



JENNIER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

**DATE:** January 8, 2016

ALL PLAN LETTER 16-001  
SUPERSEDES ALL PLAN LETTER 06-007

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** MEDI-CAL PROVIDER AND SUBCONTRACT SUSPENSIONS,  
TERMINATIONS, AND DECERTIFICATIONS

**PURPOSE:**

This All Plan Letter (APL) reiterates the protocol and notification requirements for Medi-Cal managed care health plans (MCPs) when terminating subcontracting relationships with Independent Physician Associations (IPAs), medical groups, hospitals, clinics, Primary Care Physicians (PCPs), and other subcontracted providers. It also establishes protocols relating to state initiated provider suspensions, terminations, or decertification from participation in the Medi-Cal Program, or providers whose Medi-Cal managed care operations have ceased with limited to no prior notice.

**BACKGROUND:**

This APL applies to MCPs that subcontract with providers in order to deliver services and care to Medi-Cal beneficiaries. When a subcontracting relationship ends, MCPs are required to continue to maintain adequate provider networks: Health and Safety Code (H&S) Section 1367, Title 22 California Code of Regulations (CCR) Section 53853, and the managed care contract<sup>1</sup> (Exhibit A, Attachment 6, Provider Network, Network Capacity). Additionally, MCPs remain accountable for all functions and responsibilities delegated to subcontractors (Exhibit A, Attachment 6, Provider Network, Subcontracts. To this end, Title 22 CCR Sections 53852 and 53911, as well as the managed care contract (Exhibit A, Attachment 9, Access and Availability, Changes in Availability or Location of Covered Services) require MCPs to obtain written approval from the Department of Health Care Services (DHCS) prior to making any substantial change in the availability or location of covered services.

H&S Code Section 1373.65 and Title 28 CCR Section 1300.67(1)(3) contain requirements for block transfer filings with the Department of Managed Health Care (DMHC) and beneficiary notification requirements when Knox-Keene licensed MCPs

---

<sup>1</sup> Boilerplate contracts can be accessed at the following link:  
<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

terminate or do not renew contracts with provider groups or general acute care hospitals.

Subcontracting relationships may be affected when a facility is no longer able to receive Medi-Cal funds. DHCS and the Centers for Medicare and Medicaid Services (CMS) may issue a decertification, temporary decertification, or temporary payment suspension order for Medi-Cal or Medicare programs respectively. Title 42 Code of Federal Regulations (CFR) Section 438.610 prohibits MCPs from employing, contracting, or maintaining a contract with physicians or other health care providers who are excluded, suspended, or terminated from participation in the Medicare or Medi-Cal programs. When a facility is suspended, temporarily suspended, or payments to the facility are suspended, MCPs must take steps to ensure the safe transition of Medi-Cal beneficiaries.

## **REQUIREMENTS:**

### **MCP Initiated Terminations**

MCPs are required to obtain written approval from DHCS prior to making any substantial change in the availability or location of covered services. The protocol for obtaining approval and the beneficiary notification requirements may vary depending on what type of provider is being terminated: 1) subcontracted providers; 2) clinics and PCPs; 3) IPAs and medical groups; or 4) hospitals.

#### **1. Subcontracted Providers**

All subcontracted provider contract terminations that constitute a change in the availability or location of covered services require MCPs to provide notice to DHCS. At least 60 days prior to the expected date of termination, the MCP must submit the beneficiary notice as well as a description of how the MCP intends to continue to provide covered services to affected beneficiaries to DHCS for review and approval. The beneficiary notice must be mailed to those beneficiaries who will have to change providers at least 30 days prior to the expected date of the contract termination.

The beneficiary notice must include, at a minimum:

- The effective date of the termination;
- The name of the current provider and the name of the new provider to which the beneficiary will be assigned;
- A description of how the termination will affect the beneficiary's access to covered services;
- If the beneficiary must change providers, the beneficiary should be either assigned a new provider with the option to change providers, or the MCP can

- give the beneficiary the opportunity to choose a new provider and assign a new provider if the beneficiary does not choose one;
- If the beneficiary is receiving services on an ongoing basis and must change providers, the beneficiary should be notified of the pending transition;
  - All language required by the H&S Code (exception: beneficiary notices for COHS plans in which non-applicable requirements should be omitted from the notice); and
  - Language providing the beneficiary with the MCP's Member Services telephone number and the toll-free telephone number of DHCS's Office of the Ombudsman.

