DEPARTMENT OF HEALTH CARE SERVICES

2024 MEDI-CAL MANAGED CARE PLAN TRANSITION POLICY GUIDE

Version 7 – March 22, 2024

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

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I. Updates from Prior Versions

If the requirements contained in this Policy Guide, including any updates or revisions to the Policy Guide or APL 23-018, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Manager within 90 days of the release of the Policy Guide or its updates. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD Contract Manager within 90 days of the release, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of the APL or Policy Guide, as well as the applicable release date in the subject line. Policies are effective upon release of the Policy Guide and its updates, regardless of status of P&P refinements.

- **ORIGINAL – Version 1**: June 23, 2023 – Includes introduction and policies related to protections for American Indian and Alaska Native members, member enrollment and noticing, and Continuity of Care.
- **Version 2**: June 30, 2023 – Updated to include transition policies for Enhanced Care Management (ECM) and Community Supports.
- **Version 3**: August 7, 2023 – Updated to include ***NEW*** Continuity of Care Data Sharing policy as well as:
    - Updates to the Member Enrollment and Noticing policy, including changes to noticing required for members enrolled in a Kaiser subcontract transitioning to Kaiser prime membership
    - Updates to the Continuity of Care policy, including:
        - Extension of some Continuity of Care protections to 6 months
        - Addition of members who are residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD) to Special Populations
        - Addition of Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD) to provider types eligible for Continuity of Care for providers
        - Addition of language to address inpatient billing responsibilities among Previous and Receiving MCPs
    - Updates to ECM and Community Supports Transition Policies to align with the ECM and Community Supports Policy Guides
    - Updates to the Appendix: County Level MCP Transitions to reflect the changes to noticing required for members enrolled in a Kaiser subcontract transitioning to Kaiser prime membership

- **Version 4:** September 29, 2023 – Updated to include ***NEW*** MCP Transition Monitoring and Oversight policy and ***NEW*** Transition-Related Requirements for Incentive Programs as well as:
    - Updates to the Protections for American Indian and Alaska Native Members policy regarding newly eligible members and Non-Medical Exemption requests
    - Updates to the Member Enrollment and Noticing policy, including on enrollment for children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code
    - Updates to the Continuity of Care policy on PCP retention and assignment
    - Updates to ECM and Community Supports Transition policies on mitigating provider disruption through timely payment of claims
    - Updates to the Continuity of Care Data Sharing policy including updates to reporting templates: two accompanying Excel Attachments for Previous MCP Provided Data, *Continuity of Care (CoC) Data Template - 1) Data Elements for All Members* and *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data*
    - Updates to the Appendix: County-Level MCP Transitions
- **Version 5:** November 7, 2023 – Updated to include ***NEW*** summary of Communication resources and ***NEW*** Transition Policy for Assessment and Screening Tools. The latest Policy Guide also includes:
    - Updates to the Data Sharing section clarifying the Plan Transfer Status Report layout and file naming convention
    - Updated dates for Previous MCP data sharing and Receiving MCP submission of baseline MCP member call center data
    - Additional technical updates in the Appendix
- **Version 6:** February 23, 2024 – Updated to include revisions to the following sections:
    - Updates to the Continuity of Care policy to include enforcement action through imposition of Corrective Action Plans (CAPs) for failure to meet the Primary Care Provider (PCP) retention requirement
    - Updates to the Transition Monitoring and Oversight Reporting Requirements policy to include clarification and addition of PCP retention and Continuity of Care data elements, and data file transmissions
    - Updates to the Transition Policy for Assessments and Screening Tools to align with the Population Health Management Policy Guide

- **Version 7:** March 25, 2024 – Updated to revise date of reporting for select data elements in the section on Transition Monitoring and Oversight Reporting Requirements, and corrected hyperlink errors.

Questions on the Policy Guide should be sent to MCPTransitionPolicyGuide@dhcs.ca.gov.

II. Introduction

The California Department of Health Care Services (DHCS) is transforming Medi-Cal to ensure that Californians have access to the care they need to live healthier lives. Beginning in 2024, Medi-Cal managed care plans (MCPs) will be subject to new requirements to rigorously advance health equity, quality, access, accountability and transparency to improve the Medi-Cal health care delivery system. As part of this transformation, some Medi-Cal MCPs are changing on January 1, 2024 as a result of four changes in how DHCS contracts with Medi-Cal MCPs, described below. *Collectively, these changes comprise the January 1, 2024, MCP Transition (referred to in this Policy Guide as the MCP Transition).*

- **New commercial MCP contracts:** On December 30, 2022, DHCS announced an agreement with five commercial MCPs to serve Medi-Cal members in 21 counties.
- **County-level Medi-Cal managed care model change:** In 2021, DHCS conditionally approved 17 counties to change their Medi-Cal managed care model, subject to operational readiness. Counties are shifting to one of three local plan models – Two Plan, County Operated Health System (COHS), or the new Single Plan model.
- **Contract with Kaiser Foundation Health Plan (Kaiser):** Kaiser will expand its Medi-Cal MCP contract to 32 counties and begin serving new populations, subject to a new agreement with DHCS.
- **Changes in subcontracted MCP participation:** DHCS will require Health Net in Los Angeles County to assign its subcontractor Molina 50% of its total membership in Los Angeles County. In addition, some subcontracted MCPs will serve different counties starting January 1, 2024.

Together, these changes will result in approximately 1.2 million Medi-Cal managed care members having new MCP options. In some cases, these changes will also require members to transition to new MCPs if their current MCP no longer serves members in their county. Section IV, Member Enrollment and Noticing summarizes MCP changes by county and the Appendix includes detailed transition information for each county.

DHCS Guiding Principles

DHCS is working proactively to minimize disruptions to members during the MCP Transition, including by developing this 2024 MCP Transition Policy Guide (Policy Guide), and will continue partnering with MCPs and stakeholders leading up to and after transition. DHCS' principles guiding the planning, implementation and oversight of the 2024 MCP Transition are to:

- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from disruptions in care.

- Provide outreach, education and clear communications to members, providers, MCPs, and other stakeholders.
- Proactively measure and ensure accountability of MCPs' transition responsibilities.

Purpose and Scope of the MCP Transition Policy Guide
This Policy Guide contains DHCS policy and related MCP requirements related to member transitions among Medi-Cal MCPs that take effect on January 1, 2024, including:

- **Member Enrollment and Noticing,** including member noticing requirements and member enrollment policies applicable to transitioning and new members.
- **Continuity of Care (CoC)** requirements for members transitioning due to MCP contracting changes effective January 1, 2024.
- **Enhanced Care Management (ECM) and Community Supports Transition** requirements related to members receiving those services at the time of the 2024 MCP Transition.
- **Data Sharing,** including sharing from DHCS to MCPs and between MCPs, required to minimize transitioning member disruptions and to implement related CoC, noticing and enrollment policies.
- **Monitoring and Oversight** of MCPs' compliance with requirements in the Policy Guide.
- **Transition-Related Requirements for Incentive Programs,** including how MCP contracting changes intersect with MCP incentive programs ~~and other policies~~.
- **Communication,** including key messages and collateral for explaining the transition to members and providers.

Managed Care All Plan Letter (APL) 23-018 establishes the binding nature of this Policy Guide as the DHCS authority specific to the 2024 MCP Transition. The Policy Guide contains guidance for MCPs' transition-related activities rooted in existing applicable APLs and contract requirements, as well as new MCP requirements. MCP transition requirements addressed in this Policy Guide also apply to MCPs' fully delegated subcontractors. MCPs should use this Policy Guide to develop their policies and procedures required to implement member transitions. While MCPs are the primary audience for the Policy Guide, DHCS envisions that a wide range of stakeholders will find it useful in supporting smooth member transitions.

The policies and requirements in the Policy Guide do **not** apply to routine member-initiated transitions between MCPs. The Policy Guide does not include guidance related

to exiting MCP phase-out requirements, Whole Child Model expansion, or MCP operational readiness.

The Policy Guide will be updated throughout calendar year 2023 to keep MCPs informed of new and developing guidance. Updates to this Policy Guide are effective upon publication on the DHCS website, which will be announced to MCPs via standard communication channels. Refer to Section I, Updates from Prior Version for more information.

Key Terms
Throughout the Policy Guide, MCPs will be referred to with various terminology as applicable to the policy at hand. Specifically, MCPs may be referred to as:

- **Previous MCPs, which includes Exiting MCPs**
- **Receiving MCPs, which includes Continuing MCPs and Entering MCPs**

Please refer to the Glossary for a list of key terms and their definitions.

III. Protections for American Indian and Alaska Native Members

The 2024 Managed Care Plan (MCP) Transition does not change existing protections for the American Indian and Alaska Native (AI/AN) population voluntarily enrolled in managed care. Under both Federal and State Medi-Cal policy, MCPs must provide for AI/AN members enrolled in managed care to receive services from an Indian Health Care Provider (IHCP) of their choice regardless of whether the IHCP is a Network or Out-of-Network (OON) provider. MCPs are required to make payments to Network and OON IHCPs for services provided to eligible AI/AN members at either the applicable All-Inclusive Rate (AIR) set by the Office of Management and Budget (OMB) for Tribal Health Programs or at the Prospective Payment System (PPS) Rate for Urban Indian Organizations participating in Medi-Cal as a Federally Qualified Health Center (FQHC). AI/AN members are exempt from enrollment fees, premiums, and cost sharing provisions such as deductibles and co-payments.[1] All of these protections remain in effect for AI/AN members in managed care, regardless of whether or not they are required to transition to a new MCP on January 1, 2024. AI/AN members of MCPs who are accessing care from non-IHCPs are subject to the same Continuity of Care protections as all MCP members. Members of MCPs who are not AI/AN and who are accessing care from IHCPs are also subject to the same Continuity of Care protections as all MCP members. Please see Section V, Continuity of Care for more information.

In counties that are changing to a COHS or Single Plan Model, members will be mandatorily enrolled into managed care effective January 1, 2024. As a result, members with a currently approved Non-Medical Exemption request and, beginning in Q4 2023, newly eligible members, will be automatically enrolled into an MCP in their county, effective January 1, 2024. Members have the right to be seen at an IHCP regardless if that IHCP is contracted with the MCP and the MCP must pay the All-Inclusive Rate.

Newly eligible members in counties that operate as Two-Plan, Geographic Managed Care (GMC), or Regional Model will be automatically enrolled into a new MCP, if they do not make an active plan choice on their own. Members in these counties can submit a Non-Medical Exemption request to opt out of managed care. Members with a currently approved Non-Medical Exemption request in a Two-Plan, GMC, or Regional Model, will not receive member notification and will not be enrolled into an MCP.

For further guidance, please reference All Plan Letters 09-009, 17-020, and 21-008 and their associated attachments.

[1] Title 19 SSA section 1916(j); 42 U.S.C. §1396o(j); 42 CFR Sections 447.56 and 457.535

IV. Member Enrollment and Noticing

A. Introduction

This Section includes information and policies related to member enrollment and noticing in counties affected by MCP transitions resulting from Medi-Cal managed care model changes, commercial MCP contract changes and the Kaiser Foundation Health Plan (Kaiser) direct contract effective January 1, 2024. These changes are outlined by county on the DHCS website and detailed in the Appendix to this Policy Guide. This Section applies to member enrollment and noticing policy related to prime MCP transitions. For guidance related to member enrollment and noticing specific to subcontracted MCP terminations, please refer to APL 21-003.

This information is primarily intended to enable plans, providers and other stakeholders to understand transition-related enrollment and noticing processes and timing so that they may plan for effective transitions and support of Medi-Cal members. Consistent with the terms of Managed Care All Plan Letter (APL) 23-018, it also includes MCP requirements related to noticing, data transfer to DHCS, and member assignment to subcontractors that are transitioning to a prime plan in 2024. **As most of the content in this section is intended to provide broader context, MCP requirements are flagged throughout for ease of reference.** Some policies are contingent on State or federal approval, and all are subject to change.

Specifically, this Section includes:

- Transition Noticing policies for:
  - Members of exiting MCPs
  - Members with "automatic" transitions
- Transition Enrollment policies for:
  - Exiting MCP members in Choice Counties
  - Exiting MCP members in COHS expansion / Single Plan counties
- Exiting MCP New Enrollment Freeze Policy
- Enrollment and Noticing Policies Specific to Kaiser Direct Contract

B. Transition Noticing Policy

1. Noticing for Members of Exiting MCPs

*** *MCP Requirement* * Exiting Medi-Cal managed care plans (MCPs) – prime MCPs ending operations in a county due to MCP model change or a change**

in commercial contracting – will send a "90-day" notice to members enrolled as of September 2023 month of enrollment (MOE), with limited exceptions noted below. The "90-day" notices will inform members of their MCP's upcoming exit from their county and indicate that additional information is forthcoming from DHCS regarding their MCP enrollment for 2024. DHCS provided the draft "90-day" notice templates with exiting MCPs in May 2023.

DHCS' enrollment broker, Medi-Cal Health Care Options (HCO), will send "60-day" notices (no later than November 1) and "30-day" notices (no later than December 1) to members of exiting MCPs.

- In **MCP choice counties**—including GMC, Two-Plan, and Regional Medi-Cal managed care model counties – the "60-day" and "30-day" notices will include information on:
    - Transitioning members' default MCP and other available MCP option(s); and
    - Actions members need to take to make an active MCP choice.

- In **COHS expansion and Single Plan counties without a Kaiser MCP option in 2024**, the "60-day" and "30-day" notices will inform transitioning members of their automatic enrollment into the relevant COHS or Single Plan on January 1, 2024.

- In **COHS expansion and Single Plan counties with a Kaiser MCP option in 2024**, the "60-day" and "30-day" notices will inform members of their default assignment to the COHS / Single Plan or to Kaiser and provide information about their other option (the COHS / Single Plan for members default assigned to Kaiser, or informing the member of Kaiser active choice option subject to eligibility criteria for members default assigned to the COHS / Single Plan). (*See Section IV.E, Kaiser Direct Contract for more details on Kaiser enrollment.*)

- In all counties with an exiting MCP, the DHCS/HCO "60-day" and "30-day" notices will also provide members with contact information for questions or complaints and a link to a Notice of Additional Information (NOAI) that will be posted on the DHCS and HCO website and accessible through a Quick Reference (QR) code included in the notices. The NOAI will include additional information on Medi-Cal Managed Care, how to make an active MCP choice, Medi-Cal and Medicare services, and how to access continuity

of care protections. The link to the NOAI will also be included in the "90-day" notice from exiting MCPs.

MCP Requirement Exiting MCPs and DHCS/HCO must provide the NOAI as a print copy by mail or in an alternative format for any member who requests it.[2]

2. Noticing for Members with "Automatic" Transitions

Members meeting the following criteria will be automatically enrolled into an MCP to maintain continuity of their current coverage during the 2024 MCP transition. Noticing for these members will vary from the standard noticing approach discussed above. These "automatically transitioning" members include:

- **Members who are delegated to Kaiser as a subcontractor** will be automatically enrolled with the Kaiser prime MCP effective January 1, 2024.
    - ***MCP Requirement*** In applicable counties, **Kaiser and the exiting or continuing prime MCP for which Kaiser is a subcontractor** will agree upon and submit to DHCS by December 4, 2023, a list of members enrolled in Kaiser as a subcontractor.
    - ***MCP Requirement* Kaiser** will draft and transmit "60-day" and "30-day" notices (no later than November 1 and December 1, 2023, respectively) to these members indicating their transition from subcontractor to prime MCP and that there is no change to their provider network nor member services.

- **Members enrolled in California Health & Wellness (CHW) in December 2023 who will transition to Health Net on January 1, 2024,** in the five counties for which Centene (parent company) elected to transition contracts with DHCS between its subsidiaries California Health & Wellness and Health Net.
    - ***MCP Requirement* CHW** will draft and transmit a "30-day" notice (no later than December 1, 2023) **co-branded with Health Net** to these members, indicating CHW changing to Health Net and that there is no effect on the member's provider network nor member services.

[2] For overview of alternative format options, please refer to APL 21-004.

In counties participating in the Medi-Cal Matching Plan[3] policy, if a Dual-eligible member's Medicare Advantage plan is run by the same parent company as an entering Medi-Cal MCP, that member will also automatically be transitioned to the matching Medi-Cal plan. This policy is applicable to both existing members and new members in the relevant counties. See Appendix for more information.

3. Noticing for Members with Medical Exemption Requests (MER)

In **COHS expansion / Single Plan counties**, members with a MER on file will remain in FFS until their MER expires, even after county model changes are implemented. DHCS will stop processing new MER requests in COHS expansion / Single Plan counties for October 2023 month of enrollment.

Members enrolled in FFS Medi-Cal due to an approved medical exemption request (MER), will remain in FFS until their MER expires and will receive a 45-day notice (45 days before their MER expires) informing them that they:

- Are unable to extend their MER because MERs are no longer available in the county that they live in.
- Will be automatically enrolled into a Medi-Cal managed care health plan in their county.

The notice will include a QR code that links to the NOAI that provides additional information.

C. Transition Enrollment Policy

1. Enrollment for Exiting MCP Members in Choice Counties

In MCP choice counties (GMC, Two-Plan, and Regional Medi-Cal managed care counties) with a January 2024 MCP transition, **members enrolled in Continuing MCPs** will remain in their current MCP, unless they opt to change MCPs (as is their right under current member choice policies) or unless they are transitioned based on the Medi-Cal Matching Plan policy for Dual-eligible members.

Members of Exiting MCPs will receive a choice packet from HCO with their "60-day" notice no later than November 1, 2023, including all 2024 MCP options. Members will have until approximately December 22, 2023, to make an active MCP choice. If they do not make an active choice by the cut-off date, they will be

[3] See DHCS' website for Medi-Cal Matching Plan Policy.

enrolled into the default MCP as indicated in their "60-day" and "30-day" notices, effective January 1, 2024.

Consistent with current DHCS practice during a transition, **default assignment** will be based on the following assignment hierarchy:

- **Provider Linkage** The member is default-assigned to the MCP which has the member's primary care provider (PCP) of record within their network, if only one MCP has this provider in network.

- **Plan Linkage**: If there is no provider linkage, or if more than one MCP has the member's current PCP in-network, the member is assigned to the MCP in which they were most recently enrolled, if applicable;

- **Family Linkage**: If there is no provider or prior plan linkage, or if the member has provider or Plan linkage to more than one MCP, the member is assigned to the MCP in which a family member is currently enrolled, if applicable.

- **Auto-Assignment:** If a member does not meet any of the "linkage" criteria above, their default MCP will be based on **the Auto-Assignment Incentive Program algorithm**, which uses quality and other adjustments for an annually-defined ratio of members for auto-assignment among MCPs in each county.

The default MCP will receive member-level data following the "60-day" notice to enable advance transition planning and fulfillment of related transitioning member obligations (See Section V, Continuity of Care and Section VIII, Continuity of Care Data Sharing Policy). However, members in choice counties will have until approximately December 22, 2023, to make an active choice, and the default MCP may not ultimately receive the enrollment (i.e., if the member chooses another MCP). The exact date to make an active choice will be indicated on the enrollment packet the member receives.

In Medi-Cal Matching Plan policy counties,[4] members enrolled with a Medicare Advantage plan that has a Medi-Cal MCP with the same parent company are automatically enrolled into the matching Medi-Cal MCP and will not go through the above default assignment process. This process is carried out by HCO for prime MCPs, and is carried out by the prime MCPs for subcontracted MCPs. This

[4] See DHCS' website for Medi-Cal Matching Plan Policy

does not change or affect members' choice of a Medicare Advantage plan. In these counties, Dual-eligible members will receive notices with tailored information about the Medi-Cal Matching Plan policy and the name of the MCP in which the member will be enrolled based on their Medicare Advantage plan enrollment, if applicable.[5] Members will not be compelled to change their Medicaid Advantage plan, but would need to do so if they want to enroll into a Medi-Cal MCP that does not match their Medicare Advantage plan.

In Sacramento County, Aetna (exiting MCP) members will have the option of active choice among all MCPs operating in 2024. However, default assignment will be limited to Anthem and Molina only. The Medi-Cal Matching Plan policy will also apply to all 2024 MCPs in relevant counties.

2. Enrollment for Exiting MCP Members Residing in COHS Expansion & Single Plan Counties

In counties transitioning to the Single Plan Medi-Cal managed care model, members enrolled with an MCP that will continue to operate in 2024 as the Single Plan will remain in their current MCP, unless transitioned based on the Medi-Cal Matching Plan policy for Dual-eligible members. This includes Alameda Alliance for Health members in Alameda County, Contra Costa Health Plan members in Contra Costa County, and members in a Kaiser subcontract to a prime MCP.[6] In counties transitioning to the COHS model ("COHS expansion" counties), all current prime MCPs are exiting in 2024, except Kaiser in Placer County where it is currently a prime MCP.

All members enrolled in an exiting MCP in counties transitioning to the Single Plan and COHS models will be automatically enrolled into either the Single Plan, COHS, or Kaiser, effective January 1, 2024. *See below Section on Kaiser Direct Contract for more information on enrollment in those COHS expansion and Single Plan counties where Kaiser will operate.*

[5] See DHCS' website for Medicare Medi-Cal Plans.

[6] Kaiser Foundation Health Plan is considered a continuing MCP in counties where it is transitioning to a prime MCP in 2024 from a subcontract arrangement with a current prime MCP.

3. Enrollment for Children or Youth Enrolled in the Foster Care System and Identified With a Foster Care Aid Code, As Well As Members in a Former Foster Care Aid Code

In counties transitioning to **Single Plan** Medi-Cal managed care model, per the Budget Act of 2023 (AB 118), children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code, will transition to mandatory managed care enrollment in 2025. The following policy will apply to children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code, that reside in a county transitioning to the Single Plan **(i.e., Alameda, Contra Costa, Imperial)**:

- Members currently enrolled in FFS will not receive transition notices in late 2023, as MCP options were presented to them during their initial choice period or annual renewal; and
- Members in an exiting MCP will receive a 90-day notice from the Exiting MCP and 60- and 30-day notices from HCO. Members will have the option to choose a new MCP or transition to Medi-Cal FFS until mandatory managed care enrollment becomes effective.

In **COHS expansion counties**, children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code, will transition to mandatory managed care enrollment, effective January 1, 2024. See above Section on *"Noticing for Members of Exiting MCPs"* for member noticing information.

In MCP choice counties **(GMC, Two-Plan, and Regional Medi-Cal managed care counties**), children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code, remain voluntary and can choose either a managed care plan or Medi-Cal FFS. See above Section on *"Noticing for Members of Exiting MCPs"* for member noticing information.

D. Enrollment Freeze for Exiting MCPs in Quarter 4 (Q4) 2023

Consistent with other recent MCP market exits, DHCS will stop **new** enrollment into exiting MCPs (both for active choice and default assignment) three months prior to the MCP's exit from a county. The last enrollment into an exiting MCP in a county will occur during September 2023 MOE, with the new enrollment freeze

taking effect for October 2023 effective enrollments. This policy applies to new enrollment only for exiting MCPs – inclusive of newly eligible members, current members transitioning to a new county, and existing members who decide to enroll with a new MCP in late 2023. Exiting MCPs will retain their existing membership though December 31, 2023, unless the member makes an active choice to choose a different prime MCP before then.

The exiting MCP new enrollment freeze has implications for choice and enrollment options for new Medi-Cal members in Q4 2023. In **MCP choice counties (i.e., GMC, Regional, Two-Plan model counties)** with at least one exiting MCP in 2024, DHCS/HCO will issue new MCP choice packets for newly eligible Medi-Cal members beginning September 1, 2023, that:

- *Exclude* exiting MCPs; and
- *Include* all 2024 MCP options, including those that are not yet operating in the county ("Entering MCPs") as well as MCPs that currently operate in the county and will continue operations in 2024 ("Continuing MCPs").

Default assignment for new members[7] in Q4 2023 will also exclude Exiting MCPs and include all 2024 MCP options. Members who actively choose a Continuing MCP or enroll into a Continuing MCP based on default assignment will be enrolled into the Continuing MCP on the first of the following month. The MCP enrollment effective date for members who enroll in an Entering MCP (by choice or default assignment) will be January 1, 2024, when the Entering MCP begins operations; these members will remain in Medi-Cal fee-for-service (FFS) until their MCP enrollment is effective on January 1, 2024.

In **Single Plan and COHS expansion counties,** new members in Q4 2023 will be automatically enrolled into the Single Plan or COHS for their county, or Kaiser where relevant. Specifically:

- In **Alameda and Contra Costa counties,** Alameda Alliance for Health and Contra Costa Health Plan currently operate and will transition to the Single Plan model effective January 1, 2024. New members in these counties starting with October 1, 2023, effective enrollments will be automatically enrolled into either the Single Plan or Kaiser based on default assignment and Medi-Cal Matching Plan policy. Members may then make an active MCP choice to change between the Single Plan and Kaiser (except for members with

[7] Includes newly eligible members and members enrolling with a new MCP due to an address change between counties.

matching Medicare Advantage plan), with Kaiser enrollment subject to eligibility criteria (*see "Kaiser Direct Contract" below*).
    - Members automatically enrolled into Alameda Alliance or Contra Costa Health Plan will have an enrollment effective date of first of the month following their MCP assignment.
    - Members automatically enrolled into Kaiser on the basis of plan / family linkage default assignment (*see "Kaiser Direct Contract" below*), Medi-Cal Matching Plan policy or actively enrolling in Kaiser subject to eligibility criteria will remain in Medi-Cal FFS until their Kaiser enrollment is effective on January 1, 2024 (when Kaiser begins operating as a prime MCP in these counties).
    - ***MCP Requirement** * New enrollment into the Kaiser subcontract will end effective September 2023 MOE, after which time Alameda Alliance for Health and Contra Costa Health Plan will not assign new members to Kaiser as a subcontractor. Exceptions may be made to protect continuity of care, specifically if the member is in active treatment with Kaiser and is requesting assignment to Kaiser prior to January 1, 2024 (*see below for more detail*).

