CAADS & ALE

WEBTALK

September 22, 2023
3:00 pm - 4:00 pm

2024 Medi-Cal Managed Care Contract Changes

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Presenters

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Managed Care Operations Division

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ALE webtalk

2024 Medi-Cal Managed Care Plan Transition: What Providers Should Know

California Association for Adult Day Services
September 22, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Today's Agenda

- **Welcome**
- **2024 Managed Care Plan (MCP) Transition Overview**
- **Transition Policies**
  - Policy Guide
  - Member Enrollment in Managed Care
  - Continuity of Care
  - Enhanced Care Management and Community Supports
- **Education and Communications**
- **Discussion and Feedback**

2024 Managed Care Plan Transition Overview

DHCS is Transforming Medi-Cal Managed Care Through Multiple Channels

New Mix of High-Quality Managed Care Plans Available to Members

New Commercial MCP Mix

- Contracts with commercial MCPs announced in Dec. 2022, operational readiness process has been underway since January 2023

Model Change in Select Counties

- Conditional approval for 17 counties to change their managed care model
- Includes a new Single Plan Model and expansion of COHS model

Direct Contract with Kaiser

- In 32 counties in which Kaiser operates
- Based on provider / plan linkage or population-specific criteria for active choice / assignment such as Dual-eligible or foster children

Restructured and More Robust Contract Implemented Across All Plans in All Model Types in All Counties

Improved Health Equity, Quality, Access, Accountability and Transparency

2024 Medi-Cal Managed Care Plans

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEDI-CAL MANAGED CARE PLANS BY COUNTY (AS OF 2023 AND 2024)

The following table lists Medi-Cal managed care plans[i] (MCPs) by county, as of January 1, 2023, and as they will be effective January 1, 2024. The changes are the result of an agreement among DHCS and MCPs in December 2022 to transform Medi-Cal into a more equitable health system that will result in better health outcomes for Californians. The table also reflects changes based on the County Plan Model changes that were approved in April 2022 and Assembly Bill 2724 enacted June 30, 2022 which added Section 14197.11 to the Welfare and Institutions Code. Starting in 2024, all MCPs will operate under the new restructured and rigorous contract that requires high-quality, equitable and comprehensive coverage.

County *County Plan Model Type*	2023 MCP(s)	2024 MCP(s)
Alameda *Two-Plan model (2023)* *Single Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Alameda Alliance for Health**
	Alameda Alliance for Health	**Kaiser Permanente**[ii]
Alpine *Regional model (2023)* *Two-Plan model (2024)*	**Anthem Blue Cross Partnership Plan**	**Anthem Blue Cross Partnership Plan**[iii]
	California Health & Wellness	**Health Plan of San Joaquin**

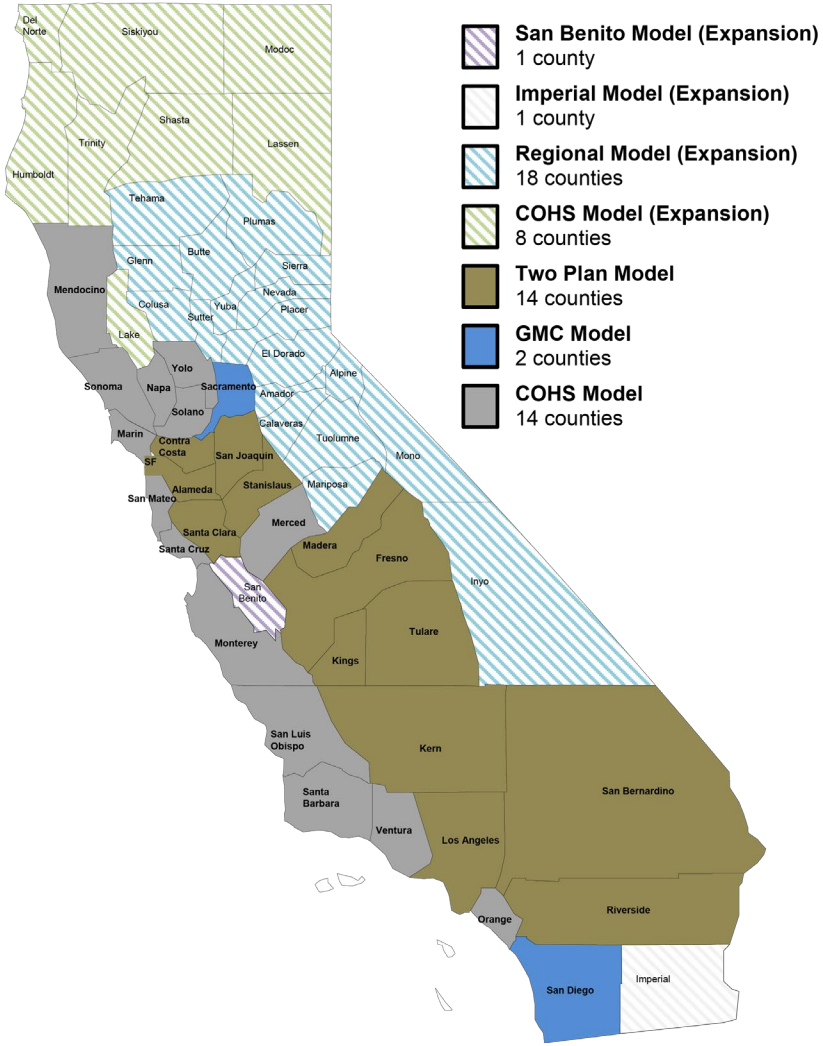
- **The full list of Medi-Cal MCPs by county for 2023 and 2024 is available on the DHCS website** at: MCP County Table (ca.gov)
- All MCPs are undergoing operational readiness reviews and participation by county is subject to readiness determinations

