Disability Rights California

California's protection & advocacy system
Toll-Free (800) 776-5746

Medi-Cal Managed Care: Access to Care in Rural Counties

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IT CAN BE HARD FOR ME TO FIND HEALTH CARE PROVIDERS IN RURAL CALIFORNIA. WHAT ARE MY RIGHTS?

You have the right to get timely access to the health providers you need, including primary care physicians, specialists, and hospital care. Sometimes we hear from clients who are having trouble finding providers. This fact sheet gives you information and tips on what to do if you live in a rural area and you have Medi-Cal managed care.

WHAT IS MEDI-CAL MANAGED CARE, AND WHAT IS A NETWORK?

Medi-Cal managed care is a relatively new way to get Medi-Cal in many rural counties in California. Managed care is a system for providing and paying for health care services. Managed care means that you receive your health care from a managed care plan. A managed care plan is an organized network of health care providers that emphasizes primary and preventive care. Some, but not all, hospitals, physicians and other health care providers are members of the network. Managed care plans usually require you to get your health care from their network of providers, and may require that you get a referral from your primary care provider before you can see certain specialists. In most cases, you can only see a provider who is not in the managed care plan's network if the plan gives you prior authorization.

WHAT DOES COUNTY ORGANIZED HEALTH SYSTEM (COHS) MEAN?

A County Organized Health System (COHS) is a local agency created by a county to contract with Medi-Cal. The health plan itself is run by the county. There are 22 COHS counties in California: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo.

In a COHS county, there is only one managed care plan choice. Everyone who gets Medi-Cal in a COHS county must enroll in the same COHS plan.

DOES MEDI-CAL REQUIRE THAT MANAGED CARE PLANS ENSURE THAT I GET THE HEALTH CARE THAT I NEED?

Yes. Medi-Cal managed care plans have a responsibility under both federal law and state law to make sure that health care providers are available. They must ensure that a range of services are available, and that there are enough health care providers in the geographic area. The managed care plan has a responsibility to ensure that you have access to the health care that you need. Managed care plans must cover everything that “regular” Medi-Cal covers. They can also cover more services.

WHAT IS THE KNOX-KEENE ACT?

The Knox-Keene Act is California’s consumer protection law for people who get health insurance through managed care. Knox-Keene applies to private managed care insurance. It also applies to some, but not all, Medi-Cal managed care plans. For example, most COHS plans are not Knox-Keene licensed.

CAN I STAY OUT OF MEDI-CAL MANAGED CARE?

In COHS counties, if you want Medi-Cal, you have to get it from your county’s managed care plan.

By contrast, in counties that do not have COHS managed care, some people may be able to stay out of Medi-Cal managed care and continue to

get regular Medi-Cal. People with serious illnesses or disabilities can apply for an exemption from managed care (medical exemption request, or MER). Additionally, people who have providers that do not accept managed care can ask to keep seeing their current providers for “continuity of care.”

For more information about medical exemption requests and continuity of care see DRC publications: Medical Exemption Requests (MERs) (pdf) (rtf) (Pub #5595.01, January 2017) and Medi-Cal Managed Care: "Continuity of Care" (pdf) (rtf) (February 2017, #5545.01). If you do not have access to the Internet, please call Disability Rights California to ask for a copy.

WHAT IF I WANT TO KEEP SEEING THE PROVIDERS I KNOW AND I DO NOT WANT TO SWITCH PROVIDERS?

Ordinarily, you must see a provider who is part of your managed care network. However, if you want to keep seeing a provider who does not accept managed care, you may have an alternative. You can ask to keep seeing your current providers for “continuity of care.” This is true in all counties, including COHS counties.

WHAT IF I DISAGREE WITH MY HEALTH CARE PROVIDER AND I WANT A SECOND OPINION?

You have the right to have the managed care plan pay for a second opinion. If you disagree with your provider, you should call the member services number located on the back of your health plan membership card and request the second opinion. If the plan says no, you can file a grievance by requesting the plan’s toll-free number for filing grievances. You can file a grievance for *any* reason. You must file a grievance within 60 days of an adverse benefit determination or at any time after any other incident or problem. In most cases, plans must provide notice of resolution of grievance within 30 calendar days. You can also request an expedited grievance, which is usually a 72-hour turnaround.

WHAT IF I DISAGREE WITH OUTCOME OF THE GRIEVANCE?