- In **Imperial county**, California Health and Wellness (CHW) will be considered a continuing MCP under DHCS' transition-related enrollment policy due to the intended subcontract arrangement by Community Health Plan of Imperial Valley (CHP-IV), the Single Plan MCP beginning in 2024.[8] In October 2023 MOE, DHCS will stop new enrollment into Molina (the Exiting MCP); Molina will retain existing members through December 31, 2023. Molina members will be automatically enrolled into either CHP-IV or Kaiser based on default assignment. Members may then make an active MCP choice to change between CHP-IV and Kaiser, with Kaiser enrollment subject to eligibility criteria. All new members in Q4 2023 will be automatically assigned to CHW. These members will automatically transfer to CHP-IV on January 1, 2024, and may make an active MCP choice to change to Kaiser, subject to eligibility criteria.
    - ***MCP Requirement** * **CHW** will draft and transmit a "30-day" notice (no later than December 1, 2023) co-branded with CHP-IV to all of its members, indicating CHW is changing to CHP-IV. There are no anticipated member experience or provider network changes associated with this transition.

[8] CHP-IV intends to fully delegate all of its members to Health Net as a subcontracted MCP, which shares a parent company with California Health and Wellness (CHW).

In **COHS expansion counties**, all current prime MCPs are exiting the Medi-Cal market effective January 1, 2024, with the exception of Kaiser in Placer County. Beginning in Q4 2023, newly eligible members in these counties will be automatically enrolled into the COHS or Kaiser, where relevant (*see "Kaiser Direct Contract" below*), for enrollment effective January 1, 2024. These members will remain in Medi-Cal FFS until their MCP enrollment is effective.

In **GMC counties** with an exiting EAE D-SNP, dual eligible members that are currently enrolled in an exiting EAE D-SNP will receive notice from DHCS. Specifically:

- In **Sacramento county,** Aetna is exiting the market in 2024. Members enrolled with Aetna Medicare Advantage Plan in Sacramento county will not be compelled to change Medicare Advantage plans and will receive a notice from DHCS that they are in a misaligned D-SNP/Medi-Cal MCP, effective January 1, 2024.
- In **San Diego county**, Aetna and Health Net are exiting the market in 2024. Members enrolled with Aetna or Health Net/Wellcare Medicare Advantage Plan will not be compelled to change Medicare Advantage plans and will receive a notice from DHCS that they are in a misaligned D-SNP/Medi-Cal MCP, effective January 1, 2024.

E. Kaiser Direct Contract

Consistent with AB2724 and the DHCS-Kaiser Memorandum of Understanding (MOU), Kaiser is currently undergoing operational readiness activities to operate as a Medi-Cal prime MCP in 32 counties in 2024, including 22 counties where Kaiser currently participates as a Medi-Cal MCP today (either as a prime MCP or subcontracted MCP) and in 10 additional counties where Kaiser currently operates another line of business. Members will be eligible to enroll into Kaiser via active choice if they:

- Have previously enrolled with a Kaiser Medi-Cal MCP at any point during calendar year 2023;
- Are an existing Kaiser member and transitioning into Medi-Cal managed care;
- Were previously enrolled with Kaiser, outside of Medi-Cal, during the 12 months preceding the effective date of their Medi-Cal eligibility;
- Were previously enrolled in a prime MCP other than Kaiser at any point during calendar year 2023 but were assigned to and made the responsibility of, Kaiser under a subcontract with that prime MCP;

- Have an immediate family member currently enrolled in Kaiser (i.e. a "family linkage")[9];
- Are dually-eligible for Medi-Cal and Medicare; or
- Are a child or youth enrolled in the foster care system and identified with a foster care aid code.

Kaiser will receive default assignment through plan and family linkage as well as the Auto-Assignment Incentive Program. Default assignment through the Auto-Assignment Incentive Program will be up to an enrollment growth target based on Kaiser's provider network capacity. Auto-assignment to Kaiser will not be subject to the above eligibility criteria; all members may be enrolled into Kaiser by auto-assignment regardless of their meeting these criteria. Once Kaiser reaches the enrollment growth target for a specific county for the year, DHCS will exclude Kaiser from the auto-assignment algorithm for that county. Kaiser enrollment based on active choice by eligible members and default assignment based on plan or family linkage will not count toward the enrollment growth target.

Kaiser's participation in auto-assignment will be phased in. For new members and transitioning members in Q4 2023, Kaiser default assignment will be limited to plan / family linkage only. For choice counties with a Kaiser option, Kaiser will participate in auto-assignment through the Auto-Assignment Incentive Program, starting with new enrollments effective July 2024. For COHS and Single Plan counties, including COHS expansion counties, Kaiser will participate in auto-assignment through the Auto-Assignment Incentive Program, starting with new enrollments effective January 1, 2025; default assignment to Kaiser in these counties will be limited to plan / family linkage only through 2024.

As noted above, members enrolled with Kaiser under subcontract arrangement in 2023 will maintain their enrollment with Kaiser as it transitions to a prime MCP. **** MCP Requirement **** *** The relevant prime MCP may not place any new members into the Kaiser subcontract after September 2023 MOE,** unless the

[9] Includes one or more of the following: spouse or domestic partner; a beneficiary's dependent child, foster child or stepchild under 26 years of age; a beneficiary's dependent who is disabled and over 21 years of age; a parent or stepparent of a beneficiary under 26 years of age; or a grandparent, guardian, foster parent, or other relative with appropriate documentation of a familial relationship of a beneficiary under 26 years of age as determined by the Department.

member is in active treatment with Kaiser and is requesting assignment to Kaiser prior to January 1, 2024.

In counties subject to the Medi-Cal Matching Plan policy where Kaiser will be a prime MCP in January 2024, Dual-eligible members with a Kaiser Medicare Advantage plan will be transitioned to the Kaiser Medi-Cal MCP. New Medi-Cal members with Kaiser Medicare Advantage enrollment will be automatically enrolled into Kaiser Medi-Cal MCP, consistent with practice for other prime MCP in Medi-Cal Matching Plan policy counties. These members will receive tailored noticing from DHCS, consistent with Medi-Cal Matching Plan policy precedent.

1. Enrollment & Noticing in Choice Counties in which Kaiser will Operate in 2024:

For members of **exiting MCPs in counties in which Kaiser will operate in 2024**, Kaiser will be included as a MCP option in the HCO choice packets that members will receive with the "60-day" transition notice. HCO choice packets will provide members information about Kaiser eligibility criteria. If a member actively chooses Kaiser, DHCS will determine if the member qualifies for Kaiser enrollment using available data. Kaiser will assist in determining eligibility on an as needed basis. If members are not eligible for enrollment, HCO will prompt them to select a new MCP. If members do not make an active choice, they will be enrolled into an MCP via default assignment. Default assignment for members of exiting MCPs will include plan / family linkage into Kaiser; Kaiser will not be included in the Auto-Assignment Incentive Program for these members.

In counties with one or more exiting MCPs that are subject to the new enrollment freeze in Q4 2023 *(discussed above)*, HCO will send choice packets to newly eligible members that include Kaiser as an option starting with new enrollment in October 2023. In counties with no exiting MCPs, HCO choice packets will include a Kaiser option for new enrollments effective January 2024. Active choice of Kaiser will be subject to eligibility criteria, which will be reflected in the choice packets. If a member actively chooses and is determined eligible for Kaiser in a county where Kaiser is an "Entering MCP" (i.e., Kaiser does not currently operate as a prime MCP), they will remain in Medi-Cal FFS until January 1, 2024. Default assignment for new members in Q4 2023 will include plan / family linkage into Kaiser; Kaiser will not be included in the Auto-Assignment Incentive Program for these members.

For **newly eligible members starting January 1, 2024,** HCO will include Kaiser in the choice packet with active choice subject to the same eligibility criteria

described above. Beginning in 2024, HCO choice packets will prompt members to select a "back up" MCP if Kaiser is their first choice, in the event that they do not qualify for Kaiser enrollment. Kaiser will be a full participant in the default assignment process beginning July 2024, including the Auto-Assignment Incentive Program, with auto-assignment limited to the county-specific Kaiser enrollment growth target described above. From January to June 2024, Kaiser default assignment participation will be limited to plan / family linkage.

For **members of continuing MCPs**, HCO will include information about the Kaiser option in annual renotification letters, distributed on each member's specific notification timeline. However, members may still request to enroll into Kaiser at any point starting January 1, 2024, by enrolling online or calling HCO, subject to eligibility criteria.

2. Enrollment & Noticing in Existing COHS Counties with a 2024 Kaiser Option:

Existing COHS members will remain enrolled with their current MCP, and may actively choose to enroll into Kaiser, subject to meeting eligibility criteria. If members requesting to move to Kaiser do not meet the Kaiser eligibility criteria, they will remain enrolled with the COHS.

Newly eligible members starting in Q4 2023 will be enrolled into either the COHS or Kaiser on the basis of default assignment and Medi-Cal Matching Plan policy, where applicable. Default assignment for Kaiser in existing COHS counties will be limited to plan / family linkage only until 2025, when a quality-based Auto-Assignment Incentive Program will take effect, with Kaiser auto-assignment up to its annual enrollment growth target. Members initially enrolled into the COHS or Kaiser may actively choose to change their enrollment to the other MCP option in their county through HCO, with Kaiser enrollment subject to eligibility criteria. Members that actively choose to change their enrollment from the COHS to Kaiser will maintain their enrollment with the COHS if they do not meet the Kaiser eligibility criteria.

3. Enrollment & Noticing in COHS Expansion and Single Plan Counties with a New 2024 Kaiser Option:

Exiting MCP members will receive "60-day" and "30-day" notices of their automatic enrollment into the applicable COHS, Single Plan, or Kaiser. Kaiser default assignment will be limited to plan / family linkage. Members initially enrolled into the COHS/Single Plan or Kaiser may actively choose to change

their enrollment to the other MCP option in their county through HCO (except for members with matching Medicare Advantage plan in Medi-Cal Matching Plan policy counties), with Kaiser choice subject to eligibility criteria. Members that actively choose to change their enrollment from the COHS or Single Plan to Kaiser will maintain their enrollment with the COHS / Single Plan if they do not meet the Kaiser eligibility criteria.

Current Alameda Alliance for Health and Contra Costa Health Plan members will not receive a transition notice informing them of the Kaiser MCP option at the time of the MCP transition, because Kaiser was an option during their initial choice period or previous annual re-notification. However, these members can still request to enroll into Kaiser at any point in 2024, subject to Kaiser eligibility criteria.

For **newly eligible members starting in Q4 2023**, members will be enrolled into either the COHS / Single Plan or Kaiser on the basis of default assignment. Default assignment for Kaiser in COHS and Single Plan counties will be limited to plan / family linkage only until 2025, when a quality-based Auto-Assignment Incentive Program will take effect, with Kaiser auto-assignment up to its annual enrollment growth target. Members initially enrolled into the COHS / Single Plan or Kaiser may actively choose to change their enrollment to the other MCP option in their county through HCO (except for members with matching Medicare Advantage plan). Members that actively choose to change their enrollment from the COHS or Single Plan to Kaiser will maintain their enrollment with the COHS / Single Plan if they do not meet the Kaiser eligibility criteria.

V. Continuity of Care

The Continuity of Care (CoC) Policy for the 2024 MCP Transition (Transition) provides guidance to Previous and Receiving MCPs, both Prime MCPs and their Subcontractors, about their obligations to ensure CoC for members required to change MCPs on January 1, 2024. Per APL 23-018, this policy contains details of MCPs' contractual requirements to ensure CoC for transitioning members.

On January 1, 2024, approximately 10 percent of Medi-Cal members will transition to new MCPs. The 2024 CoC Policy applies to members who change MCPs on January 1, 2024, for the following reasons:[10]

- The member's MCP exits the market
- The Subcontractor Agreement between the member's Prime MCP and the Subcontractor ends
- DHCS requires the Prime MCP to transition members to the Subcontractor

Leading up to and during the Transition, DHCS will work with MCPs to facilitate continued member access to high-quality, coordinated care. DHCS has established a robust CoC Policy for the 2024 MCP Transition that aims to minimize:

- Service interruptions, especially for members living with complex or chronic conditions (i.e., Special Populations)
- Member, provider, and MCP confusion
- Unnecessary administrative burden for members, providers, and MCPs

To accomplish these goals, the 2024 MCP CoC Policy aligns with and builds upon CoC protections under the Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96) and upon CoC protections for members who transitioned from Medi-Cal Fee-for-Service (FFS) to managed care in January 2023.[11, 12] The 2024 MCP CoC Policy was also informed by stakeholder

[10] This CoC policy applies to children and youth receiving foster care and former foster youth through age 25 transitioning from Fee-for-Service to managed care in COHS and Single Plan counties.

[11] State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.

[12] APL 22-032 can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

engagement, including MCP feedback and lessons learned from member transitions in 2023.

Achievement of these goals will also necessitate that MCPs engage in Transition activities during 2023, in advance of the January 1, 2024, effective date. Interaction with transitioning members who are not yet enrolled and out-of-network (OON) providers is expected to the extent necessary to curtail members' service disruptions and enhance access to care.

Transitioning members with other health coverage (OHC), such as Medicare or other private insurance, may continue to see a provider with whom they have a Pre-Existing Relationship, and may have their Medi-Cal MCP billed as secondary to their OHC, even if the provider is OON with the MCP. Providers will need to adhere to the MCP's billing requirements. Continuation of services from the OON provider for members with OHC without a CoC for Providers agreement in place (see Section V.C, Continuity of Care for Providers) is allowable since the OON provider will coordinate benefits and submit crossover billing when necessary.

The 2024 MCP CoC Policy applies to all Medi-Cal members who must change MCPs on January 1, 2024, including:

- Members who actively choose an MCP
- Members who are assigned to an MCP *(Note: All transitioning members will have the opportunity to choose a new MCP; if they do not choose a new MCP by the established deadline, DHCS will assign them to an MCP.)*

The 2024 MCP CoC Policy does **not** apply to members who change MCPs by choice **after** January 1, 2024.

In addition to issuing this Policy, DHCS will develop and implement a robust plan for communicating with members, advocates, and providers about CoC protections and other critical policies leading up to and during the 2024 MCP Transition.

A. What Is Continuity of Care?

"Continuity of Care" (CoC) refers to a set of coordination policies that are designed to protect member access to care after the 2024 MCP Transition. Robust CoC policies help members maintain trusted relationships with providers and access to needed services as they transition between MCPs, promoting positive health outcomes. CoC protections are foundational in the Medi-Cal system. These protections are in place today (see Figure 1, *Summary of Existing Continuity of Care Protections Applicable to 2024*, below) and have been tested in prior member

transitions.[13] Due to the size and scope of the 2024 MCP Transition, DHCS is both expanding CoC protections and extending those protections to all transitioning members.

Figure 1. Summary of Existing Continuity of Care Protections Applicable to 2024

Knox-Keene Act (H&S section 1373.96)
According to the Knox-Keene Act, health plan enrollees living with certain conditions who are actively undergoing certain services have the right to continue receiving covered services as a newly covered enrollee or from a terminated or non-participating provider. The duration of that continued care varies but generally ends when the specific care or condition ends, and certain exceptions apply. The Knox-Keene Act specifies the following services or conditions as eligible for CoC: • An acute condition • A serious chronic condition • A pregnancy, including postpartum and maternal mental health condition • A terminal illness • The care of a newborn child between birth and age 36 months • Performance of a surgery or another procedure to occur within 180 days from the contract termination date or new coverage's effective date that is authorized by the plan as part of a documented course of treatment The Knox-Keene Act applies to the 2024 MCP Transition. The policies in this Policy Guide align with and build upon the Knox-Keene Act.
Existing CoC Policy for Transitions from Fee-for-Services (FFS) to Managed Care
Existing CoC policy for transitions from FFS to managed care offers additional member protections beyond those set forth in the Knox-Keene Act.[14] This existing policy primarily addresses a transitioning member's right to request CoC with an OON

[13] Continuity of Care policy for members residing in ICF/DD who are in FFS as of December 31, 2023, and are transitioning to managed care on January 1, 2024, is detailed in All Plan Letter (APL) 23-023, "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefits Standardization and Transition of Members to Managed Care."

[14] CoC policy for FFS to managed care transitions is included in All Plan Letter 22-032 at the time of this publication. APLs can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

provider for 12 months when a Pre-Existing Relationship exists, regardless of the member having a condition listed in the Knox-Keene Act, H&S section 1373.96. This policy also requires MCPs to honor transitioning members' active Prior Authorizations for Covered Services. Specific provisions apply for Durable Medical Equipment rentals and medical supplies, and both non-emergency medical and non-medical transportation (NEMT and NMT).

This 2024 MCP CoC Policy includes three key protections for Medi-Cal members:

1. **Continuity of Care for Providers:** A member may continue seeing a provider with whom they have a Pre-Existing Relationship, even if the provider is OON with the Receiving MCP. See Section V.C, Continuity of Care for Providers.
2. **Continuity of Care for Covered Services:** A member may continue an Active Course of Treatment as well as receive services previously authorized by the Previous MCP. See Section V.D, Continuity of Care for Covered Services.
3. **Continuity of Care Coordination and Management Information:** The Previous MCP and the Receiving MCP must work together to share supportive information important for members' care coordination and management. See Section V.E, Continuity of Care Coordination and Management Information.

Each protection is described in detail below, first as it applies to all transitioning members and second as it applies to members who will need enhanced protections to access CoC protections and minimize interruptions in their care.

Receiving MCPs may offer added protection to transitioning members that are more expansive than the requirements contained in this CoC Policy for the 2024 MCP Transition. Receiving MCPs may consider if there are other members who have unique circumstances and who would benefit from extra MCP attention during the Transition, such as historically marginalized populations and members with culturally appropriate needs. Such considerations should be based on the local needs of each community in which the Receiving MCP is contracted.

B. Special Populations

All transitioning members have CoC protections, but some transitioning members – referred to in this 2024 MCP CoC Policy as Special Populations – will need enhanced protections leading up to and throughout the 2024 MCP Transition. Transitioning members in Special Populations are generally individuals living with complex or chronic conditions (Figure 2, *List of Special Populations*).

Under this 2024 MCP CoC Policy, DHCS is requiring both Previous and Receiving MCPs to focus attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care as detailed below. This Section of the 2024 MCP CoC Policy identifies members who will be considered Special Populations. Enhanced CoC protections for Special Populations are detailed in subsequent Sections of this 2024 MCP CoC Policy.

Transitioning members in the following Special Populations will be identified using DHCS or Previous MCP data, including program enrollment, specific pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. Data for these members will be provided to the Receiving MCP in advance of the 2024 MCP Transition. See Section V.G, CoC Data Sharing, for more details regarding data sharing requirements.

Figure 2. List of Special Populations*

Members Who Are:
• Adults and children with authorizations to receive Enhanced Care Management services[15] • Adults and children with authorizations to receive Community Supports[16] • Adults and children receiving Complex Care Management[17] • Enrolled in 1915(c) waiver programs[18] • Receiving in-home supportive services (IHSS) • Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Model

[15] Members do not have to be actively receiving ECM on December 31, 2023.

[16] Members do not have to be actively receiving Community Supports on December 31, 2023.

[17] Complex Care Management is the same as Complex Case Management as defined by National Committee for Quality Assurance (NCQA).

[18] Multipurpose senior services program (MSSP); Assisted living waiver; Home and community-based alternatives (HCBA); HIV/AIDS Waiver; Home and community-based services (HCBS) waiver for developmental disabilities; Self-determination program for intellectual and developmental disabilities.

Members Who Are:
• Children and youth receiving foster care, and former foster youth through age 25[19] • In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C • Taking immunosuppressive medications, immunomodulators, and biologics • Receiving treatment for end-stage renal disease (ESRD) • Living with an intellectual or developmental disability (I/DD) diagnosis • Living with a dementia diagnosis • In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter) • Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis) • Receiving specialty mental health services (adults, youth, and children) • Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality • Receiving hospice care • Receiving home health • Residing in Skilled Nursing Facilities (SNF) • Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)[20] • Receiving hospital inpatient care • Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023

[19] This population includes children and youth receiving foster care and former foster youth through age 25 transitioning from FFS to managed care in COHS and Single Plan counties.

[20] The 2024 MCP Transition CoC policy applies to members residing in ICF/DD who are in managed care as of December 31, 2023. Continuity of Care policy for members residing in ICF/DD who are in FFS as of December 31, 2023, and are transitioning to managed care, is detailed in All Plan Letter (APL) 23-023, "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefits Standardization and Transition of Members to Managed Care." MCPs should refer to the ICF/DD Reference Guide for more information about the ICF/DD transition to managed care occurring on January 1, 2024.

Members Who Are:
• Newly prescribed DME (within 30 days of January 1, 2024) • Members receiving Community-Based Adult Services

*DHCS is currently specifying diagnosis, pharmacy, and procedure codes and estimating the size of these populations. DHCS will provide a final list based on that analysis.

C. Continuity of Care for Providers

If a member's current provider is a network provider in both the Previous MCP and the Receiving MCP, the member may continue to see their provider when the member transitions to the Receiving MCP on January 1, 2024. No action is required by the member to continue seeing their provider in this case.

Some members who transition to a new MCP on January 1, 2024, will be receiving care from providers who are OON providers for the Receiving MCP. Some members may be comfortable switching to a network provider on January 1, 2024. For other members, transitioning to a new provider on January 1, 2024, may disrupt their care. Continuity of Care for Providers enables transitioning members to continue receiving care from their existing providers for 12 months (exceptions explained below in this Section), if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with the Receiving MCP.

All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.[21] Eligible provider types are listed in Figure 3. Provider Types Eligible for Continuity of Care for Providers. All other provider types are not eligible for CoC for Providers. Examples of ineligible provider types are listed in Figure 4. Examples of Provider Types Ineligible for Continuity of Care for Providers.

Figure 3. Provider Types Eligible for Continuity of Care for Providers

Eligible Provider Types
• Primary Care Providers (PCP) • Specialists • Enhanced Care Management Providers • Community Supports Providers

[21] Health and Safety Code section 1373.96 protects longer durations of treatment time for Members with certain conditions specified in Figure 7.

Eligible Provider Types

• Skilled Nursing Facilities (SNFs)
• Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)[22]
• Community-Based Adult Services Providers
• Select ancillary Providers
  ○ Dialysis centers
  ○ Physical therapists
  ○ Occupational therapists
  ○ Respiratory therapists
  ○ Mental health Providers
  ○ Behavioral health treatment (BHT) Providers
  ○ Speech therapy Providers
  ○ Doulas
  ○ Community Health Workers

[22] The 2024 MCP Transition CoC policy applies to members residing in ICF/DD who are in managed care as of December 31, 2023. Continuity of Care policy for members residing in ICF/DD who are in FFS as of December 31, 2023, and are transitioning to managed care, is detailed in All Plan Letter (APL) 23-023, "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefits Standardization and Transition of Members to Managed Care." MCPs should refer to the ICF/DD Reference Guide for more information about the ICF/DD transition to managed care occurring on January 1, 2024.

Figure 4. Examples of Provider Types Ineligible for Continuity of Care for Providers[23]

Examples of Ineligible Provider Types

• All other ancillary Providers, such as:
  ○ Radiology
  ○ Laboratory
  ○ Non-emergency medical transportation (NEMT)
  ○ Non-medical transportation (NMT)
  ○ Other ancillary services
• Non-enrolled Medi-Cal Providers

For coordination of care and care transition efforts required under HSC section 1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for ineligible provider types shown in Figure 4 that are delivering non-contracted services.

To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting the Receiving MCP. The requester may contact the Receiving MCP prior to the date of service up until December 31, 2024. If the services were rendered prior to the CoC request, the requester must contact the Receiving MCP within 30 calendar days after the date of service. Upon receiving the request, the Receiving MCP must confirm whether the request meets the following requirements:

- the provider is providing a service that is eligible for Continuity of Care for Providers (see Figure 3);
- the member has a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding January 1, 2024;

[23] Members with conditions specified in Health and Safety Code section 1373.96 may request to continue care with any provider type in accordance with Health and Safety Code section 1373.96.

- the provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates; [24,25]
- the provider meets the Receiving MCP's applicable professional standards and has no disqualifying quality of care issues;[26] and
- the provider is a California Medicaid State Plan approved provider.[27]

1. Expectations of the Receiving MCP

The Receiving MCP must process CoC for Providers requests and notify members according to the following timelines. When processing a CoC for Providers request, the Receiving MCP will confirm whether the request meets the requirements in Section V.C, Continuity of Care for Providers.

The Receiving MCP must accept requests made over the telephone, electronically, or in writing, according to the requester's preference. The Receiving MCP must ensure that transitioning members are able to access assistance from the Receiving MCP's call center starting November 1, 2023, prior to their enrollment with the Receiving MCP before January 1, 2024. The Receiving MCP must confirm whether or not the requirements in Section V.C, Continuity of Care for Providers are met. If requirements are met, the Receiving MCP must contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into a CoC for Providers agreement for the member's care

[24] Applicable to SNF services that are exclusive of the SNF per diem rate.

[25] Per Welfare and Institutions Code (W&I) section 14184.201(b)(2), for contract periods from January 1, 2023, to December 31, 2025, inclusive, each MCP must reimburse a Network Provider furnishing Skilled Nursing Facility services to a Member, and each Network Provider of SNF services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by the Department in the Medi-Cal State Plan and as authorized by W&I section 14184.102(d).

[26] For the purposes of this Policy Guide, "quality of care issue" means the MCP can document its concerns with the Provider's quality of care to the extent that the Provider would not be eligible to provide services to any other MCP Members.

[27] The Provider must be enrolled and participating in the Medi-Cal program. A list of suspended or ineligible Providers is available at: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx. Provider types that do not have an enrollment pathway must be vetted by the Receiving MCP.

within the timeframe listed in Figure 5. Timeframes for CoC for Providers Process that is appropriate for the member's condition. A CoC for Providers agreement must extend through December 31, 2024, unless the eligible provider and the Receiving MCP agree to a shorter or longer duration.[28]

Timeframes for Processing CoC for Providers Requests

The Receiving MCP must resolve the CoC for Providers request and notify the member and provider of the outcome of the CoC for Providers request within the following timeframes from the date of the request.

Figure 5. Timeframes for CoC for Providers Process*

Request	Description	Timeframe for Processing Request**	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the member[29]	As soon as possible, but no longer than 3 calendar days	Within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days
Immediate	The member's medical condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days

[28] Per the Knox-Keene Act, Receiving MCPs must provide more than 12 months of CoC for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including three trimesters of pregnancy, the immediate postpartum period, and 12 months following diagnosis of maternal mental health condition or end of pregnancy, whichever is later). The postpartum period is defined as 12 months by the American Rescue Plan Act Postpartum Care Expansion.