Managed Care Plan Transition

- Approximately 1.2 million members will transition to a new MCP on January 1, 2024
- These transitions will take place across 14 unique MCPs and 21 counties:
  - Alameda
  - Alpine
  - Butte
  - Colusa
  - Contra Costa
  - El Dorado
  - Glenn
  - Imperial
  - Kern
  - Los Angeles
  - Mariposa
  - Nevada
  - Placer
  - Plumas
  - Sacramento
  - San Benito
  - San Diego
  - Sierra
  - Sutter
  - Tehama
  - Yuba

Medi-Cal Managed Care Model Change

Current Models



San Benito Model (Expansion)
1 county

Imperial Model (Expansion)
1 county

Regional Model (Expansion)
18 counties

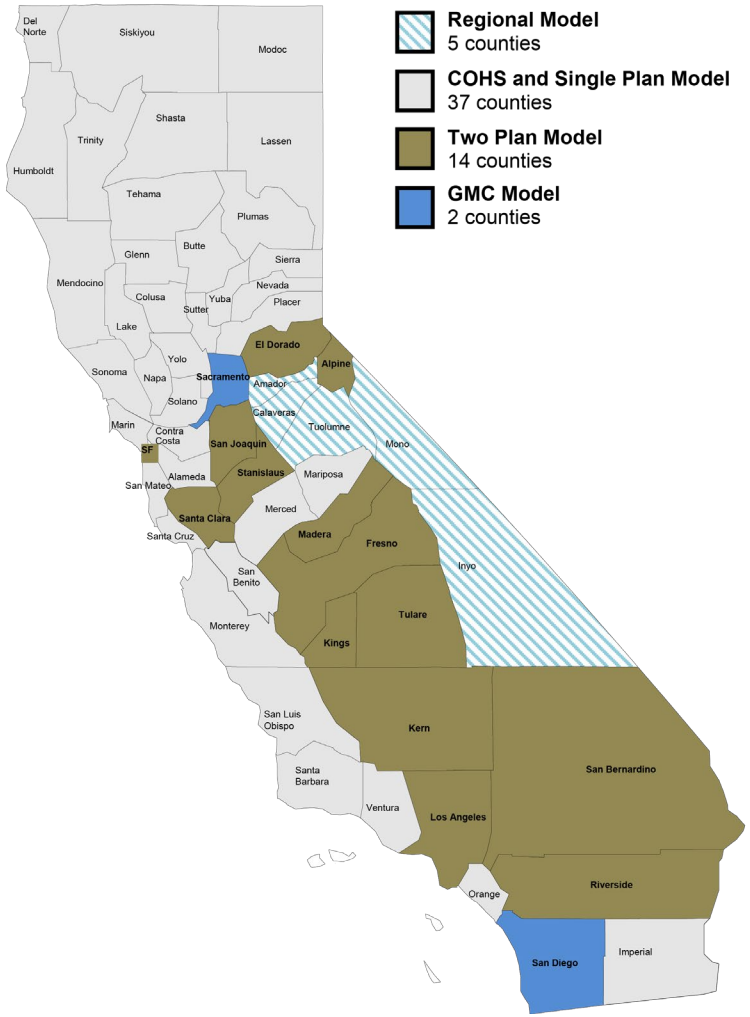
COHS Model (Expansion)
8 counties

Two Plan Model
14 counties

GMC Model
2 counties

COHS Model
14 counties

2024 Models



Regional Model
5 counties

COHS and Single Plan Model
37 counties

Two Plan Model
14 counties

GMC Model
2 counties

Kaiser Direct Contract

- In 2024, Kaiser is expanding its Medi-Cal prime plan participation through a direct contract with DHCS
- **Eligible members* may actively choose** to enroll in Kaiser in any county in which Kaiser operates, including GMC, Regional, Two Plan, COHS and Single Plan counties
- **Members already in a Kaiser subcontract** to another MCP as of September 2023, will stay with Kaiser and receive 90-, 60-, and 30-day notices from Kaiser notifying them of their transition
- **Medi-Cal Matching Plan** policy will apply to Kaiser; Kaiser Medicare Advantage members in relevant counties will be automatically assigned or transitioned to the Kaiser Medi-Cal MCP
- **Default Assignment:** New members who do not make an active choice or are in a COHS or Single Plan county where Kaiser participates may be default enrolled into Kaiser, on the basis of:
  - ***Plan / family linkage:*** Members who have a history of enrollment with Kaiser or a family member enrolled in Kaiser may be default assigned to Kaiser in any county where it operates
  - ***Auto-assignment:*** New members in certain counties may be assigned to Kaiser as part of the Auto-Assignment Incentive Program, up to a specific limit set annually based on Kaiser's growth targets and capacity. Auto-assignment is not limited to the Kaiser eligible population groups