If the grievance is not resolved 100% in your favor, the plan must provide you with the following information:

- Your right to request an independent medical review (Knox-Keene plans only);

- Your right to request a Medi-Cal fair hearing;

- Your right to continue benefits, and how to do so;

- That you may be liable for the cost of benefits if you do not succeed in the hearing.

For more information, you can also see our publications: Timely Access to Medical Care (pdf) (rtf) (May 2016, #5556.01) and Medi-Cal Managed Care: An Independent Medical Review (IMR) Can Change a Plan's No to Yes (pdf) (rtf) (January 2017, #5534.01)

TRAVELING TO GET MEDICAL CARE IS HARD. DO SERVICES HAVE TO BE AVAILABLE NEARBY?

Yes. Medi-Cal requires in most places that primary care physician services be available within 30 minutes or 10 miles of your home. There are some exceptions, especially in very rural areas. The Knox-Keene Act also provides some protections. Under Knox-Keene, primary care and hospitals must be available within 30 minutes or 15 miles of your home or workplace. Other services, like laboratories and prescriptions, must be available near the place where you get primary care.

I DO NOT WANT TO WAIT A LONG TIME TO GET MEDICAL APPOINTMENTS OR CARE. DO I HAVE A RIGHT TO TIMELY ACCESS TO MEDICAL CARE?

Yes. The law says that if you cannot get a timely appointment in your area because there are not enough providers, then your health plan must help you get an appointment with an appropriate provider. California applies the Knox-Keene timely access requirements to ALL Medi-Cal managed care plans. Here is what Knox-Keene requires:

- Urgent care must be provided within 48 or 96 hours of a request;

- Primary care must be provided within 10 business days;

- Specialist care must be provided within 15 business days;

- Non-physician mental health care must be provided within 10 business days;

- Phone access to a nurse who can help you determine what health care you need must be available 24 hours a day.

WHAT CAN I DO IF I DO NOT GET TIMELY ACCESS?

- Contact your health plan to file a grievance by phone or mail first. Your health plan membership card has a member services phone number listed on the back of the card. In most cases, this kind of violation would warrant an expedited appeal. If your plan is Knox-Keene licensed (remember, *most* COHS plans are *not* Knox-Keene licensed), you should file an internal grievance and Department of Managed Health Care (DMHC) complaint at the same time. If your plan is non-Knox-Keene licensed, you should file an internal grievance first, and then go on to a Medi-Cal fair hearing.

- If your health problem is urgent, or if you have already filed a complaint with your health plan and are not satisfied with the decision, or it has been more than 30 days since you filed a complaint, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care. If you need assistance, you can contact the Help Line at (888) 466-2219, TDD: (877) 688-9891, or http://www.dmhc.ca.gov/File-a-Complaint/Apply-for-an-Independent-Medical-Review-IMR/IMR-Application-Form.aspx#.WTsJdHllCUk.

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WHAT IF I NEED EMERGENCY CARE BUT THERE IS NO MANAGED CARE NETWORK PROVIDER AVAILABLE NEARBY?

You have the right to get emergency care when you need it, even from a provider who is not part of your managed care network. You do not have to

get prior authorization. If a reasonable person would have thought that the situation was an emergency, then the managed care plan must pay for the emergency care.

WHAT IF I NEED NON-EMERGENCY CARE BUT THERE IS NO NETWORK PROVIDER AVAILABLE?

If no network providers are available, then you have the right to get out-of-network care. In some situations, your managed care plan may require you to get prior authorization first. You should not have to pay extra for seeing an out-of-network provider.

HOW CAN I GET MORE INFORMATION?

- Call the California Department of Managed Health Care's Help Desk, 1-888-466-2219, or visit their website, http://www.dmhc.ca.gov/FileaComplaint.aspx#.U86XCeNdXMY.

- Call the local county Medi-Cal office or Health Care Options at 1-800-430-4263. Visit www.healthcareoptions.org.

Also, Disability Rights California has helpful publications posted on our Health website, http://www.disabilityrightsca.org/pubs/PublicationsHealthBenefits.htm. If you do not have access to the internet, please call us to ask for publications. You might find the following publications helpful:

- Medi-Cal Managed Care: An Independent Medical Review (IMR) Can Change a Plan's No to Yes- Timely Access to Medical Care

- Medical Managed Care Health Plans: What are they? What do I need to know about them?

- Timely Access to Medical Care

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