[29] For the purposes of this Policy Guide, "risk of harm" is defined as an imminent and serious threat to the health of the Member or if the Member is identified as a Special Population.

Request	Description	Timeframe for Processing Request**	Timeframe for Notifying Member and Provider After Processing the Request
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

*These timeframes apply to requests made prospectively. If the prospective request is made in advance of January 1, 2024, then the Receiving MCP must complete processing the request by January 1, 2024 or according to these timeframes, whichever is later. Retroactive requests cannot be considered urgent or immediate.
**Receiving MCPs must confirm whether the request meets requirements in Section V.C, Continuity of Care for Providers and must execute a Network Provider Agreement or Continuity of Care for Providers agreement.

Member notifications. The Receiving MCP must notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of the MCP's decision using the member's preferred form of communication or, if not known, by telephone call, text message, or email according to the timeframes listed in Figure 5. In addition, the Receiving MCP must send a notice by mail to the member within seven calendar days of the decision, or if urgent, within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days. Receiving MCPs must comply with the HIPAA Privacy Rule in all notifications.

In cases where the member's provider is now in the Receiving MCP's network, the notification must also state that the member may continue receiving Covered Services from the provider.

In cases where the member's eligible provider is OON, and the MCP and the eligible provider enter into a CoC for Providers agreement, the notification must also state that the member may continue receiving Medi-Cal services from the eligible provider for the specified timeframe agreed upon with the eligible provider, after which the member must transition to a network provider.

In cases where the requirements in Section V.C, Continuity of Care for Providers are not met, the member notification must also include:

- A statement that the member must switch from the eligible provider to a network provider to continue receiving Covered Services, and information on how to do so.
- A clear and concise explanation of the reason for the denial and why the Receiving MCP did not enter into a CoC for Providers agreement with the eligible provider.
- Information regarding the member's right to file a grievance or appeal, and how to do so. For additional information on grievances and appeals, refer to APL 21-011 or subsequent iterations of APL 21-011.

If the member disagrees with the Receiving MCP's CoC determination, the member has the right to file a grievance.

If a CoC for Providers agreement is established. When a CoC for Providers agreement is established, the Receiving MCP must work with the eligible provider to ensure no disruption in services for the member. In addition, the Receiving MCP must direct the eligible provider not to refer the member to other OON providers without prior approval from the Receiving MCP. If referral is needed for another OON provider, the Receiving MCP will approve the referral to the OON provider. At any time, the member may transfer care to a network provider.

After establishing a CoC for Providers agreement with the eligible provider, the Receiving MCP must reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and this Policy Guide, and as agreed upon with the provider.

As the end of the agreed-upon CoC period approaches, the Receiving MCP must establish a process to transition the member to a network provider. Sixty calendar days before the end of the CoC for Providers period, the Receiving MCP must notify the member and the eligible provider about the process for transitioning the member's care. The Receiving MCP must identify a network provider, engage and the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within 60 days to ensure continuity of Covered Services through the Transition to the network provider.

If a CoC for Providers agreement is not established. If the Receiving MCP and the eligible provider are unable to reach a CoC for Providers agreement, the Receiving MCP must offer the member an alternative network provider in

a timely manner so the member's service is not disrupted.[30] If the member does not actively choose an alternative network provider, the Receiving MCP must refer the member to a network provider. If there is no network provider to provide the Covered Service, the Receiving MCP must arrange for an OON provider.

2. PCP Retention Requirement

DHCS strongly encourages the Receiving MCP to ensure there is no disruption to the trusted relationships between all transitioning members and their PCPs. To limit interruption for all transitioning members, DHCS will require mandatory overlap of the Previous MCPs' and Receiving MCPs' PCP networks to the maximum extent possible. **DHCS will require that Receiving MCPs retain at least 90% of transitioning members' PCPs either as network providers or through CoC for Providers agreements**. If the Receiving MCP is unable to enter into a contract with a member's PCP, and the member requests to continue with their trusted PCP, the Receiving MCP must offer the PCP a CoC for Providers agreement if all requirements are met. Whether members' PCPs are network providers or CoC for Providers agreements are in place, the Receiving MCP must ensure that members retain the same PCP assignments they had with their Previous MCPs. As these members are already included in the PCP's panel, neither a closed panel status nor a status that the PCP is not accepting new members should impact the assignment of these members to the PCP. If a member desires to change their PCP, they must notify the Receiving MCP.

DHCS' monitoring efforts may result in a Receiving MCP being placed on a Corrective Action Plan (CAP) for failure to meet the 90% PCP retention requirement, in accordance with Section IX.B, Monitoring and Oversight Progression to Enforcement Action. If members' current PCPs are not in the Receiving MCP's network, DHCS will require Receiving MCPs placed on a CAP to proactively contact all eligible OON PCPs with whom transitioning members have Pre-Existing Relationships to initiate a Network Provider Agreement or a Continuity of Care for Providers agreement and regularly report progress to DHCS.

[30] MCPs regulated by the Knox-Keene Act must comply with timely access standards; COHS counties are encouraged to comply as well.

3. Enhanced CoC for Providers Protections for Special Populations

For Special Populations, established and trusted relationships with their providers, and frequent appointments and follow-ups, are often essential to managing members' care needs. If a member's current provider is a network provider in both the Previous MCP and the Receiving MCP, DHCS expects the provider to continue seeing the member with no disruption to the member's care when the member transitions to the Receiving MCP.

If a member's current provider is not in the Receiving MCP's network, DHCS requires Receiving MCPs to proactively contact all eligible providers with whom Special Population members have Pre-Existing Relationships to initiate a Network Provider Agreement or a Continuity of Care for Providers agreement. This outreach effort will minimize disruptions in care and risk of harm for transitioning Special Populations.

As explained in Section V.G, CoC Data Sharing, DHCS and Previous MCPs will identify members who meet the criteria for Special Populations for the Receiving MCP. Upon receiving data for Special Populations, the Receiving MCP must proactively begin the Continuity of Care for Providers process. Receiving MCPs must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024 by January 1, 2024 or within 30 calendar days of receiving data for Special Populations, whichever is sooner. Receiving MCPs must contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement, if requirements in Section V.C, Continuity of Care for Providers are met. DHCS encourages the Receiving MCP to streamline outreach to and communication with eligible providers for Special Populations to the greatest extent possible to minimize MCP and provider administrative burden.

The Receiving MCP must notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:

- If the member's provider is in Network, or is brought in Network as a result of the Receiving MCP's outreach, then the Receiving MCP must send notification that the member may continue with his or her provider.

- If the member's provider is OON and the Receiving MCP establishes a CoC for Providers agreement, then the Receiving MCP must notify the member that the length of time that they can stay with their provider.
- If the provider is OON and cannot establish a CoC for Providers agreement, the Receiving MCP must send notification that the member must change to a network provider, and assign the member a new network provider.

In all cases, the notification must include that the member may choose to change providers, and comply with the notification requirements in Section V.C, Continuity of Care for Providers. Expectations of the Receiving MCP, and with the timeline in Figure 6.

Figure 6. Timeframes for Processing CoC for Providers for Special Populations

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers
Special Population	30 calendar days from receipt of Special Populations data	7 calendar days

DHCS requires Receiving MCPs to closely monitor Special Population members' care utilization, especially during the first 6 months of the 2024 MCP Transition, to understand members' care needs and minimize gaps in care caused by the Transition.

a) Enhanced Protections for Members Accessing the Transplant Benefit

Members accessing the transplant benefit are especially vulnerable and will benefit from additional protections designed to ensure zero disruption and seamless transition to Receiving MCPs. To achieve this objective, DHCS will require mandatory overlap of the Previous MCP's and Receiving MCP's Center of Excellence (COE)[31] Transplant Programs to the maximum extent possible to permit any member accessing the transplant benefit to continue with the

[31] In accordance with APL 21-015 Attachment 2, "Transplant programs that perform corneal, autologous islet cell, or kidney transplants are not required to be a Medi-Cal approved COE as they are not considered [Major Organ Transplants]."

same Transplant Programs.[32] If the Receiving MCP is unable to bring a Transplant Program in Network, the Receiving MCP must make a good faith effort to:

(1) Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in Section V.C, Continuity of Care for Providers and according to the following terms:

(a) Make explicit the existing statutory requirement that Receiving MCPs are to pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)

(b) Permit the CoC for Providers agreement to continue for the duration of the member's access to the transplant benefit.

(2) If the Receiving MCP is unable to enter into a CoC for Providers agreement, the Receiving MCP must:

(a) Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in Figure 6.

(b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement. See Section IX, Transition Monitoring and Oversight Reporting Requirements, Figure 5 for guidance regarding written explanations.

b) Extended Duration of CoC for Providers

The duration of the CoC for Providers period extends beyond 12 months for certain Special Populations governed by the Knox-Keene Act. Figure 7 summarizes these extended timeframes.

Figure 7. Extended Duration of CoC for Providers[33]

Special Population	Duration
Receiving Hospice Care	For the duration of the terminal illness

[32] It is anticipated that Transplant Program networks among MCPs are already significantly aligned due to the specialized nature of the services delivered by a small number of providers

[33] Special populations specified in this 2024 CoC Policy largely overlap with the conditions specified in the Knox-Keene Act, HSC section 1373.96, shown in Figure 1.

Special Population	Duration
Pregnancy or Postpartum	Within 12 months of pregnancy completion or maternal mental health diagnosis[34, 35]
Receiving hospital inpatient care	For the duration of the acute condition

D. Continuity of Care for Covered Services

It is critical that transitioning members continue to receive care during the 2024 MCP Transition. Continuity of Care for Covered Services enables all transitioning members to continue receiving Covered Services (Services) without seeking a new authorization from the Receiving MCP during the 6-month CoC for Services period from January 1, 2024, to July 1, 2024.

CoC for Services requires the Receiving MCP to honor active Prior Authorizations when data are received from the Previous MCP and/or when requested by the member, Authorized Representative, or provider and the Receiving MCP obtains documentation of the Prior Authorization before or within the 6-month CoC for

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However, only members identifiable in data are included in special populations. For example, all members with a terminal illness may request protections in HSC section 1373.96, but only members identified as receiving hospice care will receive the enhanced protections for Special Populations for the 2024 MCP Transition. Only members identifiable in data are included in the file of Special Populations.

[34] Effective April 1, 2022, DHCS extended the postpartum care coverage period for individuals eligible for pregnancy and postpartum care services under Medi-Cal from 60 days to 365 days (12 months) as part of the American Rescue Plan Act Postpartum Care Expansion. Additional information is available at: https://files.medi-cal.ca.gov/pubsdoco/preg/pregnancy_landing.aspx and https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/DHCSStakeholderNews/032522StakeholderUpdates.aspx.

[35] The Knox-Keene Act provides for 12 months to complete services for a maternal mental health condition from the diagnosis or end of pregnancy, whichever occurs later.

Services period.[36] It is expected that many of these requests will be directed to the Receiving MCP before transitioning members are enrolled with their Receiving MCP on January 1, 2024. The MCP must be able to accept and process requests in those instances beginning November 1, 2023. Upon receipt of Prior Authorization data, the Receiving MCP and the member must work together to continue the member's authorized service with a network provider if the member's provider is OON and does not enter a CoC for Providers agreement. If the member needs to continue the service after 6 months, the provider should request a new authorization from the Receiving MCP.[37]

Because MCPs can have different authorization protocols, CoC for Services also requires the Receiving MCP to allow members to continue an Active Course of Treatment without Prior Authorization for the 6-month CoC for Services period. The Receiving MCP and the member must work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a CoC for Providers agreement.

Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024 and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.[38] An Active Course of Treatment to be honored by the Receiving MCP should be documented in utilization or authorization data transferred to the Receiving MCP or other documentation.

Additional member examples are in Figure 8.

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[36] The Member, Authorized Representative, or Provider may request for the Receiving MCP to honor an existing Prior Authorization via telephone, electronically, or in writing, according to the requester's preference.

[37] As noted previously, this CoC Policy builds on and aligns with the Knox-Keene Act. Members who have an authorized procedure or surgery scheduled with an OON provider within 180 days of transitioning may contact the Receiving MCP to request CoC for Providers. The Receiving MCP must allow for the Member to complete the surgery or procedure if requirements in HSC section 1373.96 are met.

[38] CMS Proposed Ruling: https://public-inspection.federalregister.gov/2022-26956.pdf.

Figure 8. Illustrative CoC for Services Member Examples

Meet Maria, Who Has a Prior Authorization and Qualifies for Continuity of Care for Services
Maria is a 61-year-old with an early diagnosis of osteoporosis. In October 2023, Maria was notified that her Medi-Cal Managed Care Plan, MCP A, would no longer be operating in her county of residence effective January 1, 2024. Maria followed the necessary steps to select a new plan and chose MCP B for her enrollment starting on January 1, 2024. While still enrolled with MCP A, in November 2023, Maria fell from a ladder at home and required outpatient surgery for an ankle repair, which occurred on December 3, 2023. Her surgeon, Dr. Jones, prescribed outpatient physical therapy three times weekly for six weeks with a referral to The Joynt, a physical therapy clinic near Maria's home. Maria's Previous MCP (MCP A) authorized the service and confirmed that The Joynt was a network provider, and Maria began physical therapy at The Joynt on December 18, 2023. After her first two weeks of physical therapy, effective January 1, 2024, Maria transitioned to her Receiving MCP (MCP B) with four weeks remaining of her prior authorized physical therapy. Maria contacted MCP B's member services department and learned that The Joynt was **not** a network provider with MCP B. Maria requested CoC for Providers to remain with her provider for the balance of her treatment, but MCP B and The Joynt could not come to a CoC for Providers agreement. However, MCP B understood that it must honor Maria's Prior Authorization under Medi-Cal's 2024 Continuity of Care for Services policy through July 1, 2024. MCP B worked with Maria to identify an outpatient physical therapy clinic, Ankle's Away, in MCP B's network. Maria continued her physical therapy for four additional weeks with Ankle's Away and was cleared from further therapy services effective January 26, 2024.

Meet Johanna, Who Has an Active Course of Treatment and Qualifies for Continuity of Care for Services
Johanna is a 61-year-old with an early diagnosis of osteoporosis. In October 2023, Johanna was notified that her Medi-Cal Managed Care Plan, MCP Y, would no longer be operating in her county of residence effective January 1, 2024. Johanna followed the necessary steps to select a new plan and chose MCP Z for her enrollment starting on January 1, 2024.

Meet Johanna, Who Has an Active Course of Treatment and Qualifies for Continuity of Care for Services

While still enrolled with MCP Y, in November 2023, Johanna fell from a ladder at home and required outpatient surgery for an ankle repair, which occurred on December 3, 2023. Her surgeon, Dr. Smith, prescribed outpatient physical therapy three times weekly for six weeks with a referral to Out on a Limb, a physical therapy clinic near Johanna's home. Johanna's Previous MCP (MCP Y) did not require Prior Authorization for physical therapy, but did confirm that Out on a Limb was a network provider, and Johanna began physical therapy at Out on a Limb on December 18, 2023. After her first two weeks of physical therapy, effective January 1, 2024, Johanna transitioned to her Receiving MCP (MCP Z) with four weeks remaining of her prescribed physical therapy.

Johanna contacted MCP Z's member services department and was happy to learn that Out on a Limb was also a network provider in MCP Z's network. Therefore, Johanna did not need to change providers. The member services representative explained to Johanna that MCP Z requires Prior Authorization for physical therapy services. However, based on Johanna's call, MCP Z recognized that Johanna was in an Active Course of Treatment and that, under Medi-Cal's 2024 Continuity of Care for Services policy, MCP Z must continue to cover the physical therapy services without authorization until the course of treatment was concluded, or July 1, 2024, whichever occurred first. Johanna continued her physical therapy for four additional weeks with Out on a Limb and was cleared from further therapy services effective January 26, 2024.

1. Enhanced CoC for Services Protections for Special Populations

To minimize disruptions in care for Special Populations at the end of the 6-month CoC for Services period, Receiving MCPs must continue to honor Prior Authorizations and Active Courses of Treatment for the full 6-month CoC for Services period (until July 1, 2024) and until the Receiving Plan assesses

clinical necessity for ongoing services.[39] During the 6-month CoC for Services period, the Receiving MCP must examine utilization data of Special Populations to identify any Active Course of Treatment that requires authorization, and must contact those providers to establish any necessary Prior Authorizations. DHCS encourages MCPs to contact providers as soon as possible to allow for communication with providers as needed.

a) Enhanced CoC for Services Protections for Special Population Members Accessing the Transplant Benefit

The Receiving MCP must start reassessments for clinical necessity for members to continue accessing the transplant benefit no sooner than six months after the transition date (beginning July 1, 2024). This reassessment applies to adults, and children for transplants performed to treat conditions that are not medically eligible for the California Children's Services (CCS) Program. Transplants for children who are eligible for the CCS Program shall be reauthorized as described in All Plan Letter 21-015 Attachment 2.

E. Continuity of Care Coordination and Management Information

Transitioning members in Special Populations who are receiving care management services from their Previous MCP will change to a new Care Manager on January 1, 2024, upon transitioning to the Receiving MCP. In such cases, DHCS recognizes the importance of sharing supportive information to avoid member and provider screening and assessment fatigue as well as to enable the new Care Manager to continue the member's care management services without interruption. The Previous MCP must share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans. Transitioning members receiving CCM services are expected to continue receiving these services from their Receiving MCP.

[39] A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of Covered Services specified by the pre-Transition active treatment authorization. If an MCP is reassessing Enhanced Care Management authorizations after 6 months, the MCP must reassess against ECM discontinuation criteria, not the ECM Populations of Focus eligibility criteria.

As noted in Section VI.C, Transition Policy for Enhanced Care Management, Network Overlap and Continuity of Care for Enhanced Care Management Providers, all MCPs serving Medi-Cal members in 2024 and beyond are expected to contract with all ECM providers, and thus disruptions in care by ECM providers are not expected. In rare cases where a member is receiving care management services from an ECM provider who is not a network provider in their Receiving MCP, the MCP is expected to follow the CoC for Providers requirements in Section V.C, Continuity of Care for Providers.

To facilitate the sharing of supportive information for these transitioning members, the Previous MCP shall designate key staff with appropriate training and experience to serve as the plan-level contact(s). The Previous MCP must provide to the Receiving MCP, by November 2, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members. The Receiving MCP must proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care. Previous MCPs must share supportive data for these members before January 1, 2024 or within 15 calendar days of the member changing to a new Care Manager, whichever is later. It is best practice for the Previous MCP's Transitional Care Service (TCS) care management team to discuss each transitioning member discharged from an inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023 with the Receiving MCP's TCS Care Management team.

1. Members in Inpatient Hospital Care

For members in inpatient hospital care on January 1, 2024, Receiving MCPs are responsible for initiating contact with hospitals and coordinating transitional care services.[40] The Previous MCP must inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends.[41] Once a member is known to the Receiving MCP as

[40] See "CalAIM: Population Health Management (PHM) Policy Guide," Department of Health Care Services.

[41] Previous MCPs may stop receiving ADT feeds after December 31, 2023. In the event the Previous MCP receives ADT notifications for any transitioning members, DHCS requires the Previous MCP to share relevant ADT notifications daily.

being in inpatient hospital care, either through the Previous MCP or via other means, the Receiving MCP must contact the hospital to provide for completion of and coordination of the member's care.[42] The Receiving MCP must also contact the inpatient member's Primary Care physician responsible for the patient's care while they are admitted.

In general, Previous MCPs are responsible for paying for all covered services prior to January 1, 2024 and Receiving MCPs are responsible on or after January 1, 2024. However, MCPs must honor their Network Agreements including payment arrangements that would require payments on an admission or episodic basis. It is incumbent on the Previous MCPs and Receiving MCPs to work with any hospital in which a transitioning member is admitted to clarify payment responsibility during the transition period. In no circumstance will the member be balance billed for covered Medi-Cal services.

2. Members Accessing the Transplant Benefit

For members accessing the transplant benefit on January 1, 2024, Receiving MCPs are responsible for ensuring coordination of care between all providers, organ donation entities, and Transplant Programs. Receiving MCPs must ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

F. Additional Continuity of Care Protections for All Transitioning Members

To provide a robust Continuity of Care Policy for the 2024 MCP Transition, DHCS is specifying additional protections for all transitioning members related to Durable Medical Equipment (DME) rentals and medical supplies, non-emergency medical transportation (NEMT) and non-medical transportation (NMT), and scheduled specialist appointments.

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[42] Consistent with 42 CFR sections 438.114(e), 422.113(c)(2), 422.214, and California Welfare and Institutions (W&I) Code section 14091.3, Contractor is financially responsible for payment of post-stabilization services following an emergency admission at the hospital's Medi-Cal FFS payment amounts for general acute care inpatient services rendered by a non-contracting hospital, unless a lower rate is agreed upon in writing and signed by the hospital.

1. Durable Medical Equipment Rentals and Medical Supplies

Receiving MCPs must allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for 6 months after the 2024 MCP Transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use.[43] After 6 months, the MCP may reassess the member's authorization at any time and may require the member to switch to a network provider of DME. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the original treatment authorization.

This policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case the Receiving MCP must allow the delivery and permit the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

2. Non-Emergency Medical Transportation and Non-Medical Transportation

DHCS expects Receiving MCPs to ensure no disruptions to transitioning members' access to the Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT) benefit. To guard against disruptions, Receiving MCPs must:

- Review data provided by the Previous MCP to identify members with scheduled NEMT/NMT services;
- Confirm a network provider to deliver the scheduled NEMT/NMT services. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then the Receiving MCP must make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider;
- Accept and process member requests for NEMT/NMT before January 1, 2024;
- Honor all Prior Authorizations for NEMT/NMT approved by the Previous MCP, including the modality of transportation, for 6

[43] A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of Covered Services specified by the pre-Transition active treatment authorization.

months and until the Receiving MCP is able to reassess the member's continued transportation needs.

The Previous MCP must support continuation of NEMT/NMT services for transitioning members by:

- Providing authorization data as described in Section VIII, Continuity of Care Data Sharing Policy;
- Transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to the Receiving MCP on November 2, 2023 and refresh weekly starting in December 2023.

DHCS expects that MCPs will work with SNFs where members are residing to ensure transportation is coordinated. SNFs are familiar with MCP transportation liaisons and work collaboratively to ensure all members can get appropriate and timely transportation to their appointments, such as critical dialysis appointments. MCP transportation liaisons should be proactively working with SNFs to address transportation needs.

3. Scheduled Specialist Appointments

DHCS recognizes that some specialists have long waitlists. A member with an initial scheduled appointment to see a specialist who is an OON provider for their Receiving Plan would not qualify for CoC for Providers because the member does not have a Pre-Existing Relationship with that specialist. Requiring the member to leave an OON specialist waitlist and start at the back of a network specialist's waitlist could significantly delay care.

In such cases, the member should contact the Receiving MCP and request a network specialist within the same timeframe as the scheduled appointment. DHCS encourages the Receiving MCP to arrange for the member to either keep the appointment with the OON specialist or schedule an appointment with a network provider on or before the member's scheduled appointment with the OON provider.[44]

If the MCP is unable to arrange a specialist appointment with a network provider on or before the member's scheduled appointment with the OON

[44] MCPs regulated by the Knox Keene Act must comply timely access standards; COHS counties are encouraged to comply as well.

provider, the MCP is encouraged to make a good faith effort to allow the member to keep an appointment with the OON provider.[45]

The Receiving MCP must ensure that transitioning members who seek assistance before January 1, 2024 while not yet enrolled in the Receiving MCP are offered the same level of support they would receive on and after the January 1, 2024, enrollment date.

G. CoC Data Sharing

Successful data sharing is critical to effectuating the CoC Policy for the 2024 MCP Transition. To implement the required CoC protections, Receiving MCPs must receive ingestible, accurate, and timely data from Previous MCPs and DHCS. The Previous MCP must complete all data sharing activities as described in Section VIII, Continuity of Care Data Sharing Policy. DHCS reserves the right to perform audits to confirm successful data sharing according to timeliness and quality expectations. If the Previous MCP does not meet data requirements, the MCP may be subject to enforcement actions.

Receiving MCPs will receive data from both the Previous MCPs and DHCS. DHCS will provide Receiving MCPs with utilization data in November 2023. However, these data will be lagged, and more timely data will aid Receiving MCPs in achieving Continuity of Care, particularly for Special Populations. To facilitate Receiving MCPs' Continuity of Care activities, DHCS will require MCPs to exchange data beginning November 2, 2023.[46, 47]

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[45] Since the appointment with the OON Provider occurs after the Member's Transition to the MCP, it does not establish the requisite Pre-Existing Relationship for the Member to submit a Continuity of Care for Providers request.

[46] California's Health and Human Services Data Exchange Framework (DxF) Technical Requirements for Exchange Policies & Procedures, available at: https://www.cdii.ca.gov/committees-and-advisory-groups/data-exchange-framework/.

[47] Members who do not make an active choice among available MCPs will be enrolled into an MCP in December based on the following assignment hierarchy: (1) provider linkage, (2) plan linkage, and (3) family linkage. Absent a member meeting any of the "linkage" criteria, their default MCP will be based on the Auto-Assignment Incentive Program algorithm, which includes quality and other adjustments to an annually defined

As detailed in Section VIII, Continuity of Care Data Sharing Policy, DHCS will require Previous MCPs to transmit utilization data, authorization data, member information, including preferred form of communication, accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to Receiving MCPs. Direct data sharing will be more timely than if DHCS were to facilitate data sharing. Section VIII, Continuity of Care Data Sharing Policy describes the data provided by DHCS and requirements for Previous MCPs to share data to enable Receiving MCPs to implement CoC policies.

VI. Transition Policy for Enhanced Care Management

A. Introduction

DHCS is committed to ensuring Medi-Cal members with authorizations[48] to receive Enhanced Care Management (ECM)[49] do not experience disruptions to their ECM authorizations, provider[50] relationships, or services due to the MCP Transition on January 1, 2024. The Transition Policy for ECM builds on and is aligned with the ECM Policy Guide and the Continuity of Care (CoC) provisions contained therein, as well as Section V, Continuity of Care. In some instances, this Transition Policy for ECM offers enhanced protections beyond those for other services as required by Section V, Continuity of Care.