* Members are eligible to actively choose Kaiser if they: (1) have previously enrolled with Kaiser at any point during CY 2023 or have existing Kaiser membership; (2) have family linkage to Kaiser; (3) are dually-eligible for Medi-Cal and Medicare; or (4) are a foster care child or youth.

Transition Policies

MCP Transition Principles

DHCS is applying the following principles to guide the planning, implementation and oversight of the 2024 transition:

- Plan for a smooth and effective transition
- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from interruptions in care
- Provide outreach, education and clear communications to members, providers, managed care plans and other stakeholders
- Proactively monitor MCPs' implementation of transition responsibilities

MCP Transition Policy Guide

2024 MCP Transition Policy Guide:
Expectations Specific to the 2024 MCP Transition

Purpose

- The Policy Guide includes **guidance related to the January 1, 2024, transition of Medi-Cal MCPs**
- The Policy Guide functions as a **requirements document** for MCPs' transition activity, **incorporating links to existing, applicable All Plan Letters (APLs), as well as new MCP requirements**
- The Policy Guide affords DHCS a nimble approach to **respond to feasibility challenges and issues impacting members, providers, and MCPs**

Target Audience

- **MCP staff impacted by the January 1, 2024, transition, either as an exiting MCP or a new MCP** will be the primary user of this Policy Guide

Policy Content

- **The Policy Guide contains or will contain requirements related to the following transition topics:**
  - ✓ Member Enrollment and Noticing - *Released June 23rd*
  - ✓ Continuity of Care – *Released June 23rd*
  - ✓ Transition Policies for Enhanced Care Management and Community Supports - *Released June 30th*
  - ✓ Data Sharing- *Released August 7th*
  - Monitoring and Oversight - *Forthcoming*
  - Transition-Related Requirements for Incentive Programs - *Forthcoming*
  - Communication - *Forthcoming*

DHCS released Version 1 of the 2024 MCP Transition Policy Guide on June 23, 2023.
The Policy Guide will be updated on a rolling basis as additional policies are finalized.

MCP Transition Policy Guide Outline

The Policy Guide includes the following content, with ongoing iteration through 2023.

Included In V1 – V3 Published Through August 7, 2023

- Table of Contents
- Updates from Prior Version
- Introduction
- Protections for American Indian and Alaska Native Members
- Member Enrollment and Noticing
- Continuity of Care
- Transition Policy for Enhanced Care Management
- Transition Policy for Community Supports
- Continuity of Care Data Sharing Policy
- Glossary
- Appendix: County-Level MCP Transitions

Included in V4 – Forthcoming in Q3 2023

- Transition Monitoring and Oversight Reporting Requirements
- Transition-Related Requirements for Incentive Programs

Forthcoming in Q4 2023

- Communication

https://www.dhcs.ca.gov/Documents/Managed_Care_Plan_Transition_Policy_Guide.pdf

Member Enrollment and Noticing

Member Enrollment Process for Counties with an Exiting MCP

In "Choice" Counties (GMC, Two Plan and Regional Models):

- **Members enrolled in an MCP that will continue to operate in 2024** will remain in their MCP unless they opt to change MCPs, as they are allowed to do today
- **Mandatory managed care members enrolled in an exiting MCP will need to enroll in a new MCP:**
  - Dual-eligible members in Medi-Cal Matching Plan counties will be automatically enrolled in a Medi-Cal MCP that matches their Medicare Advantage plan, where relevant
  - Other exiting MCP members will receive 90/60/30 day notices and a choice packet with their 60-day notice.
  - ***Default Assignment:*** If a member does not make an active choice, they will be enrolled in a MCP 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

In COHS Expansion and Single Plan Counties:

- **Members enrolled in a continuing MCP** (i.e., Alameda Alliance for Health, Contra Costa Health Plan, Kaiser) will remain in their MCP
- **Members enrolled in an exiting MCP** will be automatically enrolled into the COHS, Single Plan or – where relevant – Kaiser
  - Kaiser will receive default assignment for exiting MCP members in COHS and Single Plan counties where it participates on the basis of plan / family linkage and Medi-Cal Matching Plan policy (where relevant)

