State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: May 11, 2017

ALL PLAN LETTER 17-007
(SUPERSEDES ALL PLAN LETTER 15-001)

TO: ALL NON-COUNTY ORGANIZED HEALTH SYSTEM MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR NEW ENROLLEES TRANSITIONED TO MANAGED CARE AFTER REQUESTING A MEDICAL EXEMPTION AND IMPLEMENTATION OF MONTHLY MEDICAL EXEMPTION REVIEW DENIAL REPORTING

PURPOSE:
The purpose of this All Plan Letter (APL) is to notify all non-County Organized Health System model Medi-Cal managed care health plans (MCPs) that they must ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care and who are included on the Exemption Transition Data report. This APL also provides information to MCPs about the data file through which the Department of Health Care Services (DHCS) will notify MCPs of beneficiaries who are transitioning from FFS to an MCP and have submitted a Medical Exemption Request (MER) and/or an Emergency Disenrollment Exemption Request. In addition, this APL also provides new instructions for the Monthly MER Denial Reporting (MMDR) process, which will become a monthly requirement effective July 1, 2017. This APL supersedes APL 15-001.

BACKGROUND:
Health & Safety (H&S) Code Section (§) 1373.96 requires all health plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or nonparticipating health plan provider, subject to certain conditions. Under this statute, health plans shall provide those services for the following: an acute condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment. Health plans must allow for the completion of these services for certain timeframes, which are specific to each condition and defined under H&S Code § 1373.96.

In addition, state regulations allow certain beneficiaries to request a medical exemption from MCP enrollment for up to 12 months to complete a treatment with their current

Medi-Cal FFS provider(s).[1] This treatment must be for a complex medical condition and must be provided by a physician, certified nurse midwife, or licensed midwife who is participating in FFS and is not contracted with any of the MCPs available in an eligible beneficiary's county of residence.

In accordance with Welfare and Institutions Code § 14185(b), MCPs must allow beneficiaries to continue use of any (single-source) drugs that are part of a prescribed therapy (by a contracting or non-contracting provider) in effect for the beneficiary immediately prior to the date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the contracting physician.

A beneficiary who has been granted a medical exemption from MCP enrollment may remain with the FFS provider until his or her medical condition has stabilized to a level that would enable him or her to change to an MCP physician without deleterious medical effects as determined by the beneficiary's FFS Medi-Cal provider. At any time, including during the exemption verification process, DHCS may verify the complexity, validity, and status of the beneficiary's medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with an MCP in the beneficiary's county of residence. DHCS may deny a request for exemption from MCP enrollment or revoke an approved exemption if a provider fails to fully cooperate with DHCS' verification process.

If a beneficiary files a MER that DHCS denies, the beneficiary may still be entitled to continuity of care. This is further explained below.

POLICY:
MCPs are required to consider a request for exemption from MCP enrollment that is denied as a request to complete a course of treatment with an existing FFS or nonparticipating health plan provider under H&S Code § 1373.96, and in compliance with the MCP's contract with DHCS and any other DHCS continuity of care APLs. MCPs must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. The beneficiaries existing provider is identified by the National Provider Identifier on the MER. MCPs must meet the continuity of care timeframes that are specified in H&S Code § 1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities established under

[1] Exemptions from enrollment in Two-Plan health plans are governed by Title 22 of the California Code of Regulations (CCR), § 53887.

APL 11-019, Duals Plan Letter (DPL) 16-002 on continuity of care, APL 15-019 on continuity of care for Medi-Cal beneficiaries who transition into managed care, and other continuity of care APLs and DPLs. [2]

MCPs must treat every exemption listed on the Exemption Transition Data report (see Attachment A for data file format details) as an automatic continuity of care request for the identified beneficiary. Once an MCP is notified that a beneficiary is on the Exemption Transition Data report, the MCP must make every effort to ensure that the beneficiary is allowed to continue to receive ongoing medical care through his or her FFS or nonparticipating health plan provider(s) for the period specified in H&S Code § 1373.96 for a particular illness or condition. This requirement also applies to instances in which the provider identified on the MER is a specialist who is not included in the network of a subcontracted health plan, independent physicians association, medical group, or other entity to which the beneficiary is assigned. MCPs must attempt to contact the beneficiary via a letter followed by at least two phone calls before ceasing outreach attempts. If applicable, on the second failed call attempt a detailed voice message should be left explaining how the beneficiary can contact the MCP.