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ratio for auto-assignment among MCPs in each county. For more information, see https://www.dhcs.ca.gov/provgovpart/Pages/MgdCareAAIncentive.aspx.

[48] Members do not have to be actively receiving ECM on December 31, 2023.

[49] Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria, through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. More information about ECM and requirements for MCPs can be found in the ECM Policy Guide, MCP Contract, ECM APL (APL 21-012), and DHCS' ECM and Community Supports Standard Provider Terms and Conditions.

[50] Community-based entity with experience and expertise providing intense, in-person care management services to Members in one or more of the Populations of Focus for ECM.

DHCS will closely monitor MCP adherence to this Transition Policy for ECM to guard against disruptions in ECM authorizations, provider relationships and/or services. Additional information on how this Transition Policy for ECM will be monitored is included in Section IX, Transition Monitoring and Oversight Reporting Requirements.

Continuity of Care for Enhanced Care Management Covered Services

DHCS expects that transitioning members actively receiving ECM will not face disruption resulting from the MCP Transition on January 1, 2024, and member eligibility and service authorization will be honored and not have to be re-authorized at the time of the Transition.

Members with authorizations for ECM, regardless of whether they are actively receiving ECM, are considered a Special Population. As such, the Receiving MCP must honor all of the Previous MCP's authorizations for ECM. The Receiving MCP must maintain all authorizations for no less than the length of time originally authorized by the Previous MCP; if the existing authorization continues for more than 12 months beyond January 1, 2024, the Receiving MCP is not required to maintain it beyond December 31, 2024 unless it chooses to do so.

B. Network Overlap and Continuity of Care for Enhanced Care Management Providers

DHCS expects that transitioning members actively receiving ECM will continue with their existing ECM Provider.

ECM Network Development:

To ensure no interruption for transitioning members receiving ECM, DHCS will require mandatory overlap of the Previous MCP's and Receiving MCP's ECM Providers to the maximum extent possible. Receiving MCPs will be required to proactively contact all eligible Out of Network (OON) ECM Providers with whom transitioning members have Pre-Existing Relationships and contract with them as Network Providers in advance of the transition on January 1, 2024.

DHCS has other initiatives that facilitate contracting between ECM Providers and MCPs. The Incentive Payment Program (IPP) rewards MCPs for contracting with ECM providers as part of the transition and PATH CITED grants encourage awardees to enter into ECM contracts with Receiving MCPs.

If a Previous MCP's ECM Provider does not wish to enter into a contract with the Receiving MCP's network or if both parties cannot come to an agreement, the Receiving MCP must offer a CoC for Provider agreement with the ECM Provider for up to 12 months. If the Receiving MCP's efforts do not result in an agreement with the ECM

Provider, the Receiving MCP must explain in writing to DHCS why the Provider and the MCP could not execute a contract or CoC for Provider agreement. See Section IX, Transition Monitoring and Oversight Reporting Requirements, Figure 9 for guidance regarding written explanations.

Approach to Assignment of Transitioning Members

If the Receiving MCP confirms that the member's existing ECM Provider is part of its network, agrees to join its network, or participates under a CoC for Provider agreement, the Receiving MCP must assign the member to their existing ECM Provider to ensure the member's relationship with their ECM Provider is not disrupted. The Receiving MCP will receive data necessary to effectuate this policy no later than November 1, 2023. The Receiving MCP will receive data from both DHCS as well as Previous MCPs in an effort to achieve both comprehensiveness and timeliness. This data exchange is described in Section VIII, Continuity of Care Data Sharing Policy.

If the Receiving MCP does not bring the ECM provider into its network or establish an agreement with the ECM Provider, the Receiving MCP must transition the member to an in-network ECM Provider for outreach activity and continuation of ECM.

If a member desires to change their ECM Provider, they should notify the Receiving MCP.

C. Mitigating Provider Disruption Through Timely Payment of Claims

Receiving MCPs have a legal and contractual obligation to timely pay claims submitted by providers for covered services to members. To eliminate disruption for transitioning members with authorizations to receive ECM, DHCS expects that Receiving MCPs will ensure that ECM providers are paid timely. Receiving MCPs are reminded that the Requirements for Timely Payments of Claims APL 23-020 details the requirement for claims' payment timeliness, which extends to "bills or invoices submitted by Providers that adhere to billing and invoicing guidance such as for Enhanced Care Management (ECM) …" In addition, the APL articulates DHCS' expectations for MCPs to train and educate providers on their billing, invoicing, and clean claims submission protocols. DHCS expects that Receiving MCPs are compliant with all the requirements contained in the MCP contract, in the APL for all providers, including ECM providers and including any updates to the APL, throughout the 2024 MCP Transition. MCPs should also refer to and adhere to ECM and Community Support Billing and Invoicing Guidance. MCPs are to use the standardized billing and invoice data for two purposes:

- To pay ECM/Community Supports Providers, based on how their provider arrangements are structured
- To submit compliant encounters for submission to DHCS

VII. Transition Policy for Community Supports

A. Introduction

DHCS is committed to ensuring that Medi-Cal members with authorizations[51] to receive Community Supports[52] do not experience disruptions to their Community Supports authorizations, provider relationships, or services due to the MCP Transition on January 1, 2024. The Transition Policy for Community Supports builds on and is aligned with the Medi-Cal Community Supports, or In Lieu of Services, Policy Guide and the Continuity of Care (CoC) provisions contained therein, as well as Section V, Continuity of Care. In some instances, this Transition Policy for Community Supports offers enhanced protections beyond those for other services as required by Section V, Continuity of Care.

DHCS will closely monitor MCP adherence to this Transition Policy for Community Supports to guard against disruptions in Community Supports authorizations, provider relationships and/or services. Additional information on how this Transition Policy for Community Supports will be monitored will be included in Section IX, Transition Monitoring and Oversight Reporting Requirements.

B. Continuity of Care for Community Supports Covered Services

DHCS expects that transitioning members actively receiving Community Supports will not face disruption resulting from the MCP Transition on January 1, 2024 and member eligibility and service authorizations will be honored and not have to be re-authorized at the time of the Transition.

Members with authorizations for Community Supports, regardless of whether they are actively receiving Community Supports, are considered a Special Population. As such, the Receiving MCP must honor all of the Previous MCP's authorizations for Community

[51] Members do not have to be actively receiving Community Supports on December 31, 2023.

[52] Substitute services or settings for those required under the California Medicaid State Plan that the MCP may select and offer to its Members pursuant to 42 CFR section 438.3(e)(2) when pre-approved by the Department of Health Care Services (DHCS) as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan.

Supports when both MCPs offer the same Community Supports. The Receiving MCP must maintain all authorizations for no less than the length of time originally authorized by the Previous MCP; the Receiving MCP is not required to maintain the authorization for more than 12 months beyond January 1, 2024, unless it chooses to do so.

When both MCPs offer the same Community Support, the Receiving MCP must honor the Community Support that was authorized by the Previous MCP in alignment with Medi-Cal Community Supports, or In Lieu of Services, Policy Guide. If the Previous MCP's authorization exceeds the State-defined Community Support (e.g., due to member need), the Receiving MCP is strongly encouraged to honor the greater Community Support which has already been authorized.

If the Receiving MCP does not offer a Community Support offered by the Previous MCP, DHCS strongly encourages the Receiving MCP to honor the Previous MCP's authorization for the Community Support for those members with authorizations at the time of the Transition. If the Receiving MCP does not continue the Previous MCP's authorization for a member's Community Support, the Receiving MCP must assess the member's needs that are addressed by the Community Support and coordinate care to the necessary services, including ECM, to ensure an appropriate transition of care and to prevent the need for higher acuity services.

C. Network Overlap and Continuity of Care for Community Supports Providers

DHCS expects that transitioning members actively receiving Community Supports will continue with their existing Community Supports Provider.

When MCPs' Community Supports Align:
If the Previous MCP and the Receiving MCP offer the same Community Supports, even if there are variances in amount, duration or scope, DHCS will require mandatory overlap of the Previous MCP's and Receiving MCP's Community Supports providers to the maximum extent possible to ensure continuity of care and maintain delivery system capacity.

DHCS has other initiatives that facilitate contracting between Community Supports Providers and MCPs. The Incentive Payment Program (IPP) rewards MCPs for contracting with Community Supports Providers as part of the transition and PATH CITED grants encourage awardees to enter into Community Supports contracts with Receiving MCPs.

Receiving MCPs will be required to proactively contact all eligible Out of Network (OON) Community Supports Providers with whom

transitioning members have Pre-Existing Relationships and contract with them as Community Supports Providers in advance of the transition on January 1, 2024.

If a Previous MCP's Community Supports Provider does not wish to enter into a contract with the Receiving MCP's network or if both parties cannot come to an agreement, the Receiving MCP must offer a CoC for Provider agreement with the Community Supports Provider for up to 12 months. If the Receiving MCP's efforts do not result in an agreement with the Community Supports Provider, the Receiving MCP must explain in writing to DHCS why the Provider and the MCP could not execute a contract or CoC for Provider agreement. See Section IX, Transition Monitoring and Oversight Reporting Requirements, Figure 10 for guidance regarding written explanations.

When MCPs' Community Supports Are Not Aligned:

Nothing in this policy requires the Receiving MCP to offer Community Supports, as it is considered voluntary for the MCP. Therefore, if the Receiving MCP does not offer a Community Support offered by the Previous MCP, the Receiving MCP is not required to build a contracted network for delivery of the specific Community Support. However, the Receiving MCP is strongly encouraged to offer a CoC for Provider agreement with the Community Supports Provider for up to 12 months. If the Receiving MCP's efforts do not result in an agreement with the Community Supports Provider, and there is no Community Supports Provider in the Receiving MCP's Network to deliver the Community Support, the Receiving MCP is strongly encouraged to arrange for an Out-of-Network Provider.

Approach to Connecting Transitioning Members with Community Support Providers for Continuity of Care

If the Receiving MCP confirms the member's existing Community Supports Provider is part of its network, agrees to join its network, or participates under a CoC for Provider agreement, the Receiving MCP must ensure the member is connected with their existing Community Supports Provider to ensure the member's relationship with their Community Supports Provider is not disrupted. The Receiving MCP will receive data necessary to effectuate this policy in November 2023. The Receiving MCP will receive data from both DHCS as well as Previous MCPs in an effort to achieve both comprehensiveness and timeliness. This data exchange is described in Section VIII, Continuity of Care Data Sharing Policy.

If the Receiving MCP does not bring the Community Supports Provider into its network or establish an agreement with the Community Supports Provider, the Receiving MCP must transition the member to an in-network Community Supports Provider.

If a member desires to change their Community Supports Provider, they should notify the Receiving MCP.

D. Mitigating Provider Disruption Through Timely Payment of Claims

Receiving MCPs have a legal and contractual obligation to timely pay claims submitted by providers for covered services to members. To eliminate disruption for transitioning members with authorizations to receive Community Supports, DHCS expects that Receiving MCPs will ensure that Community Supports providers are paid timely. Receiving MCPs are reminded that the Requirements for Timely Payments of Claims APL 23-020 details the requirement for claims' payment timeliness, which extends to "bills or invoices submitted by Providers that adhere to billing and invoicing guidance such as for … Community Supports …" In addition, the APL articulates DHCS' expectations for MCPs to train and educate providers on their billing, invoicing, and clean claims submission protocols. DHCS expects that Receiving MCPs are compliant with all the requirements contained in the MCP contract, in the APL for all providers, including Community Supports providers and including any updates to the APL, throughout the 2024 MCP Transition. MCPs should also refer to and adhere to ECM and Community Support Billing and Invoicing Guidance. MCPs are to use the standardized billing and invoice data for two purposes:

- To pay ECM/Community Supports Providers, based on how their provider arrangements are structured
- To submit compliant encounters for submission to DHCS

VIII. Continuity of Care Data Sharing Policy

Successful data sharing among DHCS, Previous MCPs, and Receiving MCPs will be critical to effectuate the CoC Policy for the 2024 MCP Transition. To this end, Receiving MCPs must have access to ingestible, complete, accurate, and timely data from Previous MCPs and DHCS. This Section of the Policy Guide lays out the data that DHCS will provide to Receiving MCPs, and defines requirements for Previous MCPs to share necessary data for Receiving MCPs to implement CoC protections.

The requirements outlined in this Section apply to both Previous MCPs that are exiting the market and to Previous MCPs that delegate to Kaiser as a subcontractor through December 31, 2023.

For other transitions involving subcontracted MCP[53] terminations, the MCP and the subcontracted MCP are required to share all data elements outlined in this Section on a timely basis through existing channels, in accordance with subcontractor agreements, unless otherwise specified by DHCS.

Secure Transmission of Member-Level Information

Throughout the data transmission processes discussed in this Section of the Policy Guide, MCPs must have processes for receiving, storing, using, or transmitting Protected Health Information (PHI) and sharing data in accordance with applicable laws, MCP contract requirements, and DHCS data privacy and security standards. MCPs must ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules and, when applicable, the federal substance use disorder confidentiality regulation, 42 CFR Part 2. MCPs must also abide by applicable state law requirements. MCPs must have alternative, legally compliant submission processes in place for when standard secure transmission protocols are not available.

[53] As defined in Section XIV, Appendix: County-Level MCP Transitions, "subcontracted MCP" means an MCP that contracts with the Prime MCP to assume full or partial risk of a portion of the prime MCP's membership.

Overview of All Data Files

As detailed in this chapter, the following data files or reports are relevant to the 2024 MCP Transition.

File	Responsible Party for Generating the File	Relevant Subsection
Plan Transfer Status Report	DHCS	Section VIII.A.1
Member Level Data	DHCS	Section VIII.A.2
Plan Data Feed	DHCS	Section VIII.A.3
Special Populations Member File	DHCS	Section VIII.A.4
Transitioning Member Identifying Data	Previous MCP	Section VIII.B.1
Transitioning Member Utilization Data	Previous MCP	Section VIII.B.2
Transitioning Member Authorization Data	Previous MCP	Section VIII.B.3
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Previous MCP	Section VIII.B.4
Transitioning Member Special Populations Information Data	Previous MCP	Section VIII.B.5
Special Populations Member Supportive Information Data[54]	Previous MCP	Section VIII.B.6

[54] For transitioning members in Special Populations who are receiving care management services from their Previous MCP and will change to a new Care Manager on January 1, 2024, the Previous MCP must share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

A. DHCS Provided Data Files

MCPs must utilize information provided in the standard monthly *Plan Data Feed* to implement CoC protections. However, these data will not be available for all transitioning members prior to January 1, 2024. To support CoC activities, DHCS will share the data outlined in Figure 1 to MCPs for a subset of transitioning members. DHCS will refresh the files for MCPs as full replacement files, excluding the one-time *Member Level Data* file. These data will supplement data shared from the Previous MCP to the Receiving MCP described in Section VIII.B below.

Figure 1. Summary of DHCS Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Plan Transfer Status Report	Pending MCP enrollment for transitioning members	Previous MCPs	Weekly, Beginning November 3, 2023
Member Level Data	For transitioning members: *Plan Data Feed* historical utilization data Treatment Authorization Request (TAR) data	Receiving MCPs	One-Time in November
Plan Data Feed	Utilization information for all enrolled members	Receiving MCPs	Monthly, (See Section VIII.A.3)
Special Populations Member File	Member-level information, specifically CINs for transitioning members who meet Special Populations criteria*, indicating the members' Special Population group(s)	Receiving MCPs	Monthly for All Special Population Members from November 2023 through March 2024[55]

[55] Data will not include information for "Adults and children receiving Complex Care Management", as DHCS does not have access to CIN-level data for these members.

* This represents a subset of all Special Populations that can be identified by DHCS held data in eligibility and claims/encounters data.

1. Plan Transfer Status Report

DHCS will prepare the *Plan Transfer Status Report* file to identify a subset of transitioning members. The *Plan Transfer Status Report* file will include transitioning members' pending enrollment into one of the Receiving MCPs. DHCS and the Previous MCP will use the *Plan Transfer Status Report* of transitioning members to match on the member's Medi-Cal Client Index Number (CIN) and prepare data files described in this Section for transmission to the Receiving MCP. DHCS will transmit the *Plan Transfer Status* Report file to the Previous MCPs weekly, beginning in October (See Section VIII.D for more information). DHCS will share these data with the Previous MCP via SFTP.

The DHCS *Plan Transfer Status Report* file will include the data elements outlined in Figure 2 below. To ensure that the most up-to-date member enrollment information is captured in files shared from the Previous MCP to the Receiving MCP, DHCS requires Previous MCPs to use the most recently available Plan Transfer Status Report files to prepare required files.

The *Plan Transfer Status Report* will not include pending enrollment information for members whose Previous MCPs delegate to Kaiser. To identify these members, the Previous MCP must use future assignment information to compile a list of relevant Medi-Cal Member CINs as soon as it is available. The Previous MCP must use this internal file to prepare the data files outlined in this Section of the Policy Guide guidance for transmission to the Receiving MCP and DHCS.

Figure 2. Plan Transfer Status Report Data Elements

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member Date of Birth	MM/DD/YYYY, Date
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Exiting Plan	Alpha-Numeric, Text
Assignment	Alpha-Numeric, Text
Effective Date	MM/DD/YYYY, Date
Choice/Default	Alpha-Numeric, Text

2. Member Level Data

To ensure MCPs have access to comprehensive information, DHCS will provide Receiving MCPs with one-time *Member Level Data* files which will include historical utilization data and Treatment Authorization Request (TAR) data for transitioning members in November 2023, and begin the monthly *Plan Data Feed* once members are enrolled. DHCS will notify Receiving MCPs when the data are posted on their plan specific SFTP sites. The file layout will be the same as the monthly *Plan Data Feed*. See Section VIII.A.3 below for more information on the *Plan Data Feed*.

The *Member Level Data* file will not include information for transitioning members whose Previous MCPs delegate to Kaiser as a subcontractor through December 31, 2023. For these members, the Receiving MCP will only utilize information provided by the Previous MCP to support CoC activities, as outlined in Section VIII.B below.

3. Plan Data Feed

The *Plan Data Feed* includes information for all members enrolled in an MCP on the first of each month. Receiving MCPs will use the information provided in the *Plan Data Feed* in conjunction with data provided by Previous MCPs.

4. Special Populations Member File

All transitioning members have CoC protections, but some transitioning members – referred to as Special Populations – will need enhanced protections leading up to and throughout the 2024 MCP Transition. To implement CoC policies for Special Populations, the Receiving MCP will need both a file of members in each Special Population and accompanying data elements for members in certain Special Population groups.

To ensure MCPs have access to relevant data, DHCS will share monthly *Special Populations Member Files* using existing DHCS data sources from November 2023 through March 2024 for a subset of transitioning members. The monthly *Special Populations Member Files* will consist of Medi-Cal Member Client Index Numbers (CIN) for members who meet the Special Populations criteria and indicators of the members' Special Population group(s). MCPs will use the provided CIN information to match on data provided through the one-time *Member Level Data* files and recurring *Plan Data Feed* files provided by DHCS.

Receiving MCPs must use **both** the DHCS-provided *Special Populations Member File* and the Previous MCP-provided *Transitioning Member Special*

Population Information Data file to identify Special Populations members' providers and begin outreach, a key tenet of the CoC policies for Special Populations. DHCS expects that any member identified on the DHCS-provided *Special Populations Member File* OR the Previous-MCP-provided *Transitioning Member Special Population Information Data* file will be classified as a Special Population member and afforded appropriate CoC protections.

See Section VIII.B.5 for more information on Previous MCP requirements for *Transitioning Member Special Populations Information Data*.

B. Previous MCP Provided Data Files

In addition to DHCS data sharing with MCPs, DHCS is requiring Previous MCPs to share data with Receiving MCPs to ensure Receiving MCPs have access to the most timely, accurate, and comprehensive member-level information to effectuate CoC protections.

The Previous MCP must complete all data sharing requirements outlined below. This Section outlines a standardized set of "minimum necessary" data elements for data shared from the Previous MCP to the Receiving MCP, as well as standard file formats, transmission methods, and transmission frequencies.

Previous MCPs will transmit the data files in Figure 3 to Receiving MCPs, in accordance with the requirements outlined in Sections VIII.B.1-VIII.B.6. Previous MCPs will refresh the files for Receiving MCPs as full replacement files for each refresh. Previous MCPs will transmit copies of data sent to Receiving MCPs to DHCS to facilitate DHCS' oversight of the transition. DHCS will perform verification checks to confirm successful data sharing according to timeliness and quality expectations. If the Previous MCP does not meet data requirements, the MCP may be subject to enforcement actions.

Figure 3. Summary of MCP Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 9, weekly refreshes beginning in December

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Utilization Data	Claims and encounter information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 9, weekly refreshes beginning in December
Transitioning Member Authorization Data	Prior authorization information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 9, weekly refreshes beginning in December
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 9, weekly refreshes beginning in December
Transitioning Member Special Populations Information Data	Transitioning members who meet Special Populations criteria and relevant accompanying data elements	Receiving MCPs and DHCS	Initial transfer November 9, weekly refreshes beginning in December
Special Populations Member Supportive Information Data[56]	Transitioning member screening and assessment findings, and member Care Management Plans	Receiving MCPs and DHCS	Within 15 days of member changing to a new Care Manager or by January 1, 2024, whichever is later

Accompanying Excel Attachments for Previous MCP Provided Data

DHCS has compiled the outlined data elements into four accompanying Excel workbooks for Previous MCPs to prepare data files to transmit to Receiving MCPs

[56] For transitioning members in Special Populations who are receiving care management services from their Previous MCP and will change to a new Care Manager on January 1, 2024, the Previous MCP must transfer supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans.

to enable Receiving MCPs to implement Continuity of Care policies in Section V, Continuity of Care. The accompanying Excel workbooks include additional guidance for Previous MCPs around expected values and file requirements.

- *Continuity of Care (CoC) Data Template - 1) Data Elements for All Members*
    - Previous MCPs must use this template to prepare member level data files for transitioning members in accordance with requirements outlined in Sections VIII.B.1-VIII.B.4 below. Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V, Continuity of Care.
- *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications*
    - Previous MCPs must use these specifications to identify relevant members and prepare Transitioning Member Special Populations Data files using the Continuity of Care (CoC) Data Template – 2b) Special Population Member File and Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data workbooks for transmittal to Receiving MCPs.
- *Continuity of Care (CoC) Data Template – 2b) Special Population Member File*
    - Previous MCPs must use this template to prepare a file identifying members that meet the criteria outlined in *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications* for transmittal to Receiving MCPs.
- *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data*
    - Previous MCPs must use this template to prepare Special Populations accompanying data for certain Special Population groups[57] for transmittal to Receiving MCPs.

[57] Adults and children with authorizations to receive Community Supports; Adults and children with authorizations to receive Enhanced Care Management services; Adults and children receiving Complex Care Management; Members accessing the transplant benefit; Residing in Skilled Nursing Facilities (SNF); Receiving hospital inpatient care

1. Transitioning Member Identifying Data

Receiving MCPs need identifying member information to operationalize CoC policy requirements. Previous MCPs will provide the Receiving MCP with relevant member information, as identified in Figure 4. The *Transitioning Member Identifying Data* file will allow MCPs to link to the other required data files using the Medi-Cal Member CIN. Receiving MCPs will use members' contact information and preferred form of contact to send notifications about Continuity of Care for Special Populations, as appropriate (see Section V.C.2, Continuity of Care, Continuity of Care for Providers, Enhanced CoC for Providers Protections for Special Populations). Primary Care Provider (PCP) information is particularly important for transitioning members identified as meeting Special Populations criteria as Receiving MCPs will need to directly contact the PCP in cases in which the PCP is out-of-network (OON) or the member is receiving inpatient care during the MCP Transition, or for other reasons (see Section V.E.1, Continuity of Care, Continuity of Care Coordination and Management Information, Members in Inpatient Hospital Care).

Previous MCPs will share *Transitioning Member Identifying Data* files with the Receiving MCP and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D.

a. Required Data Elements

Previous MCPs must share *Transitioning Member Identifying Data* files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figures 4 and 5.

Figure 4. Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code[58]	Numeric 3-digit, Text

[58] This will be limited to the Medi-Cal 834 file acceptable values.

Data Element	Format
Member Homelessness Indicator[59]	Numeric, 1 digit, Text
Member Residential Address[60]	Alpha-numeric, Text
Member Residential City[61]	Alpha-numeric, Text
Member Residential Zip Code[62]	Alpha-numeric, Text
Member Mailing Address[63]	Alpha-numeric, Text
Member Mailing City[64]	Alpha-numeric, Text
Member Mailing Zip Code[65]	Numeric, 5-digit
Member Phone Number[66]	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact[67]	Alpha-Numeric, Text

[59] Identifier for if the member is experiencing "homelessness," as defined in the *ECM Policy Guide* (pgs. 11-12), available here. If "homeless," enter "2", if not, enter "1", if unknown, enter "0".

[60] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[61] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and Residential City is not available.

[62] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[63] MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[64] MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[65] MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[66] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[67] Member's Preferred Form of Contact, as known by MCP (e.g., "CALL", "TEXT", "EMAIL", "MAIL"). If not known, MCP may report "UNKNOWN".

Data Element	Format
Description of Member's Selected Alternative Format[68]	Alpha-Numeric, Text
Member's Preferred Language (Spoken)[69]	Alpha-Numeric, Text
Member's Preferred Language (Written)[70]	Alpha-Numeric, Text

Figure 5. Transitioning Member Primary Care Provider Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider Phone Number[71]	Numeric, 10-digit
Primary Care Facility Name	Alpha-numeric, Text
Primary Care Facility NPI	Numeric, 10-digit, Text
Primary Care Facility Phone Number	Numeric, 10-digit
Primary Care Facility Address	Alpha-numeric, Text
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date[72]	MM/DD/YYYY, Date

2. Transitioning Member Utilization Data

Receiving MCPs need timely utilization information in order to implement CoC for Providers and identify any relevant Active Courses of Treatment pursuant to CoC for Services requirements (See Sections V.C, Continuity of

[68] If applicable, member's selected alternative format, as known by MCP (e.g., "LARGE PRINT", "AUDIO CD", "DATA CD", "BRAILLE"). If not known, MCP may report "UNKNOWN".

[69] If available, Member's Preferred Spoken Language (e.g., "ENGLISH", "SPANISH"). If not known, MCP may report "UNKNOWN".

[70] If available, Member's Preferred Written Language (e.g., "ENGLISH", "SPANISH"). If not known, MCP may report "UNKNOWN".