New Enrollment Freeze for Exiting MCPs

- DHCS will stop **new** enrollment into exiting MCPs (both for active choice and default assignment) three months prior to January 1, 2024
- Exiting MCPs will retain their existing membership though December 31, 2023
- In Two-Plan, GMC, and Regional model counties, new Medi-Cal members in late 2023 will have the choice of all MCP operating in their county in 2024
- In COHS and Single Plan model counties—dually-eligible members in Medi-Cal Matching Plan counties—new Medi-Cal members in late 2023 will be automatically enrolled into an MCP for 2024.
  - If the new member chooses or is assigned to a 2024 MCP that is not yet operating in the county as a prime MCP, they will access care through the fee-for-service delivery system until the MCP is available in January 2024

Noticing for Transitioning Members

- Members of exiting MCPs will receive a:
  - 90-day notice from their exiting MCP
  - 60-day and 30-day notices from Medi-Cal Health Care Options (HCO), DHCS's enrollment broker
  - A choice packet will be sent with the 60-day notice when appropriate
  - Welcome packet from their new MCP in early January 2024
- Notices will include a QR code to an online Notice of Additional Information that will provide more details, which members can request to receive in print or alternative format
- The notices received stakeholder feedback and were reviewed by the Center for Health Literacy
- Notices will be posted on the DHCS Transition member webpage

Continuity of Care

DHCS

Continuity of Care Policy Design Principles

The 2024 CoC Policies outlined in the 2024 Medi-Cal Managed Care Plan Transition Policy Guide released on June 23, 2023 aim to **minimize**:

- Service interruptions for all members required to transition MCPs on January 1, 2024, especially for groups most at risk for harm from disruptions in care (i.e., special populations)
- Member, provider, and MCP confusion
- Administrative burden while ensuring operational feasibility for DHCS and MCPs

The 2024 CoC policy for members required to transition MCPs largely aligns with current CoC policy,* with some additional protections.

*APL 22-032

Continuity of Care Policy Levers

All members required to transition MCPs January 1, 2024, are eligible for CoC protections using the following policy levers.

- **CoC for Providers** – The member can keep their provider even if the provider is out of network for the Receiving MCP.
- **CoC for Covered Services** – The member can continue an active course of treatment and the Receiving MCP must honor prior authorizations from the member's Previous MCP.
- **CoC Coordination/Care Management Information** – Previous MCP and Receiving MCP work together to transfer additional supportive information (e.g., care plans).
- **Additional Continuity of Care Protections for All Transitioning Members** - All transitioning members are eligible for additional protections related to Durable Medical Equipment (DME) rentals and medical supplies, non-emergency medical transportation (NEMT) and non-medical transportation (NMT), and scheduled specialist appointments

These levers are currently deployed in policies through the Knox Keene Act,* the 2023 APL on CoC, and the Policy Guides for ECM and Community Supports.

*Knox Keene CoC policy provides protection for some members who will transition to new MCPs in 2024: Members with an acute condition, serious chronic condition, pregnancy and postpartum, care of child between birth and 36 months, terminal illness, and authorized surgery or procedures documented as part of treatment plan to occur within 180 days.
For purposes of the 2024 CoC Policy discussion, the reference to Knox Keene is synonymous with Health and Safety Code 1373.96.

Special Populations

All members required to transition MCPs January 1, 2024, have Continuity of Care protections, but some members – *Special Populations* will have enhanced protections to minimize the risk of harm.

- Special Populations are generally individuals living with complex or chronic conditions. Transitioning members will be identified using DHCS or Previous MCP data, including program enrollment, pharmacy claims, DME claims, screening and diagnostic codes, procedure codes, or aid codes. The Receiving MCP will receive these data in advance of the 2024 Transition.[1]
  - Data guidance, including member identification and transfer responsibility, was issued via August 7 Policy Guide update.
- MCPs will be required to take proactive steps to implement CoC or members of "Special Populations" through MCP outreach to members' providers and data transfer between MCPs.
- DHCS will monitor CoC for Special Populations as part of the monitoring that will happen for all members experiencing a Transition.

1. See Appendix for full list of Special Populations

Continuity of Care for Providers

All members required to transition MCPs will be eligible to keep their Out-of-Network (OON) providers for 12 months when transitioning to the Receiving MCP. Additional enhanced protections will apply to Special Populations.

- CoC Policy for Providers for <u>all members</u> required to transition MCPs, including Special Populations
  - Members of Previous MCPs may continue seeing their OON Medi-Cal providers[1] for 12 months[2] following the member's Transition if certain requirements are met:
    - Member and provider have a pre-existing relationship
    - Provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates
    - Provider meets professional standards and there are no quality-of-care issues
    - Provider is CA State Plan approved
- Enhanced Protection for <u>Special Populations</u>
  - MCPs contact providers treating Special Populations to initiate the process for entering a CoC agreement.
  - Extended CoC period for certain populations[3]

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[1]Depending on provider type
[2]With some exceptions to this timeframe per Knox Keene. See Appendix.
[3]In alignment with Knox Keene. See Appendix.