In order to evaluate the proposed change, the MCP must submit to DHCS a narrative of how the MCP intends to continue to provide covered services to affected beneficiaries. The narrative should include:

- The reason for the provider termination;
- The date the beneficiary notice will be mailed;
- The number of beneficiaries assigned to the terminating provider;
- If applicable, a "crosswalk" showing the number of beneficiaries and the names of the providers to which these beneficiaries are reassigned in order to retain contractual access;
- The number of beneficiaries who will be assigned to a provider who is outside contractual access standards and cannot retain access through reassignment to another provider who would meet contractual access standards;
- The number of beneficiaries who cannot be assigned to a new provider within the required time and distance standards of 30 minutes or 10 miles (Title 22 CCR Sections 53885 and 53922.5 and Exhibit A, Attachment 6, Provider Network, Time and Distance Standard);
- The number of beneficiaries receiving ongoing care who must be transitioned to another provider; and
- A copy of DMHC's block transfer filing if applicable, or assistance with working with DMHC to access the block transfer filing.

## **2. Clinics and PCPs**

At least 60 days prior to the expected date of termination, MCPs must submit the beneficiary notice as well as a description of how the MCP intends to continue to provide covered services to affected beneficiaries to DHCS for review and approval. The beneficiary notice must be mailed to affected beneficiaries at least 30 days prior to the expected date of the contract termination with the clinic or PCP. This applies only when the contract termination will result in more than 500 beneficiaries having

to change PCPs, or if there are beneficiaries who cannot be reassigned to PCPs within the time and distance standards.

In cases where the contract termination will result in less than 500 beneficiaries having to change PCPs, and all affected beneficiaries can be reassigned to PCPs within the time and distance standards, MCPs may use a boilerplate beneficiary notice that was previously approved by DHCS each time such a termination occurs.

In addition to the notification requirements outlined in the subcontracted provider section above, the notice informing beneficiaries of a change to their clinic or PCP assignment should additionally include:

- The effective date of the termination;
- The name of the terminating clinic or PCP;
- A description of how the termination will affect the beneficiary's access to covered services;
- The opportunity to choose a new PCP, or be assigned to a new PCP, with the option to change if the beneficiary does not choose a PCP;
- All language required by the H&S Code (exception: beneficiary notices for COHS plans in which non-applicable requirements should be omitted from the notice); and
- Language providing the beneficiary with the MCP's Member Services telephone number and the toll-free telephone number of DHCS's Office of the Ombudsman.

In order for DHCS to evaluate the proposed change, the MCP must submit a narrative of how it intends to continue to provide covered services to affected beneficiaries. The narrative should include:

- The reason for the clinic or PCP termination;
- The date the beneficiary notice will be mailed;
- The number of beneficiaries assigned to the terminating clinic or PCP;
- The number of beneficiaries who cannot be assigned to a new clinic or PCP within the time and distance standards; and
- A copy of the DMHC block transfer filing if applicable, or assistance with working with DMHC to access the block transfer filing.

### **3. IPA/Medical Groups**

All IPA and medical group contract terminations constitute a substantial change in the availability or location of covered services and requires MCPs to provide notice to DHCS. At least 60 days prior to the expected date of termination, the MCP must

submit the beneficiary notice as well as a description of how the MCP intends to continue to provide covered services to affected beneficiaries to DHCS for review and approval. The beneficiary notice must be mailed at least 30 days prior to the expected date of the contract termination for beneficiaries who will have to change IPAs or medical groups.

In addition to the notification requirements outlined in the subcontracted provider section above, the notice informing beneficiaries of a change to their IPA or medical group should include a description of how the termination will affect the beneficiary's access to covered services; including, whether the beneficiary has to change their PCP or specialist and/or how the beneficiary will maintain access to services.