[71] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[72] As known by the MCP; if no visits on record, MCP will enter "00/00/0000".

Care, Continuity of Care for Providers and V.D, Continuity of Care, Continuity of Care for Covered Services for more information).

Previous MCPs must share *Transitioning Member Utilization Data* files directly with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D.

a. Required Data Elements

Previous MCPs must share *Transitioning Member Utilization Data* files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figure 6.

The below data elements are specific to the data transmitted from the Previous MCP.

Figure 6. Transitioning Member Claims / Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code[73]	Alpha-Numeric, Text
HCPCS Modifier[74]	Alpha-Numeric, Text
Revenue Code[75]	Numeric, 4-digit, Text
Place of Service[76]	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
Billing Provider NPI	Numeric, 10-digit, Text
Billing Provider First Name	Alpha-Numeric, Text

[73] Primary procedure code for this line of service. Do not code decimal point.

[74] Procedure modifiers are required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. If not submitted by the provider or captured by the carrier leave blank.

[75] Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. Required for institutional claims only. Please leave blank for professional claims.

[76] Required for professional claims only, please leave blank for institutional claims.

Data Element	Format
Billing Provider Last Name	Alpha-Numeric, Text
Billing Provider Phone Number[77]	Numeric, 10-digit
Billing Provider Tax Identification Number (TIN)	Numeric, 9-digit, Text
Rendering Provider Specialty Type[78]	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text
Rendering Provider First Name	Alpha-Numeric, Text
Rendering Provider Last Name	Numeric, 10-digit
Rendering Provider Phone Number	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1[79]	Alpha-Numeric, Text
Diagnosis Code 2[80]	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

3. Transitioning Member Authorization Data

To honor active Prior Authorizations as required by the CoC for Services policy, the Receiving MCP will need accurate, up-to-date data for transitioning members. (See Section V.D, Continuity of Care, Continuity of Care for Covered Services for more information).

Previous MCPs will share *Transitioning Member Authorization Data* files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D.

[77] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[78] Standard taxonomy codes issued by the NUCC, available here. If number not available to the MCP, MCP may report "0000000000".

[79] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[80] ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank.

a. Required Data Elements

Previous MCPs must share *Transitioning Member Authorization Data* files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figure 7.

Figure 7. Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Requesting Provider Name	Alpha-numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[81]	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text
Requesting Facility Phone Number[82]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number[83]	Numeric, 10-digit
Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number[84]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units	Numeric 7-digit, Text
Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text

[81] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[82] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[83] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[84] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

Data Element	Format
Diagnosis Code[85]	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status[86]	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text
Previous MCP Authorization Number	Alpha-Numeric, Text
Discharge Status	Alpha-Numeric, Text

4. Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data

DHCS expects Receiving MCPs to ensure no disruptions to Transitioning Members' access to Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT) benefit. To guard against disruptions, the Receiving MCP will need data for Members with scheduled NEMT/NMT services from the Previous MCP. The Receiving MCP must identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedule a Network provider or an OON provider to transport the member. See Section V.F.2, Continuity of Care, Additional Continuity of Care Protections for All Transitioning Members, Non-Emergency Medical Transportation and Non-Medical Transportation for more information on CoC for NEMT/NMT.

Previous MCPs must share *Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data* files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Sections VIII.C-VIII.D.

a. Required Data Elements

Previous MCPs must share *Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data* files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in Figures 8 and 9. In addition to sharing the data elements outlined in Figure 9, the Previous MCP must share copies of the completed PCS forms for relevant members with the Receiving MCP.

[85] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[86] Indication of authorization status (e.g., "APPROVED", "DENIED", "PARTIAL")

Figure 8. Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service[87]	Numeric, 1 digit, Text
Date of Scheduled Transportation Service	MM/DD/YYYY, Date
Time of Scheduled Transportation Service	hh:mm:ss, Time
Recurring Transportation Service Indicator[88]	Numeric, 1 digit, Text
Member Phone Number[89]	Numeric, 10-digit
Pickup Location[90]	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number [91]	Numeric, 10-digit
Mode of Transport[92]	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number[93]	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number[94]	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text

[87] Identifier for NEMT and NMT services. If NEMT, enter "0", if NMT, enter "1".

[88] Identifier for if one-time or recurring NEMT/NMT services. If one-time, enter "0", if recurring, enter "1".

[89] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[90] Indicates NEMT/NMT pickup locations (e.g., "MEMBER HOME", "SNF", "LTC").

[91] If applicable. Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[92] Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").

[93] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[94] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

Data Element	Format
Transportation Notes[95]	Alpha-Numeric, Text

Figure 9. Transitioning Member PCS Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Start Date of Standing Order[96]	MM/DD/YYYY, Date
Mode of Transportation[97]	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[98]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit
PCS Notes[99]	Alpha-numeric, Text

5. Transitioning Member Special Populations Information Data

As outlined in Section VIII.A.4, DHCS will share a monthly file of Medi-Cal Member Client Index Numbers (CINs) for a subset of transitioning members who meet the Special Populations criteria and are able to be identified using existing DHCS data sources from November 2023 through March 2024.

[95] May include appointment reason (e.g., PCP visit, cardiologist visit) or member needs (e.g., oxygen, stair chair, attendants).

[96] If applicable, start date of standing orders. Please leave blank if not applicable.

[97] Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").

[98] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[99] May include functional limitations justification among other items.

To ensure that all transitioning members who meet Special Populations criteria are captured through the most recently available data, the Previous MCP will be required to share *Transitioning Member Special Populations Information Data* files for groups outlined in Figure 11.

The attachment, *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications* presents the data definitions for each Special Population that Previous MCPs will use to identify members who meet Special Population criteria. Some of the data elements the Previous MCP will provide are specific to certain Special Populations as detailed below. The Previous MCP will implement the following steps to prepare *Transitioning Member Special Populations Information Data* files for sharing with each Receiving MCP.

Steps for Previous MCPs to Prepare the *Transitioning Member Special Populations Information Data* Files

- Identify members default assigned to the Receiving MCP using the *Plan Transfer Status Report* file[100]
- Of these members, identify members who meet the Special Populations criteria using the definitions in the accompanying *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications* workbook
- Prepare *Transitioning Member Special Populations Information Data* files:
    - Compile CIN and identifiers for Special Population group(s) for each member who meets any of the Special Population criteria (outlined in *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications)* using the accompanying *Continuity of Care (CoC) Data Template – 2b) Special Population Member File* workbook

[100] The *Plan Transfer Status Report* will not include pending enrollment information for members whose Previous MCPs delegate to Kaiser. To identify these members, the Previous MCP must use future assignment information to compile a list of relevant Medi-Cal Member CINs to prepare the *Transitioning Member Special Populations Information Data* Files.

- Compile data elements outlined in Figure 12 for members in certain Special Population groups,[101] using the accompanying *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data* workbook

The Receiving MCP is responsible for intaking *Special Populations Member Files* from DHCS and *Transitioning Member Special Populations Information Data* files from the Previous MCP. DHCS expects that any member identified on the DHCS-provided *Special Populations Member Files* OR the Previous-MCP-provided *Transitioning Member Special Populations Information Data* file will be classified as a Special Population member and afforded appropriate CoC protections. Receiving MCPs will utilize information from both DHCS and Previous MCPs, as well as other data the Receiving MCP has access to, to begin implementing CoC policy for Special Populations. See Section V.C, Continuity of Care, Continuity of Care for Providers, V.D, Continuity of Care, Continuity of Care for Covered Services and V.E, Continuity of Care, Continuity of Care Coordination and Management Information for additional information on how the Receiving MCPs will use these data to provide enhanced protections for Special Populations.

Previous MCPs must share *Transitioning Member Special Populations Information Data* files with Receiving MCPs in accordance with the required transmission method and frequency outlined in outlined in Sections VIII.C-VIII.D. Previous MCPs must also share a copy of this data to DHCS to facilitate DHCS' oversight of the transition.

For transitioning members not captured in the subset of members included in the *Special Populations Member File* provided by DHCS, including transitions involving subcontracted MCP[102] terminations, the MCP and its subcontracted MCP are required to identify **both** Figure 10 and Figure 11 members and share all

[101] Adults and children with authorizations to receive Community Supports; Adults and children with authorizations to receive Enhanced Care Management services; Adults and children receiving Complex Care Management; Members post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023; Members accessing the transplant benefit; Residing in Skilled Nursing Facilities (SNF); Receiving hospital inpatient care.

[102] As defined in Section XIV, Appendix: County-Level MCP Transitions, "subcontracted MCP" means an MCP that contracts with the Prime MCP to assume full or partial risk of a portion of the prime MCP's membership.

data elements outlined in this Section. Unless otherwise specified by DHCS, MCPs and subcontracted MCPs must use existing channels in accordance with subcontractor agreements and may use the format outlined in the accompanying *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data* workbook to compile and share member information.

Figure 10. Special Populations for which DHCS Data is Primary Source of Information

Members Who Are:
• Children and youth receiving foster care and former foster youth through age 25 • Children and youth enrolled in CCS/CCS Whole Child Model • Enrolled in Assisted Living Waiver • Enrolled in HIV/AIDS waiver • Enrolled in Home and Community-Based Services (HCBS) Waiver for Developmental Disabilities (DD) • Enrolled in in Home and Community-Based Alternatives (HCBA) Waiver • Enrolled in Multipurpose Senior Services Program MSSP • Enrolled in Self-determination program for intellectual and DD • Receiving In Home Supportive Services (IHSS) • Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)[103] • Receiving Community-Based Adult Services

[103] The 2024 MCP Transition CoC policy applies to members residing in ICF/DD who are in managed care as of December 31, 2023. Continuity of Care policy for members residing in ICF/DD who are in FFS as of December 31, 2023, and are transitioning to managed care, is detailed in All Plan Letter (APL) 23-023, "Intermediate Care Facilities for Individuals with Developmental Disabilities – Long Term Care Benefits Standardization and Transition of Members to Managed Care." MCPs should refer to the ICF/DD Reference Guide for more information about the ICF/DD transition to managed care occurring on January 1, 2024.

Figure 11. Special Populations for which Previous MCP Data is Primary Source[104] of Information

Members Who Are:
• In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C • Living with an Intellectual or Developmental Disability (I/DD) diagnosis • Newly prescribed DME (within 30 days prior to January 1, 2024) • Accessing the transplant benefit • Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023 • Receiving hospital inpatient care • Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or risk of mortality • Taking immunosuppressive medications, immunomodulators and biologics • Adults and children with authorizations to receive Enhanced Care Management services • Adults and children with authorizations to receive Community Supports • Living with a dementia diagnosis • Pregnant or post-partum (within 12 months of the end of a pregnancy or maternal mental health diagnosis) • Receiving home health • Receiving hospice care • Receiving Specialty Mental Health Services (adults, youth, and children) • Receiving treatment for End Stage Renal Disease (ESRD) • Residing in Skilled Nursing Facilities (SNF) • Adults and children receiving Complex Care Management

[104] Primary source indicates likelihood of most timely data. Receiving MCPs will utilize information from both DHCS and Previous MCPs to implement CoC policy for Special Populations.

Figure 12. Previous MCP-Provided Special Population Accompanying Data Elements

Data Element	Format
Adults and children receiving Complex Care Management	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Reason for Care Management or Program type	Alpha-Numeric, Text
Care Management Open Date	MM/DD/YYYY, Date
Plan Contact Name	Alpha-Numeric, Text
Plan Contact Phone Number[105]	Numeric, 10-digit
Assessment Completion Date	MM/DD/YYYY, Date
Care Plan Date	MM/DD/YYYY, Date
Members accessing the transplant benefit	
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Transplant Stage[106]	Alpha-Numeric, Text
Eligibility Plan Code	Alpha-Numeric, Text
Organ	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Transplant Waitlisting Date[107]	MM/DD/YYYY, Date
Transplant Evaluation Date[108]	MM/DD/YYYY, Date
Transplant Date[109]	MM/DD/YYYY, Date
Request Type	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text

[105] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[106] Indicates which phase of the transplant process the member is in ("CONSULTATION/PRE-SCREEN", "EVALUATION", " PRE-TRANSPLANT/WAITLIST", "TRANSPLANT EPISODE", "POST TRANSPLANT", or "UNKNOWN").

[107] If member is in the "PRE-TRANSPLANT/WAITLIST" Transplant Stage, indicate date of waitlisting. If not applicable, leave blank.

[108] If member is in the "EVALUATION" Transplant Stage, indicate date of evaluation. If not applicable, leave blank.

[109] If member has a scheduled transplant service, indicate date of transplant. If not applicable, leave blank.

Data Element	Format
Facility Phone Number[110]	Numeric, 10-digit
Living Donor Indicator[111]	Numeric, 1 digit, Text
Transplant SAR Number[112]	Numeric, 10 digit
Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis[113]	Alpha-Numeric, Text
Discharge Date	MM/DD/YYYY, Date
Discharge Disposition	Numeric, 2 digit, Text
Facility Name	Alpha-Numeric, Text
Facility Type[114]	Numeric, 1 digit, Text
Facility NPI	Numeric, 10 digit, Text
Facility Phone Number[115]	Numeric, 10 digit
Receiving hospital inpatient care	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis[116]	Alpha-Numeric, Text
Authorization Determination	Alpha-Numeric, Text
Authorization Status	Alpha-Numeric, Text
Bed Type Code	Alpha-Numeric, Text
Level of Care	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text

[110] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[111] Indicates whether transplant involves a living donor, if "YES" enter "1", if "NO", enter "0".

[112] If applicable, Transplant Service Authorization Requests (SAR) number. If not applicable, leave blank.

[113] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[114] Indicates member facility type code.

[115] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[116] ICD-9-CM or ICD-10-CM. Do not code decimal point.

Data Element	Format
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number[117]	Numeric, 10-digit
Adults and children with authorizations to receive Community Supports	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Servicing CS Provider Name	Alpha-Numeric, Text
Member's Servicing CS Provider NPI	Numeric, 10-digit, Text
Member's Servicing CS Provider Phone Number[118]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Member received Community Supports[119]	Numeric, 1 digit, Text
Community Supports approved: Housing Transition/Navigation Services	Numeric, 1 digit, Text
Community Supports approved: Housing Deposits	Numeric, 1 digit, Text
Community Supports approved: Housing Tenancy and Sustaining Services	Numeric, 1 digit, Text
Community Supports approved: Short-Term Post-Hospitalization Housing	Numeric, 1 digit, Text
Community Supports approved: Recuperative Care (Medical Respite)	Numeric, 1 digit, Text
Community Supports approved: Respite Services	Numeric, 1 digit, Text
Community Supports approved: Day Habilitation Programs	Numeric, 1 digit, Text
Community Supports approved: Nursing Facility Transition/Diversion to Assisted Living Facilities	Numeric, 1 digit, Text
Community Supports approved: Nursing Facility Transition to a Home	Numeric, 1 digit, Text
Community Supports: Personal Care and Homemaker Services	Numeric, 1 digit, Text

[117] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[118] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[119] If the Member received Community Supports during the last 12-months, enter "1", if not, enter "0".

Data Element	Format
Community Supports: Environmental Accessibility Adaptations	Numeric, 1 digit, Text
Community Supports approved: Medically Supportive Food/Meals/Medically Tailored Meals	Numeric, 1 digit, Text
Community Supports approved: Asthma Remediation	Numeric, 1 digit, Text
Community Supports approved: Other	Numeric, 1 digit, Text
Adults and children with authorizations to receive Enhanced Care Management services	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Assigned ECM Provider Name	Alpha-Numeric, Text
Member's Assigned ECM Provider NPI	Numeric, 10-digit, Text
Member's Assigned ECM Provider Phone Number[120]	Numeric, 10-digit
Member's Servicing ECM Provider Name	Alpha-Numeric, Text
Member's Servicing ECM Provider NPI	Numeric, 10-digit, Text
Member's Servicing ECM Provider Phone	Numeric, 10-digit
ECM Population of Focus: Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness [121]	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	Numeric, 1 digit, Text
ECM Population of Focus: Individuals At Risk for Avoidable Hospital or ED Utilization	Numeric, 1 digit, Text
ECM Population of Focus: Individuals with Serious Mental Health and/or SUD Needs	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Transitioning from Incarceration	Numeric, 1 digit, Text

[120] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

[121] If member meets the definition for ECM Populations of Focus, enter "1", if not, enter "0". For more information on ECM Populations of Focus see the ECM Policy Guide.

Data Element	Format
ECM Population of Focus: Adults Living in the Community and At Risk for LTC Institutionalization	Numeric, 1 digit, Text
ECM Population of Focus: Adult Nursing Facility Residents Transitioning to the Community	Numeric, 1 digit, Text
ECM Population of Focus: Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	Numeric, 1 digit, Text
ECM Population of Focus: Children and Youth Involved in Child Welfare	Numeric, 1 digit, Text
ECM Population of Focus: Birth Equity Population of Focus	Numeric, 1 digit, Text
ECM Benefit Date Assessed/Approved	MM/DD/YYYY, Date
ECM Benefit Start Date	MM/DD/YYYY, Date
Residing in Skilled Nursing Facilities (SNF)	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number[122]	Numeric, 10-digit
Level of Care	Alpha-Numeric, Text
Authorization Start Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date

a. Data Sharing for Members in Inpatient Hospital Care

The Previous MCP must inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends. It is possible that Previous MCPs may stop receiving ADT feeds after December 31, 2023. See Section V.E.1, Continuity of Care, Continuity of Care Coordination and Management Information, Members in Inpatient Hospital Care for more information on CoC Protections for members in inpatient care.

[122] Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

6. Special Populations Member Supportive Information Data Sharing

For transitioning members in Special Populations who are receiving care management services from their Previous MCP and will change to a new Care Manager on January 1, 2024. For these members, the Previous MCP will also be responsible for sharing supportive information to the Receiving MCP including, but not limited to, the results of available member screening and assessment findings, and member care management plans. DHCS will not set a required file format for the *Special Populations Member Supportive Information Data* files but requires Previous MCPs to share any additional information via SFTP. Previous MCPs will share copies of *Special Populations Member Supportive Information Data* files sent to Receiving MCPs to DHCS to facilitate DHCS' oversight of the transition.

C. File Format and Transmission Method Requirements

Previous MCPs will share data outlined using the accompanying Excel attachments (*Continuity of Care (CoC) Data Template - 1) Data Elements for All Members, Continuity of Care (CoC) Data Template – 2b) Special Population Member File, and Continuity of Care (CoC) Data Template - 2c) Special Populations Accompanying Data*) and saved as comma-separated value (csv) files. Each tab in the accompanying Excel attachments must be transmitted as a separate csv file in accordance with the required file naming conventions outlined in Figures 13, 14, and 15. DHCS will share data as txt files.

Previous MCPs and DHCS will share files with Receiving MCPs via Secure File Transfer Protocol (SFTP) transmission. Previous MCPs will share data directly with the Receiving MCP and share copies of files with DHCS via the SFTP folders outlined in Figure 16.

See Section VIII.D for more information regarding the required reporting frequency.

Figure 13. Required File Naming Convention for Data Outlined in *Continuity of Care (CoC) Data Template - 1) Data Elements for All Members*

File	Data Elements	Required File Naming Convention
Transitioning Member Identifying Data	Member Identifying Data (See Figure 4)	C01_INFO_RECEIVING HCP
Transitioning Member Identifying Data	Primary Care Provider Information (See Figure 5)	C02_PCP_RECEIVING HCP
Transitioning Member Utilization Data	Transitioning Member Claims / Encounter Information (See Figure 6)	C03_CLAIMS_RECEIVING HCP
Transitioning Member Authorization Data	Transitioning Member Authorization Information (See Figure 7)	C04_PA_RECEIVING HCP
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Transitioning Member NEMT/NMT Schedule Data (See Figure 8)	C05_NEMTNMT_RECEIVING HCP
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Transitioning Member Physician Certification Statement (PCS) Data (See Figure 9)	C06_PCS_RECEIVING HCP

Figure 14. Required File Naming Convention for Data Outlined in *Continuity of Care (CoC) Data Template – 2b) Special Population Member File*

File	Required File Naming Convention
Transitioning Member Special Populations Information	B01_MEM_RECEIVING HCP

Figure 15. Required File Naming Convention for Data Outlined in *Continuity of Care (CoC) Data Template - 2c) Special Populations Accompanying Data*

File	Special Population	Required File Naming Convention
Transitioning Member Special Populations Information Data	Adults and children receiving Complex Care Management	M01_CCM_RECEIVING HCP
Transitioning Member Special Populations Information Data	Accessing the transplant benefit	M02_TP_RECEIVING HCP
Transitioning Member Special Populations Information Data	Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023	M03_DIS_RECEIVING HCP
Transitioning Member Special Populations Information Data	Receiving hospital inpatient care	M04_IP_RECEIVING HCP
Transitioning Member Special Populations Information Data	Adults and children with authorizations to receive Community Supports	M05_CS_RECEIVING HCP
Transitioning Member Special Populations Information Data	Adults and children with authorizations to receive Enhanced Care Management services	M06_ECM_RECEIVING HCP
Transitioning Member Special Populations Information Data	Residing in Skilled Nursing Facilities (SNF)	M07_SNF_RECEIVING HCP

Figure 16. DHCS SFTP Folder Information

File	Responsible Party for Generating the File	SFTP Folder Name*
Plan Transfer Status Report	DHCS	DHCS-MCOD-Operations/Plan Name
Member Level Data	DHCS	DHCS-MCOD-Operations/Plan Name
Plan Data Feed	DHCS	DHCS-MCQMD-Data/*PLANNAME*/Member Spec File
Special Populations Member File	DHCS	DHCS-MCQMD-Data/*planname*/2024SP
Transitioning Member Identifying Data	Previous MCP	DHCS-MCQMD-Data/*planname*/2024P2P
Transitioning Member Utilization Data	Previous MCP	DHCS-MCQMD-Data/*planname*/2024P2P
Transitioning Member Authorization Data	Previous MCP	DHCS-MCQMD-Data/*planname*/2024P2P
Transitioning Member NEMT/NMT Schedule and PCS Statement Data	Previous MCP	DHCS-MCQMD-Data/*planname*/2024P2P
Transitioning Member Special Populations Information Data	Previous MCP	DHCS-MCQMD-Data/*planname*/2024P2P

D. File Transmission Frequency

It is essential for Receiving MCPs to receive accurate, timely data from DHCS and Previous MCPs in order to implement the required CoC protections. Figure 17. Data Sharing Timeline below describes the required data sharing timeline and refresh requirements.

Figure 17. Data Sharing Timeline

File	DHCS Data Obligations	Previous MCP Data Obligations	Receiving MCP Data Obligations
Plan Transfer Status Report	• Send to Previous MCP weekly on Fridays, beginning November 3, 2023 and ending March 8, 2024.	• Ingest *Plan Transfer Status Report.*	• NA
Transitioning Member Identifying Data	• Intake *Transitioning Member Identifying Data* from the Previous MCP(s) upon each refresh. • Provide monitoring and oversight.	• Share *Transitioning Member Identifying Data* with Receiving MCPs and DHCS on November 9, 2023 and refresh weekly on Tuesdays starting December 5, 2023 and ending March 26, 2024.	• Ingest *Transitioning Member Identifying Data* from the Previous MCP(s) upon each refresh. • See Section V.C for additional information on how the Receiving MCPs will use these data.
Transitioning Member Utilization Data	• Intake *Transitioning Member Utilization Data* from the Previous MCP(s) upon each refresh.	• Share *Transitioning Member Utilization Data* with Receiving MCPs and DHCS on November 9, 2023 and refresh	• Ingest *Transitioning Member Utilization Data* from the Previous MCP(s) upon each refresh.

File	DHCS Data Obligations	Previous MCP Data Obligations	Receiving MCP Data Obligations
	• Share *Member Level Data* with Receiving MCPs according to default Member-MCP assignments in November 2023.[123] • Provide monitoring and oversight.	weekly on Tuesdays starting December 5, 2023 and ending March 26, 2024.	• See Section V.C for additional information on how the Receiving MCPs will use these data.
Transitioning Member Authorization Data	• Intake *Transitioning Member Authorization Data* from the Previous MCP(s) upon each refresh. • Provide monitoring and oversight.	• Share *Transitioning Member Authorization Data* with Receiving MCPs and DHCS on November 9, 2023, and refresh weekly on Tuesdays starting December 5, 2023 and ending March 26, 2024. • Work with Receiving MCPs to fill data gaps.	• Ingest *Transitioning Member Authorization Data* from the Previous MCP(s) upon each refresh. • See Section V.D for additional information on how the Receiving MCPs will use these data. • Work with Previous MCPs

[123] Members who do not make an active choice among available MCPs will be enrolled into an MCP in January based on the following assignment hierarchy: (1) provider linkage, (2) plan linkage, and (3) family linkage. Absent a member meeting any of the "linkage" criteria, their default MCP will be based on the auto-assignment incentive program algorithm, which includes quality and other adjustments to an annually defined ratio for auto-assignment among MCPs in each county. For more information, see https://www.dhcs.ca.gov/provgovpart/Pages/MgdCareAAIncentive.aspx.

File	DHCS Data Obligations	Previous MCP Data Obligations	Receiving MCP Data Obligations
			and providers to address missing data.
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	• Intake Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data from the Previous MCP(s) upon each refresh. • Provide monitoring and oversight.	• Share *Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data* with Receiving MCPs and DHCS on November 9, 2023 and refresh weekly on Tuesdays starting December 5, 2023 and ending March 26, 2024.	• Ingest Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data from the Previous MCP(s) upon each refresh. • See Section V.F.2 for additional information on how the Receiving MCPs will use these data.
Transitioning Member Special Populations Information Data	• Share *Special Populations Member Files* for members outlined in Figures 10 and 11 in November 2023 and refresh monthly from December 2023 through March 2024.[124]	• Share *Transitioning Member Special Populations Information Data* with Receiving MCPs and DHCS on November 9, 2023, and refresh weekly on Tuesdays starting December 5, 2023	• Ingest Special Populations Member Files from DHCS and Transitioning Member Special Populations Information Data from the Previous MCP(s) upon each refresh.

[124] Data will not include information for "Adults and children receiving Complex Care Management", as DHCS does not have access to CIN-level data for these members.