Continuity of Care for Providers

Eligible Providers:

- Primary care providers (PCPs)
- Specialists
- 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
- Enhanced Care Management providers
- Community Supports providers
- Skilled Nursing Facilities (SNFs)
- Community-Based Adult Services providers.
- Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)*

Excluded providers:

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

*The 2024 MCP Transition CoC policy only applies to members residing in ICF/DD who are in managed care as of December 31, 2023, which occurs only in COHS and Single Plan counties.

Continuity of Care for Covered Services

The policy for continuing active courses of treatment outside of Knox Keene is new, as is the expectation for MCP outreach to providers treating Special Populations. The policy for continuing authorizations is not new.

» CoC Policy for Services for all members required to transition MCPs, including Special Populations

- Members keep their existing authorizations for Covered Services for six months following the member's Transition to the Receiving MCP from the Previous MCP.
- Members can continue their "active course of treatment" without authorization for six months. Any active course of treatment is expected to be documented prior to January 1, 2024.
- Active Course of Treatment defined as: a course of treatment in which a patient is actively seeing a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

» Enhanced Protection for Special Populations *(inclusive of members receiving CBAS)*

- Following the Transition, members keep their existing authorizations for six months and until the Receiving Plan assesses clinical necessity for ongoing services.
- During the six-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.

» Enhanced Protection for Special Population Members Accessing the Transplant Benefit

- The Receiving MCP must start reassessments for clinical necessity no sooner than six months after the transition date (beginning July 1, 2024). The 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.

Continuity of Care Coordination and Care Management Information

Care coordination and care management information will travel with Members to the Receiving MCP. This is not a current expectation under the 2023 CoC Policy.

- This proposed policy applies only to Special Populations.
- Proposed CoC Policy:
  - Previous MCP provides contact information for plan-level contact and care managers to Receiving MCP
  - If a Member changes care managers,[1] the Receiving MCP contacts the Member's Previous MCP and/or care manager to obtain supportive information including, but not limited to:
    - Results of member assessments, member care plans, and ad hoc communication and coordination between incoming and outgoing care managers.
  - Information transfer must be complete before January 1, 2024, or within 15 calendar days of the Member changing to a new Care Manager, whichever is later.

[1] MCPs serving Medi-Cal Members in 2024 and beyond are expected to contract with all Enhanced Care Management (ECM) Providers, and thus, Members enrolled in ECM are not expected to change their care manager.

Enhanced Care Management and Community Supports

DHCS

Enhanced Care Management Transition Policy for the 2024 MCP Transition

DHCS is committed to ensuring that Medi-Cal Members are authorized to receive ECM and Community Supports do not experience disruptions to authorizations, provider relationships or services due to the MCP Transition on January 1, 2024.

Enhanced Care Management:

- The Transition Policy for ECM **builds on and is aligned with the ECM Policy Guide and the Continuity of Care provisions contained therein**, as well as the Continuity of Care section in this Policy Guide.
- Members authorized 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 MCPs' authorizations for ECM.**
- 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.**

Community Supports Transition Policy for the 2024 MCP Transition

Community Supports:

- 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 provisions contained therein**, as well as the Continuity of Care section in this Policy Guide
- 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 DHCS Community Supports Policy Guide. If the Previous MCPs 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 determined eligible 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.

Transition Monitoring

Overview of Dynamic Monitoring Approach

DHCS will take a multi-pronged approach to monitoring including, but not limited to, MCP reporting, proactive sampling, and stakeholder feedback.

- **MCP Data Reporting:** MCPs will submit data weekly to DHCS for the first two months of the transition (moving to monthly and then quarterly thereafter) on Continuity of Care (CoC) activity including Special Populations, for example:
  - Of the total number of Special Populations members transitioning to the MCP, how many out-of-network providers are eligible for CoC, how many have been contacted to bring in network or to initiate CoC agreements, how many have been successfully executed/not executed
  - Has the MCP examined utilization data to identify Special Populations members' active courses of treatment that require authorization (if any), and has the MCP contacted providers to establish any necessary prior authorizations
  - How many, and what is the nature of, calls from transitioning members to the MCPs' member call centers
- **Proactive Member Sampling:** DHCS will conduct proactive outreach to MCPs to confirm they are carrying out their obligations under the CoC Special Populations policies
  - MCPs will report back to DHCS based on specific DHCS inquiries for sampled members
- **Stakeholder Feedback:** DHCS will have its "ear-to-the-ground" for feedback from MCPs, providers advocates and others; this will enable issue tracking as well as proactive follow-up and oversight

Education and Communications

Transition Education and Communications: Preview of Materials in Development

- Core messages for members and providers
- Outreach and communications materials to be available for provider offices:
  - Member FAQs
  - Flyer with core messages
  - Social media posts
  - Call scripts for call centers and/or office staff
- Materials to be included in the Transition Policy Guide and on the DHCS website in September

Messaging Overview

- Incorporates feedback from members, stakeholder groups, and advocacy organizations
- Emphasizes that transition does not impact coverage or benefits
- Highlights the resources available to members and providers
- Targeting delivery of transition information to impacted members in transition counties to minimize confusion in broader member population

