cal MediConnect plan, they must still be enrolled in a Medi-Cal plan for their Medi-Cal benefits.

IMPORTANT: You do not need to be contracted with the Medi-Cal plan to bill the Medi-Cal plan for the coinsurance, but may need authorization from the plan for Medi-Cal services[1].

Continuity of Care for Cal MediConnect Beneficiaries

Even if you are not contracted with your beneficiary's Cal MediConnect plan, the beneficiary has the right to continue seeing you for a specified, temporary period following enrollment if certain criteria are met (see below). When a beneficiary enrolls in Cal MediConnect, the plan must conduct a Health Risk Assessment (HRA) to determine if there are continuity of care needs. Beneficiaries, their authorized representatives, or their physicians can also request continuity of care at any time.

[1] DPL 16-002 is available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL16-002.pdf

Physicians are in a unique position to help beneficiaries ensure that they are taking advantage of their continuity of care protections and can make continuity of care requests on their behalf.

How do I keep seeing the beneficiary who is enrolled in a Cal MediConnect plan?

Step 1: You or the beneficiary must contact the Cal MediConnect plan and request continuity of care.

Step 2: The Cal MediConnect plan must validate that you have a pre-existing relationship with the beneficiary. If you are a:

Primary care physician (PCP), a pre-existing relationship exists if you have seen the beneficiary once in the twelve months prior to the beneficiary's enrollment in the plan.

Specialist, effective October 1, 2016, a pre-existing relationship is established if you have seen the beneficiary once in the twelve months prior to the beneficiary's enrollment in the plan.

The Cal MediConnect plan will review Medicare claims data to validate this relationship. If the Cal MediConnect plan is unable to validate the relationship through claims data, the plan will ask you or the beneficiary for proof.

Step 3: You must enter into an agreement with the Cal MediConnect plan and accept either the Cal MediConnect plan rate or the applicable Medicare or Medi-Cal rate, whichever is higher. You must also agree to accept the Cal MediConnect plan's utilization management rules.

A continuity of care request will **not** be granted if you have quality of care issues or you fail to meet federal or state requirements.

How much time does it take for a request to be granted?

Each continuity of care request must be completed within:

- 30 calendar days from the date the Medicare-Medicaid Plans (MMP) receive the request;
- 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
- Three calendar days if there is risk of harm to the beneficiary.

How long can I continue to see the beneficiary under continuity of care provisions?

Effective October 1, 2016, if continuity of care is granted, at a minimum, you can continue to see the beneficiary for up to **twelve (12) months for either Medicare or Medi-Cal** services. Most likely, you will be providing Medicare services.

Enrollees in a Cal MediConnect plan are eventually required to receive all covered services from physicians and other providers who are part of their Cal MediConnect plan's network. Physicians are encouraged to enter into an agreement with these health plans to ensure beneficiaries can continue to see them after the continuity of care period. To find out how to contract with a Cal MediConnect plan in your area, visit: www.CalDuals.org/Providers or call the beneficiaries Cal MediConnect plan.

What if I rendered services to the beneficiary and did not request continuity of care first?

Physicians are required to check a patient's insurance coverage at each date of service. However, providers or patients can request retroactive continuity of care. Cal MediConnect plans must accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above, with the exception of the requirement to abide by the plan's utilization management policies. Cal MediConnect plans must approve retroactive requests for continuity of care submitted within the following timeframes:

- The date of service occurred after September 29, 2014; and,
- The dates of service you are seeking payment for are within 30 calendar days of the dates of service for which you are requesting retroactive continuity of care.

  Example: You rendered services on March 1, March 14, March 21, April 2, and April 10. You request continuity of care on April 10. You will receive retroactive payment for the services rendered on March 14, March 21, April 2, and April 10. You will not receive payment for March 1 because this is not within 30 days of the date of service you requested continuity of care.

  Exception: The Cal MediConnect plan must accept retroactive requests that are submitted more than 30 days after the first service if the physician can document that the reason for the delay is that the physician unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity—for example if the physician sent the claim to Medicare, the wrong health plan or a health plan instead of the delegated Independent Practice Associations (IPA) (see below for further information).

What if the beneficiary is enrolled in a delegated entity?

Cal MediConnect plans may contract with medical groups and IPAs (collectively "IPAs") or preferred provider groups (PPGs). Enrollees can be assigned to delegated entities, which have their own specific network of physicians. The IPA or PPG will be listed on the beneficiary's Cal MediConnect card. If you are a provider that is not in the beneficiaries IPA or PPG's network, the request for continuity of care and claims for reimbursement should be submitted to the IPA/PPG.

Balance Billing is Prohibited

"Balance billing" is the practice of billing a beneficiary for any charges for a covered service. **Balance billing is prohibited by state and federal law for Medi-Cal beneficiaries, including dual eligible beneficiaries.**

A physician may not bill a beneficiary for any charges that are not reimbursed by Medicare or Medi-Cal (or the Medicare Advantage or Medi-Cal plan), if the service is covered by Medicare or Medi-Cal. In other words, a physician must accept as payment-in-full whatever amount Medicare or Medi-Cal (or the Medicare/Medi-Cal plan) pays physicians for a Medicare or Medi-Cal covered service. The only exception is that physicians may bill Medi-Cal beneficiaries who have a monthly share of cost obligation, but only until that obligation is met for the applicable month. Physicians who violate these protections are subject to sanctions[2].

Resources for Physicians

For more detailed information on DHCS's out-of-network physician continuity of care policies, please see DHCS Dual Plan Letter16-002: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL16-002.pdf

For continuity of care questions regarding specific beneficiaries, please contact the beneficiary's Cal MediConnect plan.

For additional resources, including factsheets about billing, contracting, and other important issues for physicians who see patients with Cal MediConnect or Medi-Cal plans, visit: http://www.calduals.org/providers/physician-toolkit.

[2] 42 C.F.R. § 438.106