File	DHCS Data Obligations	Previous MCP Data Obligations	Receiving MCP Data Obligations
	• Intake *Transitioning Member Special Populations Information Data* from the Previous MCP(s) upon each refresh. • Provide monitoring and oversight.	and ending March 26, 2024. • Inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and refresh daily through January 9, 2024.	• See Section V.C.2 for additional information on how the Receiving MCPs will use these data.
Special Populations Member Supportive Information Data	• Provide monitoring and oversight.	• Share with Receiving MCPs, by November 9, 2023, contact information for plan-level staff and for the Care Managers who served impacted Members. • Work with Receiving MCPs to facilitate sharing of supportive information within 15 calendar days of the Member changing to a new Care Manager, or January 1, 2024, whichever is later.	• Facilitate sharing of supportive data within 15 calendar days of the Member changing to a new Care Manager or January 1, 2024, whichever is later. • See Section V.E for additional information on how the Receiving MCPs will use this data.

IX. Transition Monitoring and Oversight Reporting Requirements

This Section presents DHCS' approach to monitoring the transition of members between MCPs on January 1, 2024. The monitoring approach encompasses both Previous and Receiving MCPs, and allows DHCS to determine whether MCPs are meeting mandated requirements relative to the transition including, but not limited to, adherence to DHCS' Guiding Principles in Section II, Introduction and the Continuity of Care (CoC) requirements in Sections V – VIII.

DHCS has established a multi-pronged monitoring approach for the 2024 MCP Transition:

1. Receiving MCPs (and Previous MCPs to a limited extent) will submit Continuity of Care performance data via SurveyMonkey related to:
    a. PCP retention and assignment[125] for all transitioning members
    b. CoC for all transitioning members and Special Populations members
    c. CoC for Enhanced Care Management and Community Supports
    d. Member issues

    This Section of the Policy Guide focuses primarily on monitoring via MCP-submitted performance data, which is explained in more detail below. In addition to MCP-submitted performance data, DHCS will use approaches 2 – 4 below to monitor the 2024 MCP Transition.
2. DHCS will proactively outreach to Receiving MCPs and require detailed reporting on samples of transitioning members related to CoC for Special Populations, including transitioning members authorized to receive ECM and Community Supports.
3. Previous MCPs will submit copies of all data files shared with Receiving MCPs to DHCS for validation. More information regarding these shared files is found in Section VIII, Continuity of Care Data Sharing Policy.
4. DHCS will solicit and track feedback from stakeholders, including members. Receiving MCPs will also track and trend stakeholder input, and ensure that a feedback loop within the MCP keeps its leadership and relevant units of its

[125]DHCS will require that Receiving MCPs retain at least 90% of transitioning members' PCPs either as network providers or through CoC for Providers agreements.

organization apprised of this critical input. MCPs will utilize stakeholder feedback to improve on topics of concern. For example, tracking calls to the Receiving MCP's member call center identifies that numerous members expressed concern about loss of access to a large outpatient provider group. This information should be shared with the MCP's provider network team to determine if the MCP is seeking to contract or enter into a CoC for Providers agreement with the provider group.

DHCS will conduct monitoring and oversight activities leading up to and after the January 1, 2024, transition from November 2023 through December 2024. The reporting cadence fluctuates throughout the period, as noted in A.2. DHCS has made efforts to ensure that transition monitoring is not duplicative of existing data reporting. MCPs are expected to comply with all other performance monitoring and data reporting requirements in accordance with their contract and DHCS policy.

A. MCP Data Submission Via SurveyMonkey

1. Submission Requirements and Interface

Data related to the January 1, 2024, MCP transition will be reported by Receiving MCPs[126] and Previous MCPs will have limited submission requirements.[127] Receiving and Previous MCPs will report required data elements at the county level, as noted in the Data Element Detail in A.3. below. Some data elements will require MCPs to submit baseline data as noted in A.2. below.

SurveyMonkey will be the interface for MCPs to submit each transition data element. The interface will include submission of narrative fields to allow MCPs to include additional detail regarding the data submitted.

2. MCP Reporting Cadence

MCP reporting will begin with baseline reporting in November 2023 for select data elements, pre-transition reporting in November 2023, and post-transition reporting continuing through December 2024. Reporting timeframes vary by measure and are subject to change at DHCS' discretion. The reporting cadence for all data elements is

[126] Receiving MCPs include Kaiser as a Prime MCP effective January 1, 2024.

[127] Previous MCPs include MCPs that are exiting the market and MCPs that delegate to Kaiser as a subcontractor through December 31, 2023.

indicated in the table below, with the exception of PCP retention which will be reported monthly through June 2024.[128]

Figure 1. Data Element Reporting Cadence

Month(s)	Data Elements	Cadence
November 22, 2023	Baseline for select data element	One-time reporting
November 2, 2023 – December 31, 2023	Select data elements	Bi-weekly reporting[129]
January 1, 2024 – February 29, 2024	All data elements	Bi-weekly reporting
March 2024 – June 30, 2024	Select data elements	Monthly reporting
July 1, 2024 – December 31, 2024	Select data elements	Quarterly reporting

MCPs will report data to DHCS on Wednesdays with up to a three-business day lag from the end of the reporting period. *For example*:

- Data for the first two weeks of January 2024 (January 1 – 14, 2024) will be reported to DHCS on Wednesday, January 17, 2024
- Data for February 12 – 25, 2024 will be reported to DHCS on Wednesday, February 28, 2024
- Data for the month of March 2024 will be reported to DHCS on Wednesday, April 3, 2024[130]
- Data for the month of April 2024 will be reported to DHCS on Friday, May 6, 2024

3. Data Element Detail

The tables below provide details regarding the data elements that MCPs will be required to submit to DHCS via the SurveyMonkey interface.

[128] The reporting period may be extended if PCP retention does not meet DHCS' expectations.

[129] MCPs will submit the first bi-weekly report on Wednesday, November 22, 2023, for the period of November 2 through November 19, 2023. This is the only data reporting period that exceeds two weeks.

[130] The reporting period for the month of March will include data for February 26 – 29, 2024.

To assist MCPs, immediately below is a key to the table layouts which follow in sections a through d below.

Figure 2. Table Layout Key

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
1	Brief description of data element MCP will electronically report to DHCS	Entity responsible for reporting	Date range during which data will be reported[131]	Detailed description of data element to assist MCP with submission

a. PCP Retention Data Elements

Figure 3. PCP Retention – All Members[132]

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
1	Cumulative number of members who transitioned on or after January 1, 2024	Receiving MCP	2/1/24 – 6/30/24	Cumulative count*
2	Cumulative number of transitioning members who retain their Primary Care Provider (PCP) from their	Receiving MCP	1/1/24 – 6/30/24 This may be extended if PCP	Cumulative count*

[131] The end date is subject to change as DHCS reserves the right to extend the data reporting period if MCP performance indicates a need for continued monitoring.

[132] Effective February 1, 2024, DHCS collects the data elements on PCP Retention displayed in Figure 3 in a stand-alone tool via the SurveyMonkey interface.

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	Previous MCP on or after January 1, 2024		retention does not meet DHCS' expectations	
3	Cumulative number of transitioning members who did not retain their PCP from their Previous MCP on or after January 1, 2024	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(i)	Cumulative number of transitioning members who did not retain their PCP because the member chose a different PCP upon transition	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(ii)	Cumulative number of transitioning members who did not retain their PCP because the PCP retired or is deceased	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(iii)	Cumulative number of transitioning members who did not retain their PCP because, upon review, the MCP determined the PCP does not accept Medi-Cal members	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(iv)	Cumulative number of transitioning members who did not retain their	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	PCP because the PCP declined to contract or declined a CoC for Providers agreement			
4(v)	Cumulative number of transitioning members who did not retain their PCP because the member is enrolled in comprehensive Other Health Coverage (OHC) or the member is dually eligible with Medicare as the primary payer	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(vi)	Cumulative number of transitioning members who did not retain their PCP for another reason	Receiving MCP	1/1/24 – 6/30/24	Cumulative count*
4a(vii)	Please provide an explanation or reason the member(s) did not retain their PCP for another reason	Receiving MCP	1/1/24 – 6/30/24	Narrative
5	Please describe how the MCP is minimizing disruptions and impact to delivery of services for members who did not retain their PCP	Receiving MCP	1/1/24 – 6/30/24	Narrative

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
6	Optional: MCPs may provide additional information about PCP retention if pertinent.	Receiving MCP	1/1/24 – 6/30/24	Narrative

*Cumulative counts mean the sum of counts over time.

b. Continuity of Care Data Elements

Figure 4. CoC for Providers – All Members

Includes requests made by or on behalf of transitioning members who meet Special Population criteria				
Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** (MCPs will report for each county unless indicated)
4[133]	Cumulative number of Continuity of Care for Providers requests received from transitioning members, providers, or authorized representatives	Receiving MCP	11/22/23 – 12/31/24	Cumulative count
5	Status of CoC for Providers Requests: Cumulative number of requests approved that result in a contract or a CoC agreement	Receiving MCP	11/22/23 – 12/31/24	Cumulative count
6a	Status of CoC for Providers Requests: Cumulative number of requests denied	Receiving MCP	11/22/23 – 12/31/24	Cumulative count
6b	Status of CoC for Providers Requests: Cumulative number of requests for Providers who are already in the Receiving MCP's network	Receiving MCP	1/31/24 – 12/31/24	Cumulative count: Of the total denials reported for Data Element 6a, the MCP must report the number of denials for providers who are already in the Receiving MCP's network

[133] The data element numbering aligns with the SurveyMonkey numbering.

Includes requests made by or on behalf of transitioning members who meet Special Population criteria				
Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** (MCPs will report for each county unless indicated)
7	Status of CoC for Providers Requests: Cumulative number of requests pending	Receiving MCP	11/22/23 – 12/31/24	Cumulative count
8	Status of CoC for Providers Requests: Cumulative number of requests cancelled by requester	Receiving MCP	11/22/23 – 12/31/24	Cumulative count
9a	Reason for denials of CoC for Providers request	Receiving MCP	11/22/23 – 12/31/24	Attestation Y/N: The MCP attests that the following are the only reasons for which the MCP denied the CoC for Provider request. Reasons: No relationship between member and provider; Provider refused to work with MCP; Provider not State approved; Quality of care issues; Provider and MCP did not agree to a rate; Provider is in the MCP's Network; Provider type is not protected by Continuity of Care for Providers
9b	Reason for denials of CoC for Providers request: Explanation	Receiving MCP	11/22/23 – 12/31/24	Narrative: If the MCP selected No to Data Element 9a, a request was denied for a reason not

Includes requests made by or on behalf of transitioning members who meet Special Population criteria				
Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** (MCPs will report for each county unless indicated)
				listed, the MCP must report each denial and the reason for each denial.
9c	Status of CoC for Providers Requests: Continuation with In-Network Provider	Receiving MCP	1/31/24 – 12/31/24	Attestation Y/N: The MCP attests that members with CoC for Providers Requests for providers who are already in the Receiving MCP's network were permitted to continue with the requested, in-network provider without disruption.
9d	Status of CoC for Providers Requests: Discontinuation explanation	Receiving MCP	1/31/24 – 12/31/24	Narrative: If the MCP selected No to Data Element 9c, a member's Continuity of Care with the requested provider was disrupted and/or was not permitted to continue, the MCP must report each disruption and/or discontinuation and provide an explanation.
10	Timeliness: Cumulative number of CoC for Providers requests that took more than 30 days to complete.	Receiving MCP	1/1/24 – 12/31/24	Cumulative count

Includes requests made by or on behalf of transitioning members who meet Special Population criteria				
Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** (MCPs will report for each county unless indicated)
11	Total number of CoC agreements with end dates during the reporting period	Receiving MCP	Q2 – Q4 2024	Total count
12	Total number of CoC agreements for which the MCP completed end-of-CoC period 60-day requirements during the reporting period	Receiving MCP	Q2 – Q4 2024	Total count 60-day requirements include: the Receiving MCP must notify the member and the eligible provider about the process for transitioning the member's care. The Receiving MCP must identify a network provider; engage the member, eligible provider, and the member's new network provider; and ensure the member's record is transferred within 60 days to ensure continuity of Covered Services through the Transition to the network provider
13	Optional: MCPs may provide additional information about CoC for Providers – All Members – data elements if pertinent.	Receiving MCP	11/22/23 – 12/31/24	Narrative

Figure 5. CoC for Providers – Special Populations

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
14	Cumulative number of Special Population members	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
15	Cumulative number of out-of-network (OON) Providers for Special Populations that are eligible for CoC for Providers agreements. Eligible Providers: *PCP, specialists, ECM providers, Community Supports providers, SNFs, ICF/DD, CBAS, dialysis centers, physical therapists, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment providers, speech therapy providers, doulas, community health workers*	Receiving MCP	11/22/23 – 6/30/24	Cumulative count This number should not decrease as contracts and CoC for Provider agreements are executed. Before the transition, this number may fluctuate based on transitioning member plan choice before the plan-choice cut-off date in December 2023.
16	Cumulative number of OON providers for Special Populations contacted to bring in network or to initiate CoC agreements	Receiving MCP	12/1/23 – 6/30/24	Cumulative count

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
17	CoC for Providers for Special Populations Status: Cumulative number of eligible OON Special Populations' Providers with no contract or CoC for Providers agreement	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
18	CoC for Providers for Special Populations Status: Cumulative number of OON Special Population providers the Receiving MCP contracted with after 11/1/23 to bring in network	Receiving MCP	11/22/23 – 6/30/24	Cumulative count (Network contracts only; excludes CoC for Providers agreements)
19	CoC for Providers for Special Populations Status: Cumulative number of OON Special Population providers with whom the Receiving MCP entered a CoC for Providers agreement	Receiving MCP	11/22/23 – 6/30/24	Cumulative count (CoC for Providers agreements only; excludes network contracts)
20	CoC for Providers for Special Populations Status: Cumulative number of OON	Receiving MCP	11/22/23 – 6/30/24	Cumulative count

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	Special Populations providers with whom a contract or CoC for Providers agreement is pending/in process			
21	Reason for not contracting or establishing a CoC for Providers agreement for Special Populations	Receiving MCP	11/22/23 – 6/30/24	Attestation Y/N: The MCP attests that the following are the only reasons for which the MCP did not contract with or establish a CoC for Providers agreement with eligible OON providers for special populations. *Reasons: No relationship between member and provider; Provider refused to work with MCP; Provider not state approved; Quality of care issues; Provider and MCP did not agree to a rate; Provider is in MCP Network; Provider type is not protected by Continuity of Care for Providers* If a contract or agreement was not established for any reason not listed, the

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
				MCP must report the reason to DHCS.
22	Timeliness: Cumulative number of CoC for Providers agreements that took more than 30 days to complete after contacting the OON providers	Receiving MCP	1/1/24 – 6/30/24	Cumulative count (exclude agreements that took longer than 30 days but were completed by January 1, 2024)
23	Optional: MCPs may provide additional information about CoC for Providers – Special Populations – data elements if pertinent.	Receiving MCP	11/22/23 – 6/30/24	Narrative

Figure 6. CoC for Services – All Members

Includes authorizations for transitioning members who meet Special Population criteria				
Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** *(MCPs will report for each county unless indicated)*
24	Reason for closing authorizations before July 1, 2024	Receiving MCP	1/1/24 – 6/30/24	Attestation Y/N: The MCP attests that authorizations were closed before June 30, 2024 only for the reason of expiration. If No, and an authorization is closed for any other reason than expiration during that time, the MCP must report the type(s) of service(s) and reason(s) (e.g., member declined service)

Figure 7. CoC for Services – Special Populations

Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** *(MCPs will report for each county unless indicated)*
25	Confirm the MCP examined utilization data to identify Special Populations members' active courses of treatment and contacted providers	Receiving MCP	1/1/24 – 6/30/24	Attestation Y/N: The MCP attests that it examined utilization data for active courses of treatment that will require authorization to continue, and contacted 100% of those providers to establish prior authorizations. If No, the MCP must provide explanation

Figure 8. CoC Coordination and Management Information

(No active measures as of 3/31/2024)

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
26	The Previous MCP provided key staff contact(s) for the Receiving MCPs to contact by Nov. 2, 2023	Previous MCP	One-time 11/22/23	Attestation Y/N: The Previous MCP attests that it provided key staff contacts to the Receiving MCP(s) by Nov. 2, 2023 to facilitate sharing of supportive information. If No, the Previous MCP must provide an explanation
27	The MCP attests to obtaining supportive information from the Previous MCP by 1/1/24 or within 15 calendar days the transitioning member changes care managers, whichever is later	Receiving MCP	11/22/23 – 3/31/24	Data element applies only to Special Population members who change care managers. Attestation Y/N: The MCP attests that it obtained supportive information for 100% of members changing care managers before 1/1/24 or within 15 calendar days of changing, whichever is later. If No, the MCP must provide an explanation

c. Enhanced Care Management and Community Supports Data Elements

Figure 9. CoC for Enhanced Care Management (ECM) Covered Services and Providers

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
28	Cumulative number of transitioning members with authorizations to receive ECM	Previous MCP	11/22/23 – 3/31/24	Cumulative count by Receiving MCP For this data element, MCPs should report separate counts for each MCP receiving members from the Previous MCP in the county. For example, if Plan A is the Previous MCP, and Plan A sends members to Plan B and Plan C in County X, then Plan A will report a separate number for Plan B and Plan C in County X.
29	Optional: MCPs may provide additional information about the ECM Covered Services data element if pertinent.	Previous MCP	11/22/23 – 3/31/2024	Narrative
30	Cumulative number of transitioning members automatically authorized by the Receiving MCP to receive ECM upon transitioning	Receiving MCP	1/1/24 – 6/30/24	Cumulative count by Previous MCP For this data element, MCPs should report separate counts for members transitioning from each

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
				Previous MCP in the county. For example, if Plan B is the Receiving MCP in County X, and Plan A and Plan D are Previous MCPs in County X, then Plan B will report a separate number for Plan A and Plan D in County X.
31	Cumulative number of out-of-network (OON) ECM providers	Receiving MCP	11/22/23 – 6/30/24	Cumulative count This number should not be reduced as contracts and CoC for Provider agreements are executed. Before the transition, this number may fluctuate based on transitioning member plan choice before the plan-choice cut-off date in December 2023.
32	CoC for ECM Providers status: Cumulative number of OON ECM providers with which the Receiving MCP either contracted or established a CoC for Providers agreement	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
33	CoC for ECM Providers status: Cumulative number of OON ECM providers with which the Receiving MCP	Receiving MCP	11/22/23 – 6/30/24	Cumulative count

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	neither contracted nor established a CoC for Providers agreement			
34	CoC for ECM Providers status: Cumulative number of OON ECM providers with which a contract or CoC for Providers agreement is pending/in process	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
35	Reason for not contracting with or establishing a CoC for Providers agreement with ECM providers	Receiving MCP	11/22/23 – 6/30/24	Attestation Y/N: The MCP attests that the following are the only reasons for which the MCP did not contract with or establish a CoC agreement with eligible OON ECM providers. *Reasons: No relationship between any transitioning ECM member and provider; Provider refused to work with managed care plan; Provider did not meet criteria to be an ECM provider, as defined by DHCS; Quality of care issues; Provider and plan did not agree to a rate* If a contract or agreement was not established for any reason not listed, the MCP

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
				must report the reason to DHCS.
36	Optional: MCPs may provide additional information about ECM Covered Services and Providers data elements if pertinent.	Receiving MCP	11/22/23 – 6/30/24	Narrative

Figure 10. CoC for Community Supports Covered Services and Providers

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
37	Cumulative number of transitioning members with authorizations to	Previous MCP	11/22/23 – 3/31/24	Cumulative count by Receiving MCP For this data element, MCPs should report separate

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	receive Community Supports			counts for each MCP receiving members from the Previous MCP in the county. For example, if Plan A is the Previous MCP, and Plan A sends members to Plan B and Plan C in County X, then Plan A will report a separate number for Plan B and Plan C in County X.
38	Optional: MCPs may provide additional information about the Community Supports Covered Services data element if pertinent.	Previous MCP	11/22/23 – 3/31/2024	Narrative
39	Cumulative number of transitioning members automatically authorized by the Receiving MCP to receive Community Supports upon transitioning	Receiving MCP	1/1/24 – 6/30/24	Cumulative count by Previous MCP For this data element, MCPs should report separate counts for members transitioning from each Previous MCP in the county. For example, if Plan B is the Receiving MCP in County X, and Plan A and Plan D are Previous MCPs in County X, then Plan B will report a separate number for Plan A and Plan D in County X.
40	Reason for not automatically	Receiving MCP	1/1/24 - 6/30/24	Attestation Y/N:

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	authorizing Community Supports for transitioning members			The MCP attests that the only reasons the MCP does not automatically authorize Community Supports are: 1) the MCP does not provide the Community Support, 2) the transitioning member already completed the Community Support. If No, the MCP must provide an explanation
41	Confirm the MCP coordinates transitioning members' transitions to necessary services if the MCP does not offer the Community Support the member was receiving from the Previous MCP	Receiving MCP	1/1/24 – 6/30/24	Attestation Y/N: The MCP attests that it coordinates care to necessary services to ensure transition of care if the MCP does not offer the Community Supports the member was receiving If No, the MCP must provide an explanation
42	Cumulative number of out-of-network (OON) Community Supports Providers	Receiving MCP	11/22/23 – 6/30/24	Cumulative count This number should not be reduced as contracts and CoC for Provider agreements are executed. Before the transition, this number may fluctuate based on transitioning member plan choice before the plan-choice cut-off date in December 2023.

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
43	CoC for Community Supports Providers status: Cumulative number of OON Community Supports providers with which the Receiving MCP either contracted or established a CoC for Providers agreement	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
44	CoC for Community Supports Providers status: Cumulative number of OON Community Supports providers with which the Receiving MCP neither contracted nor established a CoC for Providers agreement	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
45	CoC for Community Supports Providers status: Cumulative number of OON Community Supports providers with which a contract or CoC for Providers agreement is pending/in process	Receiving MCP	11/22/23 – 6/30/24	Cumulative count
46	Reason for not contracting with or establishing a CoC for	Receiving MCP	11/22/23 – 6/30/24	Attestation Y/N: The MCP attests that the following are the only

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(MCPs will report for each county unless indicated)*
	Providers agreement with Community Supports providers			reasons for which the MCP did not contract with or establish a CoC agreement with eligible OON Community Supports providers. *Reasons: When MCPs' Community Supports are not aligned; No relationship between any transitioning ECM member and provider; Provider refused to work with managed care plan; Provider did not meet criteria to be an ECM provider, as defined by DHCS; Quality of care issues; Provider and plan did not agree to a rate* If a contract or agreement was not established for any reason not listed, the MCP must report the reason to DHCS.
47	Optional: MCPs may provide additional information about Community Supports Covered Services and Providers data elements if pertinent.	Receiving MCP	11/22/23 – 6/30/24	Narrative

d. Member Issues Data Elements

Figure 11. Member Issues Via Receiving MCP Member Call Centers

(No active measures as of 3/31/2024)

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated*)
48	Total call volume to MCP member call centers*	Receiving MCPs	1/1/24 – 3/31/24	Total count
49	Total transition-related calls to MCP member call centers	Receiving MCPs	1/1/24 – 3/31/24	Total count MCPs will flag member calls as related to the "2024 Transition" and categorize by call types listed in Figure 28.
50	Optional: MCPs may provide additional information about Member Issues via Receiving MCP Member Call Centers data element if pertinent.	Receiving MCP	1/1/24 – 3/31/2024	Narrative

**This data element will require the Receiving MCP to submit baseline data as noted in A.2.*

Figure 12. Transition-Related Categorization of Member Calls to MCP Member Call Centers

Category	Type
Access to Care	• General category that includes access to care types: geographic access, physical access, language access, timely access, rural member denied Out of Network request.
Continuity of Care	• Provider
	• Case management/care coordination
	• Treatment/Authorization
	• Transplant
	• ECM
	• Community Supports
	• DME
	• Transportation

Category	Type
	• Other Continuity of Care
General Transition	• General category which would include other issues such as enrollment, quality of service, referrals, confusion with plan change, information seeking or transition-related complaint (not leading to a formal grievance)

Figure 13. Member Issues Via Receiving MCP Grievances and Appeals

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated)*
51	Total transitioning member grievances filed with MCP	Receiving MCPs	1/1/24 – 6/30/24	Total count* of all grievances
52	Total transitioning member grievances filed with MCP for the top five grievance types	Receiving MCPs	1/1/24 – 6/30/24	Total count* for each of the top five grievance types
53	Total transitioning member grievances by benefit type	Receiving MCPs	1/1/24 – 6/30/24	Total grievance count* for select benefit types as indicated in Survey Monkey
54	Total transitioning member appeals filed with MCP	Receiving MCPs	1/1/24 – 6/30/24	Total count* of all appeals
55	Total transitioning member appeals filed with MCP by appeal type	Receiving MCPs	1/1/24 – 6/30/24	Total count* for each appeal type
56	Total transitioning member appeals filed with MCP by benefit type	Receiving MCPs	1/1/24 – 6/30/24	Total appeal count* for select benefit types as indicated in Survey Monkey

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated)*
57	Optional: MCPs may provide additional information about Member Issues via Receiving MCP Grievances and Appeals data element if pertinent.	Receiving MCP	1/1/24 – 6/30/24	Narrative

*Total count should be limited to the total data collected during the data reporting period**.*** For example, during the bi-weekly reporting period, the total count would equal the number of grievances or appeals received/categorized over those two weeks**.**

Figure 14. MCP Member Call Center Baseline Data

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated)*
58	Total call volume to MCP member call centers in October 2023	Receiving MCP	One-time 11/22/24	Total calls for periods 10/1 – 10/7; 10/8 – 10/14; 10/15 – 10/21; 10/22 – 10/28.