In order for DHCS to evaluate the proposed change, the MCP must submit to DHCS a narrative of how the MCP intends to continue to provide covered services to affected beneficiaries.

The narrative should include:

- The reason for the provider termination;
- The date the beneficiary notice will be mailed;
- The number of beneficiaries assigned to the terminating provider;
- If applicable, a "crosswalk" showing the number of beneficiaries and the names of the providers to which these beneficiaries are reassigned in order to retain contractual access;
- The number of beneficiaries who will be assigned to a provider who is outside contractual access standards and cannot retain access through reassignment to another provider who would meet contractual access standards;
- The number of beneficiaries who cannot be assigned to a new provider within the required time and distance standards of 30 minutes or 10 miles (Title 22 CCR Sections 53885 and 53922.5 and Exhibit A, Attachment 6, Provider Network, Time and Distance Standard);
- The number of beneficiaries receiving ongoing care who must be transitioned to another provider; and
- A copy of DMHC's block transfer filing if applicable, or assistance with working with DMHC to access the block transfer filing.

#### **4. Hospitals**

Beneficiaries do not have to be assigned to a hospital for a termination to constitute a substantial change in the availability or location of covered services requiring notice to DHCS. MCPs contracting with DHCS are fully responsible for reporting changes in the availability or location of covered services for subcontracting plan partners and other entities.

All hospital contract terminations constitute a substantial change in the availability or location of covered services and require MCPs to provide notice to DHCS. At least 30 days prior to the termination of a contract, MCPs must submit the beneficiary notice as well as a description of how the MCP intends to continue to provide covered services to affected beneficiaries to DHCS for review and approval. The beneficiary notice must be mailed no more than five days after the termination to beneficiaries who:

- Received services at the terminating hospital within the last 12 months; and
- Are scheduled to receive services at the terminating hospital within the next six months.

In addition to the notification requirements outlined in the subcontracted provider section above, the notice informing beneficiaries of a hospital termination should include:

- If applicable, the name of the beneficiary's current PCP, the name of the PCP selected by the beneficiary, or the PCP the beneficiary will be assigned to with the option to change; and
- If applicable, the name of another hospital the beneficiary will be assigned to, or can access in the service area.

In order for DHCS to evaluate the proposed change, the MCP must submit to DHCS a narrative of how the MCP intends to continue to provide covered services to affected beneficiaries. The narrative should include:

- The number of beneficiaries who will need to change PCPs due to the terminating hospital having a primary care clinic, or having a PCP with admitting privileges only at the terminating hospital;
- The number of beneficiaries who do not need to change PCPs, but will rely on hospitalists to access hospital services;
- The number of beneficiaries who will need to change PCPs and cannot be reassigned to another PCP within the time and distance standards;
- The number of beneficiaries who must change specialists due to the termination;
- The number of beneficiaries who must change specialists due to the termination and do not have access to another appropriate specialist within 30 miles;

- A list of specialty services available at the terminating hospital not available at other hospitals within 30 minutes or 15 miles from the terminating hospital; and
- A list of contracted hospitals within 30 minutes or 15 miles of the terminating hospital.

If, prior to a contract termination, MCPs successfully negotiate an agreement with a 1) subcontracted provider; 2) clinic or PCP; 3) IPA or medical group; or 4) a hospital after sending a notice of termination to affected beneficiaries, MCPs must send another notice to inform beneficiaries of the continuation of the contractual relationship. MCPs must immediately inform and submit a notice to DHCS for review and approval. The notice should include, at a minimum:

- An explanation that an agreement has been reached with the subcontracting entity;
- An explanation of the beneficiary's option to remain with, or change providers;
- All language required by H&S Code (exception: beneficiary notices for COHS plans in which non-applicable requirements should be omitted from the notice); and
- Language providing the beneficiary with the MCP's Member Services telephone number and the toll-free telephone number of DHCS's Office of the Ombudsman.