MCPs must begin processing requests for continuity of care within five working days from their receipt of the request. In this case, receipt of the Exemption Transition Data report constitutes such a request. MCPs must complete their responses to each request within 30 calendar days from the date the MCP receives it, or within 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs. If there is a risk of harm to the beneficiary, the request must be completed in three days. If a beneficiary voluntarily chooses to change MCPs, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

MCPs must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out-of-network) about the requirements set forth in this APL. MCPs must, at a minimum, include information about continuity of care in provider training and new member orientation materials.

MCPs must oversee and remain accountable for the requirements in this APL even if they subcontract with another health plan, independent physicians association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this APL. If the beneficiary's FFS or nonparticipating health plan provider is not an in-network provider, the MCP must contact the provider and make a

[2] All APLs and DPLs are available at http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx.

good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the beneficiary.

For coordination of care and care transition efforts required under H&S Code § 1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

A continuity of care request is considered completed when:

- The beneficiary is informed of his or her right of continued access or if the MCP and the out-of-network FFS provider are unable to agree to a rate;
- The MCP has documented quality of care issues; or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

MCPs may choose to work with a beneficiary's out-of-network doctor past the 12 month continuity of care period, but MCPs is not required to do so.

EXEMPTION TRANSITION DATA REPORT:
DHCS provides a data file to notify MCPs of beneficiaries who received a MER denial in the past 45 days who have or will transition into an MCP. The Exemption Transition Data report is accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: http://healthcareoptions.maximus.com/sdes/.

The Exemption Transition Data report is posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The file posting schedule is available for download from the SDES website by clicking on the SDES web link above. Authorized MCP representatives who have access to the WPF can access the exemption file.

The data file includes beneficiaries who have had a MER denied in the past 45 days. It contains information for both pending and active beneficiaries. The data file uses the most recent choice/default information on record. For beneficiaries who are pending and not yet active, MCPs should use the data provided in the WPF to contact the beneficiary and initiate the continuity of care process. If there is no exemption denial activity for beneficiaries enrolling in a particular MCP, an empty exemption file will not be posted to the SDES.

The record layout for the Exemption Transition Data file is provided as Attachment A. MCPs should download and review the files and submit any technical questions to MAXIMUS at: cahcohelpdesk@maximus.com. Please use "MER/EDER Data File" in the subject line of the email.

REPORTING REQUIREMENTS:
Beginning with the reporting period of July 2017, MCPs must submit a MMDR to DHCS using the instructions and report template that are provided with this APL as Attachment B. The MMDR must be submitted to the DHCS Secure File Transfer Protocol (SFTP) site by the 15th day of the second month following the reporting period.

If you have any questions regarding this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Medi-Cal Managed Care Quality and Monitoring Division

Attachments

Attachment A

Exemption Transition Data Report
File Format

Field #	Field Name	Field Description	Attributes (length)
1.	BeneficiaryID	Beneficiary ID (MAXIMUS assigned)	Int (09)
2.	ExemptionID	Exemption record ID (MAXIMUS assigned)	Int (09)
3.	CIN	Beneficiary CIN	Char (09)
4.	FirstName	Beneficiary First Name	Char (15)
5.	MiddleInitial	Beneficiary Middle Initial	Char (01)
6.	LastName	Beneficiary Last Name	Char (20)
7.	DOB	Date Of Birth (format = MM/DD/YYYY)	Char (10)
8.	ReasonCode	Denial Reason Code	Char (01)
9.	ReasonDescription	Denial Reason Description	Char (400)
10.	Denial Date	Denial Date of MER (format = MM/DD/YYYY)	Char (10)
11.	ProviderID	Provider ID	Vchar (10)
12.	ICD9-1	International Classification of Diseases (Ninth Edition) – first code	Vchar (06)
13.	ICD9-2	International Classification of Diseases (Ninth Edition) – second code	Vchar (06)
14.	PlanOfLastTrans	Plan Number in which beneficiary is to be enrolled	Vchar (03)