Education and Communications Strategy

Before member messaging begins in October:

- Ensure MCPs, providers, county eligibility workers, and advocates are knowledgeable about the transition, its scope, and impact on members, and can serve as resources for members
- Create a central online source for transition information
- Disseminate information widely to these audiences via multiple avenues

Once member messaging begins in October:

- Provide multilingual online resources for members and their families
- Deploy targeted multimedia communications to members in transition counties to minimize confusion
- Continue to disseminate information to non-member audiences so they can support member inquiries and actions

Communications Resources

Collateral	Description	Launch Timeline
Member and Provider FAQs	• Information about the transition that utilizes core messaging	August
Web pages (members, providers, MCPs, and other stakeholders)	• Widely-accessible online source of truth with links to other resources for these audiences	August- September
Webinars (MCPs, Providers, County Eligibility Workers, Indian Health Program)	• Broad and targeted webinars providing an overview of the transition. Webinars are recorded and recordings are available online.	August - September
Newsletter updates	• Periodic updates in newsletters to various audiences during the transition	September - December
Informational Flyers	• Multi-lingual flyers for providers to share with their patients to direct them to member resources	October
Social Media (Facebook, Twitter, LinkedIn, Instagram)	• Periodic updates about the transition and calls to action for targeted audiences	October - December

Questions?

Q&A

Question	DHCS Response
Payment Continuity	
• Which MCP is responsible for paying for services rendered when there is a change in plan? CAADS has raised this as part of discussions with the state. Even 8 months after the DSNP transition there are centers that have not been paid.	• MCPs are responsible for paying for the services rendered at the time the member is enrolled in the plan. If there remain concerns about receiving payment, please let us with this information and we are happy to assist.
• More than the usual number of CBAS participants will be moved to FFS temporarily. Operationally, how will payment be handled for services provided during the transition into and from FFS?	• Providers should contact the LTSS liaison at the MCP for any concerns about receiving payments. If concerns persist, please contact DHCS by e-mailing DHCS_PMMB@dhcs.gov. • Please note that DHCS has stopped only **new enrollment** into **exiting MCPs**, starting with October 2023 month of enrollment. This policy does not apply to existing members and the intention is not to move anyone from managed care into fee for service. A new Medi-Cal member who actively chooses or is default assigned to a prime MCP that is operating today and will continue to operate in their county in 2024 will be enrolled into the MCP effective the first of the following month. A new Medi-Cal member who actively chooses or is default assigned into an MCP that is newly operating as a prime MCP in their county starting January 1, 2024 **will remain in Medi-Cal FFS until their MCP enrollment is effective on January 1, 2024**.

Q&A

Question	DHCS Response
Continuity of Care	
• How will new Medi-Cal members know what is happening in transitioning counties? If there are any new referrals to CBAS while a member is in FFS, does DHCS expect to do a Face-to-Face or can that be waived (as currently permitted) or be done via telehealth so that access to care is not delayed? Who is our primary contact at DHCS for authorization questions or problems?	• If specific concerns arise around a FFS member TAR that you are unable to resolve by working through the normal TAR process, please contact the DHCS Clinical Assurance Division for a resolution.
• ERS is new so we request that a clear statement be included in the Policy Guide that ERS is part of the authorization that must be accepted by a receiving plan or DHCS FFS. MCPs and FFS need to follow the ERS policy guidance.	• ERS would be covered under an authorization. Continuity of Care for Covered Services enables all transitioning members to continue receiving Covered 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. Therefore, CoC would apply to ERS.

Q&A

Question	DHCS Response
Rural Populations	
• Based on past experiences, special attention to rural communities transitioning to new plans is needed to ensure there are no barriers to access including hand-offs to new contracted transportation providers that are critical in making sure people get to medical appointments.	• Section V.F.2 of the Policy Guide addresses DHCS' expectation that there be no disruption in Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT) access. There is specific emphasis regarding members residing in SNFs. But, overall for all members, 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; and ○ Honor all Prior Authorizations for NEMT/NMT approved by the Previous MCP, including the modality of transportation, for 6 months and until the Receiving MCP is able to reassess the member's continued transportation needs.

APPENDIX

2024 MCP Transition All Plan Letter

The purpose of the MCP Transition APL (23-018) is to provide guidance to all Medi-Cal MCPs regarding the 2024 MCP Transition effective January 1, 2024.

- The APL establishes the Policy Guide as the DHCS authority, along with applicable Contracts and any APLs or guidance documents incorporated in the Policy Guide by reference, regarding the 2024 MCP Transition.
- If the requirements contained in the APL or the Policy Guide, including any updates or revisions to the APL or the Policy Guide, necessitate a change in an MCP's contractually required policies and procedures, the MCP must submit its updated P&Ps to its DHCS Managed Care Operations Division Contract Manager.

MCP Transition APL 23-018 was released on June 23, 2023.