### **Federal and/or State Initiated Suspensions, Terminations, and Decertifications**

Welfare and Institutions (W&I) Code Sections 14043.6 and 14123 require DHCS to suspend Medi-Cal providers from participation in the Medi-Cal program when an individual or entity has:

- Been convicted of a felony;
- Been convicted of a misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Been suspended from the federal Medicare or Medicaid programs for any reason;
- Lost or surrendered a license, certificate, or approval to provide health care; or
- Breached a contractual agreement with DHCS that explicitly specifies inclusion on the Suspended and Ineligible Provider List as a consequence of the breach, thus providers cannot be paid post the effective suspension, termination, or decertification date.

Upon the issuance of a notice of provider suspension, termination, or decertification from Medi-Cal, DHCS will immediately contact MCPs via email, and provide them with information on the suspended, terminated or decertified provider. DHCS will advise MCPs of the termination and provide a copy of the notice, which will provide guidance on the effective date of the Medi-Cal suspension, termination, or decertification. DHCS will provide any other supporting documentation to MCPs when available.

In response to a discovery or final notification of provider suspension, termination, or decertification, the MCP must immediately:

- Communicate the notification to all related downstream entities including subcontractors and delegated entities;
- Ensure the provider receives no payment for Medi-Cal services provided on or after the effective date of action; and
- Maintain ongoing communication with DHCS about the transition of any affected beneficiaries.

After receiving final notification of a provider suspension, termination, or decertification, the MCP must:

- Communicate the provider termination notice to all related delegated entities, subcontractors, impacted beneficiaries or the beneficiaries guardian, conservator, or personal representative as applicable (within three business days); and
- Ensure the safe transition of beneficiaries to a new provider for services and if necessary, and be on-site to ensure effective logistical transport of personal belongings.

Within three business days of receiving a final notification, the MCP must provide DHCS with the following:

- Contract status (by delegated entity, if applicable) with the named provider; and
- The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, Medi-Cal Managed Long Term Services and Supports, or Cal MediConnect.



Within five business days of receiving a final notification of provider suspension, termination, or decertification, the MCP must:

- Submit a transition plan to DHCS for approval that includes:
  - A timeline for prompt transition of affected beneficiaries no sooner than 30 days after notification of the Medi-Cal suspension, termination, or decertification unless the beneficiary wishes to move sooner;
  - A timeline for the MCP care manager to contact and speak with all affected beneficiaries;
  - A process to consult with the Long Term Care Ombudsman and other related entities as appropriate;
  - A process to work with affected beneficiaries, guardians, conservators, or personal representatives, as applicable, regarding the transition and the beneficiary's options or choices;
  - A process for the review of all affected beneficiaries' medical records including a process for communication with beneficiaries' providers as appropriate; and
  - A plan of action to ensure that beneficiaries' personal belongings are transitioned to beneficiaries' new providers in a timely manner.

Attachment A provides a template notice that must be used by all MCPs unless otherwise approved by DHCS. If an MCP chooses to create its own notice informing beneficiaries of a suspended, terminated, or decertified provider, the notice should include, at a minimum:

- The effective date of the termination;
- The name of the provider;
- A description of how the suspension, termination, or decertification will affect the beneficiary's access to covered services;
- All language required by H&S Code and the Knox-Keene Act (for Knox-Keene licensed plans);
- Language providing the beneficiary with the MCP's Member Services telephone number and the toll-free telephone number of DHCS's Office of the Ombudsman for questions or concerns;
- A description of how the MCP maintains the ability to continue to provide covered services to affected beneficiaries;
- The reason for the suspension, termination, or decertification; and
- The date the beneficiary notice will be mailed.

If residential, and the facility remains open, beneficiaries must have at least 30 days post-notice to transition to a new provider with the following exceptions:

- The safety of a beneficiary in a facility (e.g., Skilled Nursing Facility) is endangered;
- The health of a beneficiary in a facility is endangered;
- A beneficiary's health improves sufficiently so that the beneficiary no longer requires the services provided by the facility;
- A beneficiary's urgent medical needs require an immediate transfer or discharge;
- A beneficiary has not resided in a facility for 30 days or more;
- A beneficiary, his or her guardian, conservator, or personal representative has requested a transition to another facility; and
- A facility closes or is no longer operational.

Beneficiaries may choose not to transition to a new provider; however, they may become responsible for the costs of the services provided by the suspended, terminated, or decertified provider, and should be informed if they choose not to transition.