Figure 15. Data Files Transmitted From Previous MCPs

(No active measures as of 3/31/2024)

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated)*
59a	Data files transmitted from Previous MCPs	Receiving MCP	12/18/23 – 3/31/24	Y/N: The MCP received all required CoC data files from Previous MCPs on the required refresh date, and data files were complete and of expected quality

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (*MCPs will report for each county unless indicated)*
59b	Data files transmitted from Previous MCPs	Receiving MCP	12/18/23 – 3/31/24	If No to 59a, the MCP must provide a written explanation for each Previous MCP with which the Receiving MCP has a data sharing concern, with the following information: 1) Previous MCP(s) name and HCP code(s) 2) File name(s) that had the issue 3) Specific data element name(s) in each file 4) Description of the issue with each data element
60	Optional: MCPs may provide additional information about data file transmitted from Previous MCPs if pertinent.	Receiving MCP	12/18/23 – 3/31/24	Narrative

B. Monitoring and Oversight Progression to Enforcement Action

Through monitoring and oversight activities, DHCS may determine that MCP enforcement action becomes necessary to address transition performance issues. DHCS will apply administrative and/or monetary sanctions in accordance with Welfare and Institutions Code (WIC) 14197.7, Title 42 of the Code of Federal Regulations (CFR) section 438.700 et seq., the DHCS MCP contract, and APL 23-012. DHCS may take any one or a combination of enforcement actions including, but not limited to, require a CAP, assess a monetary sanction, or impose a non-monetary sanction.

In alignment with the Transition Guiding Principles in Section II, Introduction, MCPs must work proactively to minimize disruptions to members during the Transition, particularly for vulnerable populations when the disruption can lead to member harm. For example, if a member is unable to access a medically necessary dialysis treatment

due to a missed Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) service, DHCS may sanction the MCP for causing harm to the member and its failure to comply with the CoC policy outlined in V.F.2. Pursuant to state and federal laws and regulations, DHCS may immediately impose financial sanctions on MCPs in the event of any harm caused to members. For a compliance issue that impacts members, each member impacted constitutes a separate violation, and DHCS may impose sanctions for every violation.

X. Transition-Related Requirements for Incentive Programs

The 2024 MCP Transition has intersections with various Medi-Cal initiatives. For example, and as noted in Section VI, Transition Policies for Enhanced Care Management and Section VII, Transition Policy for Community Supports, PATH CITED grants encourage awardees to enter into ECM and Community Supports contracts with Receiving MCPs and require that awardees contract with at least one MCP per county. MCP Transition-related components of select incentive programs are outlined below for ease of reference for MCPs. These requirements are consistent with underlying program-specific guidance previously issued and linked herein. MCPs should refer to each incentive program's primary documentation for further information and reach out to the appropriate DHCS program staff with questions.

A. Incentive Payment Program (IPP)

Program Description: The IPP supports implementation and expansion of Enhanced Care Management (ECM), Community Supports and other CalAIM initiatives, focusing on incentivizing member engagement and service delivery; building sustainable infrastructure and capacity; promoting program quality; and creating equitable access for ECM Populations of Focus. APL 23-003 provides comprehensive guidance related to IPP. DHCS does not direct or restrict the use of IPP funds once they are earned by an MCP.

Transition Considerations: IPP has transition-specific measures to incentivize collaboration across exiting, entering and continuing MCPs to maximize ECM and Community Supports provider network overlap and support continuity of care for members authorized to receive ECM and Community Supports during the MCP Transition.

- July – December 2023 Measurement Period: To earn IPP funds, MCPs must submit a transition plan to support MCPs exiting the market in a given county and collaborate with MCPs entering the market or transitioning from subcontract to prime MCP. These transition plans must describe cross-MCP collaboration with ECM and Community Supports provider networks to promote continuity of care for Medi-Cal members in the county. Exiting, continuing, and entering MCPs must attest that they had the opportunity to provide input into the transition plan.
- January – June 2024 Measurement Period: Continuing MCPs must demonstrate coordination and collaboration to ensure smooth network transitions in the counties in which they operate. In addition, entering MCPs will have an opportunity to earn IPP funds in their new counties,

based on submission of a needs assessment and gap-filling plan as well as performance on IPP measures.

B. Housing and Homelessness Incentive Program (HHIP)

Program Description: The HHIP awards incentive funds to MCPs for making investments and progress in addressing homelessness and keeping people housed. The funds are based on a Homelessness Plan that MCPs submit to DHCS, prepared in partnership with the local homeless Continuum of Care, local public health jurisdictions, county behavioral health, public hospitals, county social services, and local housing departments. APL 22-007 (REVISED) provides comprehensive guidance related to HHIP. DHCS does not direct or restrict the use of HHIP funds once they are earned by an MCP.

Transition Considerations: The HHIP will conclude at the end of December 2023. As such, MCPs newly entering counties will not be eligible for HHIP funds associated with their new service areas. While MCPs' HHIP Investment Plans included planned investments through 2023 only, in order to earn HHIP funds MCPs were required to address the sustainability of their approach and investments. MCPs should familiarize themselves with sustainability plans and support transition of knowledge, partnerships, and strategies across continuing, exiting and entering MCPs beyond the conclusion of HHIP and the MCP Transition. Entering MCPs must engage with the Continuum of Care and review the HHIP Homelessness Plan for their new counties.

C. Student Behavioral Health Incentive Program (SBHIP)

Program Description: The SBHIP provides incentive payments to MCPs for improving coordination among MCPs, Local Education Agencies, and county mental health plans to deliver a comprehensive and continuous system of care for Medi-Cal students to access the entire scope of available behavioral health benefits. Incentive payments reward MCPs that meet predefined goals and metrics that are associated with targeted interventions that increase access to preventive, early intervention and behavioral health services by school-affiliated behavioral health providers for children enrolled in Transitional Kindergarten through grade 12 in public schools. DHCS does not direct or restrict the use of SBHIP funds once they are earned by an MCP.

Transition Considerations: The SBHIP will conclude at the end of December 2024. MCPs will earn incentive payments for achievement of milestones and

performance metrics outlined in MCP Project Plans submitted in 2022. MCPs newly entering counties with no exiting MCP(s) will not be eligible for SBHIP funds associated with their new service areas. However, MCP(s) newly entering a county with exiting MCP(s) will be eligible for SBHIP funds, as the dollars will be shifted from the exiting MCP(s) to the incoming MCP(s) within a county. MCPs are strongly encouraged to continue the targeted interventions included in those Project Plans and support transition of knowledge, partnerships, and strategies across continuing, exiting and entering MCPs in 2024 and beyond the conclusion of SBHIP and the MCP Transition.

XI. Communication

DHCS has created and shared transition-related resources that MCPs should utilize to support members, providers, and other stakeholders leading up to and following the MCP transition on January 1, 2024. These resources should be especially utilized among Previous and Receiving MCPs to address questions from members who will transition between MCPs, but the information may be helpful for any MCP that receives questions about the transition. These resources are available online at Medi-Cal MCP Transition homepage[134]; as DHCS develops new or updates existing resources, they will be posted to this URL.

A. Resources Overview

The following resources are available on the DHCS website. All of these resources are accessible from the Medi-Cal MCP Transition homepage which provides an overview of the 2024 MCP Transition and how it fits into California's transformation of Medi-Cal.

- Members page – This page explains the transition to members and actions they may need to take if they are impacted by the transition. It includes other resources, such as:
    - A search tool that enables a member to determine whether their MCP is changing by entering their county; the tool displays specific MCP information for each county, whether members have to take any actions, and provides information for members in special situations.
    - The notices members received from DHCS related to the transition as well as the Notice of Additional Information (NOAI) that is accessible from a QR code on the notices. The NOAI is translated into all threshold languages and is available as downloadable PDFs. See Section IV. Member Enrollment and Noticing, B. Transition Noticing Policy for more detail about member noticing.
    - General Frequently Asked Questions (FAQs) that address anticipated member questions about the transition.
    - Continuity of Care FAQs that address anticipated member questions about how they can continue seeing their providers and accessing treatments and services during the transition.
- Providers page featuring FAQs addressing anticipated provider questions about the transition.

[134] https://www.dhcs.ca.gov/MCP-Transition/Pages/Home.aspx

- MCPs and Stakeholders page featuring policy resources, as well as news and updates about the transition.
- Contact Us page with contact information for members, providers, MCPs and stakeholders to learn more about the MCP transition including, but not limited to, MCP and provider choices.

B. How MCPs Should Use These Resources

MCPs should leverage DHCS materials to support members who are transitioning MCPs on January 1, 2024, as well as members' impacted providers. Specifically, MCPs should:

- Share the Frequently Asked Questions and other webpages (above) with members via regular MCP outreach and communication channels such as member newsletters, bulletins, flyers and emails.
- Use these resources to inform MCP-specific communication resources about the transition, such as FAQs or emails to members.
- Use the materials to train MCP member call center staff about the transition and how best to address member and provider questions.
- Ensure that all member and provider newsletters/bulletins include accurate information and resources regarding the transition.
- Point members to the search tool to help them determine whether and/or how they are impacted by the MCP transition.

XII. Transition Policy for Assessments and Screening Tools

Managed Care Plans (MCPs) provide assessments and screenings for new members as part of Population Health Management (PHM) policy requirements, as outlined in the MCP contract (section 4.3.6) and the PHM Policy Guide. This section explains requirements for three assessment and screening tools in the context of the 2024 MCP Transition:

- Health Information Form (HIF)/Member Evaluation Tool (MET)
- Initial Health Appointment(s)
- Health Risk Assessment (HRA)

MCPs should continue referring to the DHCS PHM Policy Guide that sets forth comprehensive requirements applicable for MCPs for the implementation of PHM.

1. Health Information Form (HIF)/Member Evaluation Tool (MET)

The Health Information Form (HIF)/Member Evaluation Tool (MET) is a screening tool that is required to be completed within 90 days of MCP enrollment for new members. It fulfills the federal initial screening requirement.[135] Receiving MCPs must complete the HIF/MET for transitioning members within 90 days of January 1, 2024 regardless of whether the Previous MCP completed a HIF/MET for the member. Consistent with the PHM Policy Guide, MCPs may fulfill the HIF/MET requirement in one of two ways:

a) The MCP contracts with a provider to complete the HIF/MET. The provider is responsible for following up on positive screening results. If the HIF/MET is not contracted to be done by providers, the MCP must either directly follow up on positive screening results or contract with the provider to complete the follow-up (and share relevant information with the provider to do so).

b) A provider completes the Initial Health Appointment(s) requirement for a transitioning member after the member transitions to the Receiving MCP and shares the completed Initial Health Appointment(s) with the Receiving MCP within 90 days of the member joining the MCP.

[135] 42 CFR 438.208(b)(3)-(4)

2. Initial Health Appointment(s)

Receiving MCPs must ensure that a member has **Initial Health Appointment(s)** within 120 days of the member transitioning to the Receiving MCP. The Initial Health Appointment(s) must include a history of the transitioning member's physical and behavioral health, an identification of risks, an assessment of needs for preventive screens or services and health education, and the diagnosis and plan for treatment of any diseases.[136] The Initial Health Appointment(s) requirement can be completed over the course of multiple visits. Telehealth visits can be used as an option for completing one or more components of the Initial Health Appointment(s) requirement, but not all of the requirement.

The Receiving MCP is not required to complete the Initial Health Appointment(s) requirement within 120 days if the member's primary care physician determines that the member's medical record contains complete information, updated within the previous 12 months. The conclusion of the PCP's assessment must be documented in the member's medical record. Even if the member's PCP determines that the member's record contains complete information such that an Initial Health Appointment(s) does not need to be conducted within 120 days, the receiving MCP still needs to complete a HIF/MET for members within 90 days of a member transitioning.

Other reasons a member may not complete the Initial Health Appointment(s) are the following: Member disenrolled before 120 days; Member refuses Initial Health Appointment(s) completion; and reasonable attempts by the MCP or delegated provider to contact the member were unsuccessful. All Initial Health Appointment(s) attempts should be documented in the member's medical record.

Per the PHM Policy Guide, the following also applies:

a) For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule, as referenced in APL 19-010.
b) MCPs should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the United States Preventive Services Taskforce (USPSTF). While MCPs may find it convenient for providers to complete the USPSTF required preventive screening during the first visit, DHCS no longer requires all of these elements to be completed during

[136] "CalAIM: Population Health Management (PHM) Policy Guide"

the first visit so long as members receive all required screenings in a timely manner consistent with USPSTF.

c) DHCS will measure primary care visits as a proxy for the Initial Health Appointment(s), leveraging Managed Care Accountability Sets (MCAS) measures specific to infant and child/adolescent well-child visits and adult preventive visits. For children, DHCS will measure both primary care visits and childhood screenings, including but not limited to screenings for ACEs, developmental, depression, autism, vision, hearing, lead, and SUD.

3. Health Risk Assessment (HRA)

The Health Risk Assessment (HRA) is an assessment required for Seniors and Persons with Disabilities (SPD).[137] Receiving MCPs must adhere to the following for transitioning members identified as SPD:

- **Transitioning members with no record of an HRA:** The Receiving MCP must complete an HRA for transitioning members identified as SPD who do not have a record of an HRA and meet the definition of "high risk" per guidance outlined in the CalAIM: Population Health Management (PHM) Policy Guide and APL-22-024. [138]

- **Transitioning members who have an existing HRA:**
    - For transitioning members authorized to receive Long-Term Services and Supports (LTSS), the Receiving MCP may rely upon an HRA conducted by the Previous MCP on or after January 1, 2023. The Receiving MCP must conduct an HRA if the Previous MCP conducted the HRA before January 1, 2023, or if the transitioning member experienced a significant change in health status or level of care since the previous HRA, or upon receipt of new information that the Receiving MCP determines as potentially changing a member's level of risk and need.
    - For all other transitioning members, the Receiving MCP may rely upon an HRA conducted by the Previous MCP before, on, or after January 1, 2023. The Receiving MCP must conduct an HRA if the transitioning member experienced a significant change in health status or level of care since the previous HRA, or upon receipt of new information that the Receiving MCP determines as potentially changing a member's level of risk and need.

[137] "CalAIM: Population Health Management (PHM) Policy Guide"

[138] "CalAIM: Population Health Management (PHM) Policy Guide;" APL-22-024

XIII. Glossary

2024 MCP Transition: Refers to changes to the Medi-Cal Managed Care Plans (MCPs) operating in specific counties slated to take effect on January 1, 2024, as a result of county-level Medi-Cal model change, changes to commercial MCP contracting, and the Kaiser direct contract.

Active Course of Treatment: A course of treatment in which a member is actively engaged with a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

Authorized Representative: Any individual appointed in writing by a competent member or potential member to act in place or on behalf of the member or potential member for purposes of assisting or representing the member or potential member with grievances and appeals, state fair hearings, independent medical reviews, or in any other capacity, as specified by the member or potential member.

Care Manager: For the purposes of this policy, a Care Manager is inclusive of the Complex Care Management (CCM) Care Manager and the Enhanced Care Management (ECM) lead care manager, as well as other care managers.

Care Management Plan: A written plan that is developed with input from the member and/or their family members, parents, legal guardians, Authorized Representatives, caregivers, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and to make recommendations for clinical and non-clinical service needs.

Center of Excellence (COE) Transplant Program: A designation assigned to a Transplant Program by DHCS upon confirmation that the Transplant Program meets DHCS' criteria. MCPs are required to ensure all Major Organ Transplant (MOT) procedures are performed in a Medi-Cal approved COE **Transplant Program** which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, Parts 405, 482, 488, and 498 and section 1138 of the Social Security Act (SSA).

Community Supports (CS): Substitute services or settings for those required under the California Medicaid State Plan that the MCP may select and offer to its members pursuant to 42 CFR section 438.3(e)(2) when pre-approved by the Department of Health Care Services (DHCS) as medically appropriate and cost-effective substitutes for Covered Services or settings under the California Medicaid State Plan.

Complex Care Management (CCM): A service for MCP members who need extra support to avoid adverse outcomes but who are not in the highest risk group designated for ECM. CCM provides both ongoing chronic care coordination and interventions for episodic, temporary needs, with a goal of regaining optimum health or improved functional capability, in accordance with all National Committee for Quality Assurance CCM requirements.

Continuing MCP: A prime MCP that operates within a county today and will continue to operate as a prime MCP within the county in 2024. A Continuing MCP is one type of Receiving MCP.

Continuity of Care for Providers Agreement: A single case agreement (for a specific, named member) or letter of agreement (for multiple members) between a Receiving MCP and OON provider, intended to maintain trusted member/provider relationships until a member can transition to a network provider with the Receiving MCP. A Continuity of Care for Providers agreement enables transitioning members to continue receiving care from their existing providers for a period of time, if certain requirements are met.

Covered Services: Those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14132 *et seq*., 22 California Code of Regulations (CCR) section 51301 *et seq.*, 17 CCR section 6800 *et seq.*, the Medi-Cal Provider Manual, the California Medicaid State Plan, the California section 1115 Medicaid Demonstration Project, the MCP Contract, and All Plan Letters (APLs), that are made the responsibility of the Prime MCP pursuant to the California section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Default Assignment: Process of assigning a member to an MCP to be enrolled into in the event that they do not make an active choice of MCP, where applicable; default assignment is inclusive of provider, plan and/or family "linkage" – by which a member is default assigned to an MCP that will maximize member continuity if one is available – and the Auto-Assignment Incentive Program, which assigns remaining members on the basis of MCP quality scores and other factors.

Durable Medical Equipment (DME): Medically necessary medical equipment as defined by 22 CCR section 51160 that a provider prescribes for a member that the member uses in the home, in the community, or in a facility that is used as a home.

Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members who meet ECM Populations of Focus eligibility criteria, through systematic

coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.[139]

ECM Provider: Community-based entity with experience and expertise providing intense, in-person care management services to members in one or more of the Populations of Focus for ECM.

Entering MCP: An MCP that does not operate as a Prime MCP within a county today but will operate as a Prime MCP within the county starting January 1, 2024. An Entering MCP is one type of Receiving MCP.

Exiting MCP: An MCP that operates as a Prime MCP within a county today and is exiting the market in that county effective January 1, 2024, due to county-level Medi-Cal managed care model change or changes in commercial MCP contracts for the county. An Exiting MCP is one type of Previous MCP.

Medi-Cal Matching Plan policy: A policy in specific counties under which Dual-eligible members that choose to enroll in a Medicare Advantage (MA) plan are automatically enrolled with a matching Medi-Cal MCP with the same parent company, if one is available. This policy does not change or impact a member's MA plan choice.

Member: A person eligible for Medi-Cal and enrolled in an MCP.

Network Provider: Any provider or entity that has a Network Provider Agreement with the Prime MCP, Subcontractor, or downstream Subcontractor and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to members. A network provider is not a Subcontractor or downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: A written agreement between a network provider and the Prime MCP, the MCP's Subcontractor, or the MCP's Downstream Subcontractor.

Out-of-Network (OON) Provider: A provider that is not a network provider (i.e., does not have a contract to participate in an MCP network).

Pre-Existing Relationship: When a member had at least one non-emergency visit with the provider during the 12 months preceding January 1, 2024. This Pre-Existing Relationship does not limit the Continuity of Care protections for members who have a health condition listed in the Knox-Keene Health Care Service Plan Act, California Health and Safety Code (H&S) section 1373.96.

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[139] For the definition of "Populations of Focus," see the "CalAIM Enhanced Care Management Policy Guide" at: https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf.

Previous MCP: A Prime MCP or Subcontractor MCP that a member is required to leave effective January 1, 2024, for one of the following reasons: (1) the MCP exits the market (i.e., an Exiting MCP), (2) the Subcontractor and the MCP terminate their Subcontractor Agreement, or (3) DHCS requires the Prime MCP to transition members to a Subcontractor MCP.

Prior Authorization: A formal process requiring a provider to obtain advance approval of the amount, duration, and scope of non-emergent Covered Services.

Primary Care Provider (PCP): A provider responsible for supervising, coordinating, and providing initial and primary care to members, for initiating referrals, for maintaining the continuity of member care, and for serving as the Medical Home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist. For Senior and Person with Disability (SPD) members, a PCP may also be a specialist or clinic.

Prime MCP: An MCP that directly contracts with DHCS to provide Covered Services to members within the county or counties specified in their contract.

Prior Authorization: A formal process requiring a Provider to obtain advance approval of the amount, duration, and scope of non-emergent Covered Services.

Provider: Any individual or entity that is engaged in the delivery of Covered Services, or in ordering or referring for those services, and is licensed or certified to do so.

Receiving MCP: A Prime MCP or Subcontractor MCP that a member joins by choice or default after being required to leave a Previous MCP effective January 1, 2024. Receiving MCPs may be Continuing MCPs or Entering MCPs in a county.

Senior and Person with Disability (SPD): A Member who falls under a specific SPD aid code as defined by DHCS.

Special Populations: Members most at risk for harm from disruptions in care or who are least able to access CoC protections by request and who are identifiable in DHCS data or Previous MCP data.

Subcontractor: An individual or entity that has a Subcontractor Agreement with an MCP that relates directly or indirectly to the performance of the MCP's obligations under the MCP Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement: A written agreement between the Prime MCP and a Subcontractor. The Subcontractor Agreement must include a delegation of the Prime MCP's duties and obligations under the contract.

Subcontracted MCP: An MCP that contracts with the prime MCP to assume full or partial risk of a portion of the prime MCP's membership.

Transitioning Member: A member of a Previous MCP who enrolls in a Receiving MCP on January 1, 2024, due to the Previous MCP exiting the county or another required transition to a new Prime MCP or Subcontractor. The term "transitioning member" excludes those members who opt to change MCP by choice.

Transplant Program: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current member of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS). Bone marrow Transplant Programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.

XIV. Appendix: County-Level MCP Transitions

Background

The following table lists Medi-Cal managed care plan (MCP) changes by county slated to take effect January 1, 2024. The changes are the result of county Medi-Cal model changes, commercial MCP contracting agreements and the Kaiser Foundation Health Plan (Kaiser) direct contract.[140] The table also outlines relevant transition-related policies as applicable to each county's Medi-Cal members.

Updates may be made on an ongoing basis to this appendix as relevant. This appendix will also be revised to include links to county and member scenario-specific member notices, once they are final.

The following Key Terms are defined as follows for the purpose of this appendix:

- **Prime MCP:** An MCP that directly contracts with DHCS to provide Medi-Cal services to members within the county or counties specified in their contract.
- **Subcontracted MCP:** An MCP that contracts with the Prime MCP to assume full or partial risk of a portion of the prime MCP's membership.
- **Exiting MCP:** An MCP that operates as a Prime MCP within a county today and is exiting the county effective January 1, 2024 due to county-level Medi-Cal managed care model change or changes in commercial MCP contracts for the county.

[140] Members are eligible to enroll into Kaiser in counties where Kaiser will operate under direct contracts if they meet the following criteria: (1) previously enrolled with Kaiser at any point during calendar year 2023; (2) existing Kaiser membership; (3) Kaiser member at any time during the 12 months preceding the effective date of their Medi-Cal eligibility; (4) spouse/domestic partner, child, foster child, stepchild, dependent who is disabled, parent, stepparent, grandparent, guardian, foster parent, or other relative with appropriate documentation is a Kaiser member; (5) previously enrolled in a prime MCP other than Kaiser, but was assigned to Kaiser as a subcontracted MCP to that prime MCP at any time during calendar year 2023; (6) dually eligible for Medi-Cal and Medicare in select counties in which Kaiser operates as a MCP; (7) in foster care or is a former foster care youth that elects to enroll in Medi-Cal managed care; (8) assigned to Kaiser by DHCS' default assignment process, subject to an annual cap based on projected capacity.