Special Populations for Continuity of Care

Members Who Are:
• Adults and children determined eligible to receive Enhanced Care Management services • Adults and children determined eligible to receive Community Supports • Adults and children receiving Complex Care Management • Enrolled in 1915(c) waiver programs • Receiving in-home supportive services (IHSS) • Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Model • Children and youth receiving foster care, and former foster youth through age 2519 • 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) • Receiving hospital inpatient care • Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023 • Newly prescribed DME (within three months prior to January 1, 2024) • Members receiving Community-Based Adult Services

Knox Keene Continuity of Care Policy

Knox Keene protections (HSC § 1373.96) apply to plan-to-plan transitions due to market exit, but *only* if the Member "raises their hand" and the MCP reaches an agreement with the provider.

- **Keep your provider:** An enrollee receiving covered services from a nonparticipating provider when starting coverage with a MCP may complete services from their provider if all the following requirements are met:
  - **If you have one of six conditions:** acute condition* (for the duration), serious chronic condition (up to 12 months), pregnancy and postpartum (up to 21 months),* care of child between birth and 36 months (up to 12 months), terminal illness (for the duration),* and authorized surgery or procedures documented as part of treatment plan to occur within 180 days.
  - **If you raise your hand**: The enrollee must request to complete services from their provider by contacting the Receiving MCP.
  - **If you have a pre-existing relationship:** The enrollee must be receiving covered services for one of the six conditions from the provider at the time of the change in coverage or provider contractual termination.
  - **If the MCP and Provider agree to terms:** The provider and MCP must agree on a rate, contractual terms, and conditions (similar to currently contracting providers who are not capitated in the same area), and the provider is not terminated for medical disciplinary, fraud, or other criminal activity.
  - **If you did not voluntarily choose to change health plans**: This protection does not apply to a newly covered enrollee who had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans.

*Members with this condition are eligible for extending the CoC period longer than 12 months after transitioning.

Continuity of Care for Providers – 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.

» Enhanced Protection for Special Population Members Accessing the Transplant Benefit
- DHCS will require mandatory overlap of the Previous MCP's and Receiving MCP's Center of Excellence (COE) Transplant Programs to the maximum extent possible to permit any member accessing the transplant benefit to continue with the same Transplant Programs

» 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 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[1]
   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 timelines outlined in the 2024 Medi-Cal Managed Care Transition Policy Guide
   b. Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement. Guidance regarding written explanations will be clarified in the forthcoming section, Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide

1. (Section 14184.201(d)(2) of the Welfare and Institutions Code)

Additional Continuity of Care Protections – DME and Medical Supplies

DHCS specifies additional protections for all transitioning members related to Durable Medical Equipment (DME) rentals and medical supplies.

- Receiving MCPs must allow members to keep their existing DME rental and medical supplies from their existing DME providers without further authorization for six months after the 2024 MCP Transition and until reassessment, and the new equipment of supplies are in possession of the member and ready for use.
  - After 6 months, the MCP may reassess the member's authorization 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.
- The policy applies to DME or medical supplies that have been arranged for but not yet delivered, in which case the Receiving MCP must allow for the delivery and permit the member to keep the equipment or supplies for a minimum of six months and until reassessment.

Additional Continuity of Care Protections – NEMT and NMT

To provide a robust CoC Policy for the 2024 Transition, DHCS is specifying additional protections for all transitioning members related to non-emergency medical transportation (NEMT) and non-medical transportation (NMT).

- To guard against disruptions in members' access to the NEMT/NMT benefit, the Receiving MCP 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, the Receiving MCP must make a good faith effort to allow the transitioning member to keep the scheduled transportation with OON 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 six months and until the Receiving MCP is able to reassess the member's continued transportation need
- The Previous MCP must support continuation of NEMT/NMT services for transitioning members by:
  - Providing authorization data as described in the 2024 Medi-Cal Managed Care Plan Transition Policy Guide
  - Transmitting all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to the Receiving MCP on November 1, 2023 and refresh weekly starting in December 2023.

Additional Continuity of Care Protections – Scheduled Specialist Appointments

DHCS specifies additional protections for all transitioning members related to scheduled specialist appointments.

- 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.
- 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 scheduled appointment data with the OON provider.
- If the MCP is unable to arrange a specialist appointment with a network provider on or before the member's scheduled appointment data, the MCP is encouraged to make a good faith effort to allow the member to keep the appointment with the OON provider
- The Receiving MCP must ensure that the 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 upon enrollment

Member Enrollment and Noticing Scenario:
COHS Expansion County – Exiting MCP Member

- Tom is enrolled with Anthem Blue Cross Partnership Plan (Anthem) as of September 1, 2023.
- Tom lives in Butte county, which is transitioning to the COHS Medi-Cal managed care model. Effective January 1, 2024, Partnership Health Plan of California (PHC) will enter the market as a COHS, while Anthem Blue Cross Partnership Plan (Anthem) and California Health and Wellness (CHW) will exit.
- No later than October 1, 2023, Tom will receive notice from Anthem of their pending exit from the county effective January 1, 2024. No later than November 1 and December 1, 2023, Tom will receive "60-day" and "30-day" notices from Medi-Cal Health Care Options (HCO) informing him of his enrollment with PHC effective January 1, 2024.
- He will remain enrolled with Anthem for the remainder of 2023 and will not have the option to switch his enrollment to CHW for the remainder of 2023, due to the exiting MCP new enrollment freeze.