The aforementioned requirements pertaining to federal and/or state-initiated suspensions, terminations, and decertification are held to be applicable across all the various provider types, unless listed as an exception to the 30-day stay requirement. In the case of an immediate closure of a provider by the California Department of Public Health (CDPH), CDPH is responsible for the transition of all the affected beneficiaries. MCPs are responsible for tracking the transition of these beneficiaries and coordinating care as needed.

DHCS will provide assistance to all MCPs during this process. All submissions, communications and MCP updates should be sent to [pmmp.monitoring@dhcs.ca.gov](mailto:pmmp.monitoring@dhcs.ca.gov).

Attachment B outlines CDPH's annual or compliant investigation process. For a process outline, please refer to the attached survey decision chart.

MCPs will not receive payment for services provided after the decertification, suspension, or termination date. Services paid for by the MCP must not be included in the MCP's rate development template. Requirements for MCPs to pay a provider after the decertification, suspension, or termination date are dependent on language set forth in the contract between the MCP and the provider. DHCS encourages MCPs to amend provider contracts that do not include language regarding payment to providers who have been decertified, suspended, or terminated from the Medi-Cal program.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

*Original Signed by Nathan Nau*

Nathan Nau, Chief  
Managed Care Quality and Monitoring Division  
Department of Health Care Services

Attachment(s)

## **Important Information on your Medi-Cal Services**

John Sample  
1234 Sample Street  
Address 2  
Anytown, CA 90000

XX/XX/XXXX

The purpose of this letter is to let you know of changes in your facility's relationship with the Medi-Cal (and Medicare) program and how these changes affect you.

On XX/XX/XXXX, Medi-Cal (and Medicare) will stop paying for you to get care at <Insert facility name>. You will need to choose a new facility. A facility is the place where you live and get your care.

### **Why do I have to choose a new facility?**

State law says that you can only get services from a licensed provider. And they must meet Medi-Cal certification requirements. <Insert facility name> no longer meets all of the requirements to be a Medi-Cal provider. So you will need to choose a new facility.

This letter tells you your options. And it tells you how to choose a new facility. You do not need to move to a new place until <XX/XX/XXXX>. But you can choose to move sooner.

### **How will this change affect me?**

<Insert facility name> will:

- Still provide services to you while you are living there.
- Work with us to arrange your move to a new place.
- Assess your social and physical functions. This will help us make sure that you are placed in a new health care facility that is best for you.

<Insert plan name> will:

- Work with <Insert facility name> to plan your move.
- Move your medical records, clothes, and other items to your new place.
- Contact you to talk about your options. We can also contact your family or legal guardian.
- Check in with you after you move to see how you are doing.

### **How do I choose a new facility?**

A care manager with <Insert plan name> will contact you soon. Your care manager will tell you your options and can answer your questions or concerns. We will work with you to choose a new place to live. We can also work with your family or other person that helps you to choose a new facility.

The California Advocates for Nursing Home Reform (CANHR) has a web site. It has information that can help you choose a new facility. Here is the link to the web site: [http://canhr.org/NH\\_Data/index.html](http://canhr.org/NH_Data/index.html).

**What if I don't want to move?**

If you want Medi-Cal to pay for your care, you will need to move to a new place by <XX/XX/XXXX>. If you stay at <Insert facility name> after <XX/XX/XXXX>, you may have to pay for some or all of your services.

**What if I have questions?****Health Plan Contact Information**

If you have questions, you can ask your care manager or call us at:

<Insert plan contact information>

**Long-Term Care Ombudsman**

You may also call your Long-Term Care Ombudsman. The Long-Term Care Ombudsman is trained to help with questions or problems about the nursing home and to assist you in exercising your rights. Your long-term care ombudsman is <Insert name of local long-term care ombudsman> and can be contacted at XXX-XXX-XXXX.

CCI Ombudsman

If you want help with problems or you have a complaint about your health plan, you should contact the CCI Ombudsman at 1-855-501-3077.

**Please do not call your eligibility worker about these changes. This change does not affect your Medi-Cal eligibility.**