- **Continuing MCP:** A Prime MCP that operates within the county today and will continue to operate as a Prime MCP within the county in 2024.
- **Entering MCP:** An MCP that does not operate as a Prime MCP within a county today and will operate as a Prime MCP within the county starting January 1, 2024.
- **Default Assignment:** The process of assigning a member to an MCP to be enrolled into in the event that they do not make an active choice of MCP, where applicable; Default Assignment is inclusive of provider, plan and/or family "linkage" – by which a member is default assigned to an MCP that will maximize member continuity if one is available – and the Auto-Assignment Incentive Program, which assigns remaining members on the basis of MCP quality scores and other factors.
- **Medi-Cal Matching Plan policy:** A policy in specific counties under which Dual-eligible members that choose to enroll in a Medicare Advantage (MA) plan are automatically enrolled with a matching Medi-Cal MCP with the same parent company, if one is available. This policy does not change or impact a member's MA plan choice.[141]

[141] Please see 2023 Medicare Medi-Cal Plan List

MCP Changes	Transition-Related Enrollment & Noticing Policy
Alameda County * - Transitioning from Two-Plan to Single Plan Model***	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) ***Continuing MCPs*** • Alameda Alliance for Health (AAH) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing Anthem Members*** • Anthem will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to Dual-eligible members in Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to all other Anthem members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with AAH or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members' new MCP will send member information within one week of enrollment ***Existing AAH Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy • All other members enrolled in the Kaiser subcontracted MCP to AAH as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with AAH by contacting Medi-Cal Health Care Options • All other AAH members will not receive transition notices and will not be compelled to change MCPs; they may choose to

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	enroll with Kaiser starting Jan. 2024, subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (Anthem) • Medi-Cal Health Care Options will notify new members of automatic enrollment with AAH or Kaiser, based on Medi-Cal Matching Plan policy for Dual-eligible members and plan/family linkage default assignment[142^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • New members assigned to or choosing Kaiser in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing AAH in Q4 2023 will be enrolled at the beginning of the following month
Alpine County – Transitioning from Regional to Two-Plan Model	
Exiting MCPs • California Health & Wellness (CHW) ***Continuing MCPs***	***Existing CHW Members*** • CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send members an MCP choice packet and a "60-day" notice (no later than Nov. 1, 2023), which will indicate a member's default assigned MCP, followed by a "30-day" notice (no later than Dec. 1, 2023)

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) ***Entering MCPs*** • Health Plan of San Joaquin, d.b.a Mountain Valley Health Plan (MVHP)	• Members may actively choose between Anthem or MVHP for Jan. 1, 2024, effective enrollment • Members that do not make an active choice by late Dec. 2023 will be automatically enrolled into an MCP based on default assignment • Members' new MCP will send member information within one week of enrollment ***Existing Anthem Members*** • Anthem members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (CHW) • Medi-Cal Health Care Options will send a MCP choice packet to members at the time of initial eligibility; members may actively choose between Anthem and MVHP • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment • New members assigned to or choosing MVHP in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing Anthem in Q4 2023 will be enrolled the first of the following month
Amador County – Continuing under Regional Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing CHW Members*** • CHW sends 30-day notice indicating change to Health Net (no later than Dec. 1, 2023); CHW members automatically enrolled with Health Net effective Jan. 1, 2024

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) /Health Net Community Solutions (Health Net) *** • Kaiser Foundation Health Plan (Kaiser) ***Entering MCPs*** • N/A	***Existing Anthem and Kaiser Members*** • Anthem & Kaiser members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • Medi-Cal Health Care Options will send a MCP choice packet to members at the time of initial eligibility; members may actively choose between Anthem, Health Net, and Kaiser, with Kaiser active choice subject to eligibility criteria • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[143+]
Butte County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A	***Existing Anthem and CHW Members*** • Anthem & CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Entering MCPs • Partnership Health Plan of California (PHC)	***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024
Calaveras County – Continuing under Regional Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) / Health Net Community Solutions (Health Net) *** ***Entering MCPs*** • N/A	***Existing CHW Members*** • CHW sends 30-day notice indicating change to Health Net (no later than Dec. 1, 2023); CHW members automatically enrolled with Health Net effective Jan. 1, 2024 ***Existing Anthem Members*** • Anthem members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • No change to current process; members may actively choose between CHW / Health Net and Anthem
Colusa County – Transitioning from Regional to COHS Model	
Exiting MCPs	***Existing Anthem and CHW Members*** • Anthem & CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC)	• DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem or CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024
Contra Costa County * - Transitioning from Two-Plan to Single Plan Model***	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) ***Continuing MCPs*** • Contra Costa Health Plan (CCHP) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing Anthem Members*** • Anthem will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to Dual-eligible members in Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to all other Anthem members (no later than Nov. 1 and Dec. 1, 2023) indicating automatic enrollment with CCHP or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members' new MCP will send member information within one week of enrollment ***Existing CCHP Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy • All other members enrolled in the Kaiser subcontracted MCP to CCHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with CCHP by contacting Medi-Cal Health Care Options • All other CCHP members will not receive transition notices and will not be compelled to change MCPs; they may choose to enroll with Kaiser starting Jan. 2024, subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (Anthem) • Medi-Cal Health Care Options will notify new members of their automatic enrollment with CCHP or Kaiser, based on Medi-Cal Matching Plan policy for Dual-eligible members and plan/family linkage default assignment[144]^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• New members assigned to or choosing Kaiser in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing CCHP in Q4 2023 will be enrolled at the beginning of the following month
Del Norte County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county
El Dorado County – Transitioning from Regional to Two-Plan Model	
Exiting MCPs • California Health & Wellness (CHW) ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • Kaiser Foundation Health Plan (Kaiser) ***Entering MCPs***	***Existing CHW Members*** • CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send members an MCP choice packet and a "60-day" notice (no later than Nov. 1, 2023), which will indicate a member's default assigned MCP, followed by a "30-day" notice (no later than Dec. 1, 2023) • Members may actively choose between Anthem, Kaiser, or MVHP for Jan. 1, 2024 effective enrollment, with active choice of Kaiser subject to eligibility criteria • Members that do not make an active choice by late Dec. 2023 will be automatically enrolled into an MCP based on default assignment

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Health Plan of San Joaquin, d.b.a Mountain Valley Health Plan (MVHP)	• Members' new MCP will send member information within one week of enrollment ***Existing Anthem and Kaiser Members*** • Anthem and Kaiser members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (CHW) • Medi-Cal Health Care Options will send a MCP choice packet to members at the time of initial eligibility; members may actively choose between Anthem, Kaiser, and MVHP, with Kaiser active choice subject to eligibility criteria • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[145+] • New members assigned to or choosing MVHP in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing Anthem or Kaiser in Q4 2023 will be enrolled the first of the following month
Fresno County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing Anthem & CalViva Health Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) • CalViva Health ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	• Other Anthem and CalViva Health members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Anthem, Kaiser, and CalViva Health, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[146+]
Glenn County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem)	***Existing Anthem and CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC)	• DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024
Humboldt County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county
Imperial County – Transitioning from Imperial to Single Plan Model	
Exiting MCPs • California Health & Wellness (CHW)	***Existing Molina Members*** • Molina will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Molina Healthcare of California (Molina) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Community Health Plan of Imperial Valley (CHP-IV) • Kaiser Foundation Health Plan (Kaiser)**	• Medi-Cal Health Care Options will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023) indicating automatic enrollment with CHP-IV or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • Members' new MCP will send member information within one week of enrollment ***Existing CHW Members*** *(see note below)* • CHW and CHP-IV will send a "30-day" co-branded notice (no later than Dec. 1, 2023), notifying CHW members of change and automatic enrollment with CHP-IV effective Jan. 1, 2024 • CHW members will be automatically transitioned to CHP-IV; CHP-IV members may choose to enroll with Kaiser subject to meeting eligibility criteria ***New Medi-Cal Members in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCP (Molina); CHW will continue to enroll members (*see below note*) • Medi-Cal Health Care Options will notify new members in Q4 2023 of automatic enrollment with CHW or Kaiser, based on plan/family linkage default assignment[147] • New members assigned to or choosing Kaiser in Q4 2023 will be held in FFS until effective enrollment Jan 1, 2024. New members

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	assigned to or choosing CHW in Q4 2023 will be enrolled in CHW at the beginning of the following month and automatically transitioned to CHP-IV effective Jan. 1, 2024 • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria ***New Medi-Cal Members Beginning in 2024*** • Medi-Cal Health Care Options will notify new members of automatic enrollment with CHP-IV or Kaiser, based on plan/family linkage default assignment[148^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria ***Note:*** *CHP-IV intends to contract with Health Net as a fully delegated subcontracted MCP for all of its members in 2024. CHW is a current prime MCP in Imperial County that shares a parent company with Health Net and has full network and member operations overlap with Health Net for the purposes of its CHP-IV subcontracted MCP agreement. Consequently, CHW will continue to accept new enrollment in Q4 2023 and not be subject to the exiting MCP new enrollment freeze.*
Inyo County – Continuing under Regional Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing CHW Members*** • CHW sends 30-day notice indicating change to Health Net (no later than Dec. 1, 2023); CHW members automatically enrolled with Health Net effective Jan. 1, 2024

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) / Health Net Community Solutions (Health Net) *** ***Entering MCPs*** • N/A	***Existing Anthem Members*** • Anthem members will not receive notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • No change to current process; members may actively choose between CHW / Health Net and Anthem
Kern County * – Continuing Under Two-Plan Model***	
Exiting MCPs • Health Net Community Solutions (Health Net) ***Continuing MCPs*** • Kern Family Health Care (KFHC) ***Entering MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • Kaiser Foundation Health Plan (Kaiser)*	***Existing Health Net Members*** • Health Net will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to Dual eligible members with a KFHC, Kaiser or Anthem Medicare Advantage plan indicating that they are automatically enrolled into the matching Medi-Cal MCP per Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other members an MCP choice packet and a "60-day" notice (no later than Nov. 1, 2023), which will indicate a member's default assigned MCP, followed by a "30-day" notice (no later than Dec. 1, 2023) • Members may actively choose between Anthem, Kaiser, or KFHC for Jan. 1, 2024, effective enrollment, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members that do not make an active choice by late Dec. 2023 will be automatically enrolled into an MCP based on default assignment • Members' new MCP will send member information within one week of enrollment ***Existing KFHC Members*** • Members enrolled in the Kaiser subcontracted MCP to KFHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with KFHC or Anthem by contacting Medi-Cal Health Care Options • All other KFHC members will not receive transition notices and will not be compelled to change MCPs; they may choose to enroll with Anthem or Kaiser starting Jan. 2024, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (Health Net) • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; members may actively choose between Anthem, Kaiser, and KFHC, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[149+] • New members assigned to or choosing Anthem or Kaiser in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing KFHC in Q4 2023 will be enrolled the first of the following month
Kings County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • CalViva Health ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	***Existing Anthem & CalViva Health Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other Anthem and CalViva Health members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; starting

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	December 2023, members may actively choose between Anthem, Kaiser, and CalViva Health, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[150+]
Lake County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county
Lassen County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC)	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Entering MCPs • N/A	
Los Angeles County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Health Net Community Solutions (Health Net) – with 50% of membership subcontracted to Molina Health Care of California (Molina) • L.A. Care Health Plan (L.A. Care) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing Health Net Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • All other members will remain in the Health Net prime MCP • DHCS will identify Health Net members to be assigned to the Molina subcontracted MCP as of January 1, 2024, to meet minimum 50% subcontracting requirements. Health Net will send a "30-day" notice to these members (no later than Dec 1, 2023) notifying them of their transition to Molina (as a subcontracted MCP) • All other Health Net members will not receive transition notices • Kaiser members may actively choose Kaiser at any point starting Jan. 1, 2024 by contacting Medi-Cal Health Care Options, with Kaiser choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***Existing L.A. Care Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Other members who are in the Kaiser subcontracted MCP to L.A. Care as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with L.A. Care or Health Net (including Molina subcontracted MCP) by contacting Medi-Cal Health Care Options • All other L.A. Care members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between L.A. Care, Health Net (including Molina subcontracted MCP), or Kaiser, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[151+] • Health Net will maintain a minimum of 50% of its membership in its Molina subcontracted MCP

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Madera County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • CalViva Health ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	***Existing Anthem & CalViva Health Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other Anthem and CalViva Health members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Anthem, Kaiser, and CalViva Health, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment+
Marin County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing PHC Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with PHC and may choose to enroll with Kaiser, subject to eligibility criteria

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Partnership Health Plan of California (PHC) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing PHC Members (In Kaiser Subcontracted MCP)*** • Members in Kaiser subcontracted MCP to PHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with PHC by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[152^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Mariposa County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs***	***Existing Anthem and CHW Members*** • Anthem & CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with CCAH or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• N/A ***Entering MCPs*** • Central California Alliance for Health (CCAH) • Kaiser Foundation Health Plan (Kaiser)**	• Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW) • Medi-Cal Health Care Options will notify new members of their automatic enrollment with CCAH or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[153]^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • New members in Q4 2023 will be held in fee-for-service (FFS) until Jan. 1, 2024, when their enrollment in CCAH or Kaiser will be effective
Mendocino County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	
Merced County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Central California Alliance for Health (CCAH) ***Entering MCPs*** • N/A	***Existing CCAH Members*** • CCAH members will not receive transition notices; no MCP transition in the county
Modoc County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	
Mono County – Continuing under Regional Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) / Health Net Community Solutions (Health Net) *** ***Entering MCPs*** • N/A	***Existing CHW Members*** • CHW sends 30-day notice indicating change to Health Net (no later than Dec. 1, 2023); CHW members automatically enrolled with Health Net effective Jan. 1, 2024 ***Existing Anthem Members*** • Anthem members will not receive notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • No change to current process; members may actively choose between CHW / Health Net and Anthem

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Monterey County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Central California Alliance for Health (CCAH) ***Entering MCPs*** • N/A	***Existing CCAH Members*** • CCAH members will not receive transition notices; no MCP transition in the county
Napa County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing PHC Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with PHC and may choose to enroll with Kaiser, subject to eligibility criteria ***Existing PHC Members (in Kaiser Subcontracted MCP)*** • Members in Kaiser subcontracted MCP to PHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with PHC by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[154^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Nevada County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC)	***Existing Anthem and CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem or CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early January 2024

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Orange County * – Continuing under COHS Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • CalOptima Health (CalOptima) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing CalOptima Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to CalOptima as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with CalOptima by contacting Medi-Cal Health Care Options • All other members not in the Kaiser subcontracted MCP will maintain enrollment with CalOptima and may choose to enroll with Kaiser subject to meeting eligibility criteria with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy. ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with CalOptima or Kaiser effective Jan. 1, 2024, based on the Medi-Cal Matching Plan policy for Dual-eligible members and plan/family linkage default assignment[155]^

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy
Placer County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • Kaiser Foundation Health Plan (Kaiser) ***Entering MCPs*** • Partnership Health Plan of California (PHC)	***Existing Anthem and CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023), indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023) indicating automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • Members' new MCP will send member information within one week of enrollment ***Existing Kaiser Members*** • Kaiser members will not receive transition notices and will not be compelled to change to MCPs; they may choose to enroll with PHC starting Jan. 2024 ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem or CHW)

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Medi-Cal Health Care Options will notify new members of automatic enrollment with PHC or Kaiser, based on plan/family linkage default assignment[156^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • New members assigned to or choosing PHC in Q4 2023 will be held in FFS until effective enrollment on Jan. 1, 2024. New members assigned to or choosing Kaiser will be enrolled the first of the following month
Plumas County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC)	***Existing Anthem and CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Riverside County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Molina Healthcare of California (Molina) • Inland Empire Health Plan (IEHP) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing Molina & IEHP Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to IEHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with IEHP or Molina by contacting Medi-Cal Health Care Options • All other members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser choice subject to eligibility criteria and Medi-Cal Matching Plan policy ** Health Net will no longer be participating as a plan partner to Molina Healthcare effective 1/1/2024. Members currently enrolled in Health Net will be notified by Molina and assigned a primary care provider to make sure they keep getting the healthcare services needed. ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Molina,

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	Kaiser, and IEHP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[157+]
Sacramento County * – Continuing under Geographic Managed Care (GMC) Model***	
Exiting MCPs • Aetna Better Health of California (Aetna) ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • Health Net Community Solutions (Health Net) • Molina Health Care of California (Molina) • Kaiser Foundation Health Plan (Kaiser)	***Existing Aetna Members*** • Aetna will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send members an MCP choice packet and a "60-day" notice (no later than Nov. 1, 2023), which will indicate a member's default assigned MCP, followed by a "30-day" notice (no later than Dec. 1, 2023) • The "60-day" and "30-day" notices sent to Dual-eligible members in Aetna Medicare Advantage plan will indicate that they will need to move to a non-aligned Medi-Cal MCP if they choose to remain in Aetna Medicare Advantage • Members may actively choose between Anthem, Health Net, Molina, or Kaiser for Jan. 1, 2024, effective enrollment, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Exiting MCP (Aetna) members that do not make an active choice by late Dec. 2023 will be automatically enrolled into Anthem or Molina only based on limited default assignment

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Entering MCPs • N/A	***Existing Anthem, Health Net, Molina, and Kaiser Members*** • Anthem, Health Net, Molina, and Kaiser members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (Aetna) • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; members may actively choose between Anthem, Health Net, Molina, and Kaiser, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment, which will include all prime MCPs[158+]
San Benito County – Transitioning from San Benito to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) ***Continuing MCPs***	***Existing Anthem and CHW Members*** • Anthem will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023) indicating automatic enrollment with CCAH effective Jan. 1, 2024

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• N/A ***Entering MCPs*** • Central California Alliance for Health (CCAH)	• Members' new MCP will send member information within one week of enrollment ***Existing Medi-Cal Fee-for-Service (FFS) Members / Members Transitioning from Voluntary to Mandatory Managed Care*** • Currently, members residing in San Benito County can choose Anthem or choose Fee for Service (voluntary managed care). With the transition to a COHS model, most members will be in mandatory managed care • DHCS will send tailored "60-day" and "30-day" notices to members transitioning to mandatory managed care, informing them of the transition and automatic enrollment with CCAH effective Jan. 1, 2024 ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCP (Anthem) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in CCAH will be effective • CCAH will send member information in early Jan 2024
San Bernardino County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Molina Healthcare of California (Molina)	***Existing Molina & IEHP Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to IEHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Inland Empire Health Plan (IEHP) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	to enroll with IEHP or Molina by contacting Medi-Cal Health Care Options • All other members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ** Health Net will no longer be participating as a plan partner to Molina Healthcare effective 1/1/2024. Members currently enrolled in Health Net will be notified by Molina and assigned a primary care provider to make sure they keep getting the healthcare services needed. ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Molina, Kaiser, and IEHP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment+

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
San Diego County * – Continuing Under Geographic Managed Care (GMC) Model***	
Exiting MCPs • Aetna Better Health of California (Aetna) • Health Net Community Solutions (Health Net) ***Continuing MCPs*** • Blue Shield of California Promise Health Plan (Blue Shield) Community Health Group Partnership Plan (Community Health Group) • Kaiser Foundation Health Plan (Kaiser) • Molina Healthcare of California (Molina) ***Entering MCPs*** • N/A	***Existing Aetna and Health Net Members*** • Aetna and Health Net will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send members an MCP choice packet and a "60-day" notice (no later than Nov. 1, 2023), which will indicate a member's default assigned MCP, followed by a "30-day" notice (no later than Dec. 1, 2023) • The "60-day" and "30-day" notices sent to Dual-eligible members in Aetna or Health Net Medicare Advantage plans will indicate that they will need to move to a non-aligned Medi-Cal MCP if they choose to remain in Aetna or Health Net Medicare Advantage plans • Members may actively choose between Blue Shield, Community Health Group, Kaiser, or Molina for Jan. 1, 2024, effective enrollment, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice by late Dec. 2023 will be automatically enrolled into an MCP based on default assignment • Members' new MCP will send member information within one week of enrollment ***Existing Blue Shield, Community Health Group, Kaiser, and Molina Members*** • Blue Shield, Community Health Group, Kaiser, and Molina members will not receive transition notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023***

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with the exiting MCPs (Aetna and Health Net) • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; members may actively choose between Blue Shield, Community Health Group, Kaiser, and Molina, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[159+]
San Francisco County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • San Francisco Health Plan (SFHP) ***Entering MCPs***	***Existing Anthem & SFHP Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to SFHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with SFHP or Anthem by contacting Medi-Cal Health Care Options • All other members will not receive transition notices

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Kaiser Foundation Health Plan (Kaiser)*	• Members may actively choose Kaiser at any point starting Jan. 1, 2024 by contacting Medi-Cal Health Care Options, with Kaiser choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Anthem, Kaiser, and SFHP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[160+]
San Joaquin County – Continuing under Two-Plan Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Health Net Community Solutions (Health Net)	***Existing Health Net Members*** • Health Net members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria ***Existing HPSJ Members*** • Members who are in the Kaiser subcontracted MCP to HPSJ as of September 2023 will receive "60 and 30-day" notices from Kaiser

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Health Plan of San Joaquin (HPSJ) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	indicating they will stay with Kaiser; they may choose to enroll with HPSJ or Health Net by contacting Medi-Cal Health Care Options • All other HPSJ members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria ***New Medi-Cal Members Beginning in Late 2023*** • Medi-Cal Health Care Options will send new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Health Net, Kaiser, and HPSJ, with active choice of Kaiser subject to eligibility criteria • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[161+]
San Luis Obispo County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • CenCal Health ***Entering MCPs*** • N/A	***Existing CenCal Health Members*** • CenCal Health members will not receive transition notices; no MCP transition in the county

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
San Mateo County * – Continuing under COHS Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Health Plan of San Mateo (HPSM) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing HPSM Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to HPSM as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with HPSM by contacting Medi-Cal Health Care Options • All other members not in the Kaiser subcontracted MCP will maintain enrollment with HPSM and may actively choose to enroll with Kaiser, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with HPSM or Kaiser effective Jan. 1, 2024, based on the Medi-Cal Matching Plan policy for Dual-eligible members and plan/family linkage default assignment[162] ^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Santa Barbara County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • CenCal Health ***Entering MCPs*** • N/A	***Existing CenCal Health Members*** • CenCal Health members will not receive transition notices; no MCP transition in the county
Santa Clara County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem) • Santa Clara Family Health Plan (SCFHP) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing Anthem Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • All other Anthem members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***Existing SCFHP Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per Medi-Cal Matching Plan policy • Other members who are in the Kaiser subcontracted MCP to SCFHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	choose to enroll with SCFHP or Anthem by contacting Medi-Cal Health Care Options • All other SCFHP members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members an MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Anthem, Kaiser, and SCFHP, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[163+]
Santa Cruz County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing CCAH Members*** • Members will maintain enrollment with CCAH and may choose to enroll with Kaiser, subject to eligibility criteria ***New Medi-Cal Members Beginning in Late 2023***

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Central California Alliance for Health (CCAH) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	• Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with CCAH or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[164]^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Shasta County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county
Sierra County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem)	***Existing Anthem & CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC)	• DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem or CHW) • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024
Siskiyou County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
Solano County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing PHC Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with PHC and may choose to enroll with Kaiser, subject to eligibility criteria ***Existing PHC Members (In Kaiser Subcontracted MCP)*** • Members in Kaiser subcontracted MCP to PHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with PHC by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[165]^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Sonoma County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing PHC Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with PHC and may choose to enroll with Kaiser, subject to eligibility criteria ***Existing PHC Members (In Kaiser Subcontracted MCP)***

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Partnership Health Plan of California (PHC) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	• Members in Kaiser subcontracted MCP to PHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with PHC by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment^ • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Stanislaus County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Health Net Community Solutions (Health Net) • Health Plan of San Joaquin (HPSJ) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	***Existing Health Net & HPSJ Health Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other Health Net and HPSJ members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Health Net, Kaiser, and HPSJ, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[+]
Sutter County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCP*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC) • Kaiser Foundation Health Plan (Kaiser)**	***Existing Anthem & CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW)

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[166^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC or Kaiser will be effective
Tehama County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs***	***Existing Anthem & CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • DHCS will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC effective Jan. 1, 2024 • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW)

[^] Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Partnership Health Plan of California (PHC)	• New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC will be effective • PHC will send member information in early Jan 2024
Trinity County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • N/A	***Existing PHC Members*** • PHC members will not receive transition notices; no MCP transition in the county
Tulare County * – Continuing under Two-Plan Model***	
Exiting MCPs • N/A ***Continuing MCPs*** • Anthem Blue Cross Partnership Plan (Anthem)	***Existing Anthem & Health Net Members*** • Medi-Cal Health Care Options will send a letter to Dual-eligible members in a Kaiser Medicare Advantage plan indicating that they are automatically enrolled into the Kaiser Medi-Cal MCP per the Medi-Cal Matching Plan policy • Other Anthem and Health Net members will not receive transition notices • Members may actively choose Kaiser at any point starting Jan. 1, 2024, by contacting Medi-Cal Health Care Options, with Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Health Net Community Solutions (Health Net) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)**	active choice subject to eligibility criteria and Medi-Cal Matching Plan policy ***New Medi-Cal Members Beginning in Late 2023*** • Dual-eligible members enrolled in a Medicare Advantage plan with a matching Medi-Cal MCP will be automatically enrolled in the matching Medi-Cal MCP per the Medi-Cal Matching Plan policy • Medi-Cal Health Care Options will send all other new members a MCP choice packet at the time of initial eligibility; starting December 2023, members may actively choose between Anthem, Kaiser, and Health Net, with active choice of Kaiser subject to eligibility criteria and Medi-Cal Matching Plan policy • Members that do not make an active choice will be automatically enrolled into an MCP based on default assignment[167+]
Tuolumne County – Continuing under Regional Model	
Exiting MCPs • N/A ***Continuing MCPs***	***Existing CHW Members*** • CHW sends 30-day notice indicating change to Health Net (no later than Dec. 1, 2023); CHW members automatically enrolled with Health Net effective Jan. 1, 2024

[+] Starting July 1, 2024, Kaiser will be included in the Auto-Assignment Incentive Program in choice counties where Kaiser will operate as a prime MCP.

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
• Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) → Health Net Community Solutions (Health Net) *** ***Entering MCPs*** • N/A	***Existing Anthem Members*** • Anthem members will not receive notices and will not be compelled to change MCPs ***New Medi-Cal Members Beginning in Late 2023*** • No change to current process; members may actively choose between CHW / Health Net and Anthem
Ventura County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Gold Coast Health Plan (GCHP) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing GCHP Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with GCHP and may choose to enroll with Kaiser, subject to eligibility criteria ***Existing GCHP Members (In Kaiser Subcontracted MCP)*** • Members in Kaiser subcontracted MCP to GCHP as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with GCHP by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with GCHP or

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[168^] • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Yolo County – Continuing under COHS Model	
Exiting MCPs • N/A ***Continuing MCPs*** • Partnership Health Plan of California (PHC) ***Entering MCPs*** • Kaiser Foundation Health Plan (Kaiser)*	***Existing PHC Members (Not in Kaiser Subcontracted MCP)*** • Members will maintain enrollment with PHC and may choose to enroll with Kaiser, subject to eligibility criteria ***Existing PHC Members (In Kaiser Subcontracted MCP)*** • Members in Kaiser subcontracted MCP to PHC as of September 2023 will receive "60 and 30-day" notices from Kaiser indicating they will stay with Kaiser; they may choose to enroll with PHC by contacting Medi-Cal Health Care Options ***New Medi-Cal Members Beginning in Late 2023*** • Starting in December 2023, Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[169^]

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

^ Starting January 2025, an Auto-Assignment Incentive Program will be implemented in COHS and Single Plan counties where Kaiser operates as a prime MCP, inclusive of the COHS / Single Plan and Kaiser

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria
Yuba County – Transitioning from Regional to COHS Model	
Exiting MCPs • Anthem Blue Cross Partnership Plan (Anthem) • California Health & Wellness (CHW) ***Continuing MCPs*** • N/A ***Entering MCPs*** • Partnership Health Plan of California (PHC) • Kaiser Foundation Health Plan (Kaiser)**	***Existing Anthem & CHW Members*** • Anthem and CHW will send "90-day" notices to their members (no later than Oct. 1, 2023) indicating their Jan. 1 exit from the county • Medi-Cal Health Care Options will send "60-day" and "30-day" notices to members (no later than Nov. 1 and Dec. 1, 2023), indicating their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment • Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • Members' new MCP will send member information within one week of enrollment ***New Medi-Cal Members Beginning in Late 2023*** • After Sep. 1, 2023, newly eligible Medi-Cal members will no longer be able to enroll with exiting MCPs (Anthem and CHW) • Medi-Cal Health Care Options will notify new members of their automatic enrollment with PHC or Kaiser effective Jan. 1, 2024, based on plan/family linkage default assignment[170^]

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
** Kaiser does not currently have Medi-Cal membership in this county and will newly operate under direct contract with DHCS starting in 2024
*** CA Health & Wellness contract transitioning to Health Net, which shares a parent company (Centene)
**** County with Medi-Cal Matching Plan Policy in 2024 (Medi-Cal enrollment follows Medicare Advantage enrollment)

MCP Changes	Transition-Related Enrollment & Noticing Policy
	• Members may contact Medi-Cal Health Care Options to actively choose the other MCP, with active choice of Kaiser subject to eligibility criteria • New members in Q4 2023 will be held in FFS until Jan. 1, 2024, when their enrollment in PHC or Kaiser will be effective

* Kaiser currently has Medi-Cal members under a subcontract with a prime MCP. Starting in 2024, Kaiser will operate under direct contract with DHCS
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