Scenario	October 2023	November 2023	December 2023	January 2024	
Tom Lives in a County with No Continuing MCPs	***No Later than Oct. 1*** *Tom receives notice from Anthem of their exit from Butte county effective Jan. 1, 2024*	***No Later than Nov. 1*** *Tom receives "60-day" notice from HCO indicating his enrollment with PHC effective Jan. 1, 2024*	***No Later than Dec. 1*** *Tom receives "30-day" notice from HCO indicating his enrollment with PHC effective Jan. 1, 2024*	***Jan. 1*** *Tom is enrolled into PHC*	***Early Jan.*** *Tom receives a welcome packet and ID card from PHC*

Member Enrollment and Noticing Scenario:
MCP Choice County – Exiting MCP Member

Tom

- Tom is enrolled with California Health & Wellness (CHW) as of September 1, 2023
- Tom lives in Alpine county. Effective January 1, 2024, Health Plan of San Joaquin d.b.a. Mountain Valley Health Plan (MVHP) will enter the market while California Health and Wellness (CHW) will exit. Anthem Blue Cross Partnership Plan (Anthem) will continue to operate in the county as it does today.
- No later than October 1, 2023, Tom will receive notice from CHW of their pending exit from the county effective January 1, 2024. No later than November 1, 2023, Tom will receive a "60-day" notice and choice packet from Medi-Cal Health Care Options (HCO). Tom has Anthem and MVHP to choose from for enrollment effective Jan. 1, 2024.
- He will remain enrolled with CHW for the remainder of 2023 unless he actively choose to switch enrollment to Anthem sooner consistent with his rights as a Medi-Cal member.

Tom maintains enrollment with CHW for the duration of 2023

Scenario	Oct. 2023	Nov – Dec. 2023		Jan. 2024	
Tom Chooses or is Default Assigned to Anthem	***No Later than Oct. 1*** *Tom receives notice from CHW of their exit from Alpine county effective Jan. 1, 2024*	***No Later than Nov. 1*** *Tom receives a "60-day" notice and choice packet from HCO. Tom can actively choose between Anthem or MVHP.*	***No Later than Dec. 1*** *Tom receives a "30-day" notice from HCO. Tom has until late December to select an MCP and he chooses Anthem / does not make an active MCP choice and is default assigned to Anthem.*	***Jan. 1*** *Tom is enrolled into Anthem*	***Early Jan.*** *Tom receives a welcome packet and ID card from Anthem*

***Note**: Tom could alternatively actively choose MVHP or be default assigned to MVHP if he does not make an active choice*

Member Enrollment and Noticing Scenario:
MCP Choice County – New Medi-Cal Member in Late 2023

Maria

- Maria is determined eligible for Medi-Cal managed care and receives her Benefits Identification Card (BIC) in early September 2023.
- Maria lives in Alpine county. Effective January 1, 2024, Health Plan of San Joaquin d.b.a. Mountain Valley Health Plan (MVHP) will enter the market while California Health and Wellness (CHW) will exit. Anthem Blue Cross Partnership Plan (Anthem) will continue to operate in the county as it does today.
- Maria receives a choice packet in early September and has Anthem and MVHP to choose from. CHW is excluded because they are exiting. If she selects MVHP or does not make an active choice and is default assigned to MVHP, she will be held in fee-for-service (FFS) prior to her enrollment with MVHP effective on Jan 1, 2024. If she chooses or is assigned to Anthem, she will be enrolled at the first of the following month, consistent with current processes.

Scenario	Sep. 2023	Oct. 2023		Nov. 2023	Dec. 2023	Jan. 2024	
Maria Chooses or is Default Assigned to Anthem (Continuing MCP)	***Early Sept.*** *Maria receives a choice packet that includes Anthem and MVHP. Maria actively selects Anthem **or** does not make an active choice within 30 days and is assigned to Anthem.*	***Oct. 1*** *Maria is enrolled into Anthem*	***Early Oct.*** *Maria receives a welcome packet and ID card from Anthem*				
Maria Chooses or is Default Assigned to MVHP (Entering MCP)	***Early Sept.*** *Maria receives a choice packet that includes Anthem and MVHP. Maria actively selects MVHP **or** does not make an active choice within 30 days and is assigned to MVHP.*	***Oct. 1 – Dec. 31*** *Maria remains in fee-for-service (FFS) until MVHP can take enrollment in Alpine County, when contract is effective Jan. 1, 2024*				***Jan. 1*** *Maria is enrolled into MVHP*	***Early Jan.*** *Maria receives a welcome packet and ID card from MVHP*

CLICK HERE FOR REGISTRATION DETAILS