



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

**DATE:** April 5, 2018

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

**SUBJECT: APL 17-011E: ERRATA TO TRANSITION OF CARE POLICY**  
Clarification on Exhibit A, Attachment 13 – Case Management and  
Coordination of Care

SUPERSEDES DENTAL ALL PLAN LETTER 17-011

Note: This Errata is an updated All Plan Letter (APL) to reflect the changes noted below.

- Additional language has been added to the existing Continuity of Care Provisions under 42 CFR § 438.62 (b)(1).
- A new section titled Covered California to Medi-Cal Transition has been added to specify requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal coverage.

**PURPOSE:**

The purpose of this Dental All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide Medi-Cal Dental Managed Care (DMC) plans with instructions regarding transition of care policy requirements in accordance with federal regulations. This APL also provides instruction to the DMC plans concerning the requirement to submit a transition of care policy to DHCS no later than February 1, 2018.

**BACKGROUND:**

Current DMC plan contract provisions in Exhibit A, Attachment 13, require DMC plans to provide dental case management to each member. Federal regulations, 42 Code of Federal Regulations (CFR) § 438.62, require DHCS to have in effect a transition of care policy for individuals who transition to DMC from Dental Fee-for-Service (FFS), or from one DMC plan to another. Further, in accordance with 42 CFR § 438.62 (b)(1), federal regulations require Medicaid managed care plans, including DMC plans, to implement a transition of care policy consistent with these requirements. Attachment 13 of the DMC contract amendment signed in April 2017 requires DMC plans to submit and implement a DHCS-approved transition of care policy for individuals transitioning to DMC from FFS, or from one DMC plan to another, when a member without continued services would experience serious detriment to their health or put them at risk of hospitalization

or institutionalization. DMC transition of care policies must be consistent with the requirements in 42 CFR § 438.62(b)(1).

**DHCS POLICY:**

Consistent with the provisions of 42 CFR § 438.62 (b)(1), the DHCS transition of care policy for DMC is listed below.

Medi-Cal beneficiaries assigned a mandatory DMC aid code and who are transitioning from Medi-Cal Dental fee-for-service (FFS) into a Medi-Cal DMC plan have the right to request continuity of care in accordance with state law and the DMC contracts, with some exceptions. All DMC members with pre-existing provider relationships who make a continuity of care request to a DMC plan must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal dental FFS provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal Dental FFS or through another DMC plan.

DMC plans must provide continuity of care to members with an out-of-network provider when:

1. The DMC plan is able to determine that the member has an existing relationship with the provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
  - a. An existing relationship means the member has seen an out-of-network primary care dentist (PCD) or specialist at least once during the 12 months prior to the date of his or her initial enrollment in the DMC plan for a non-emergency visit, unless otherwise specified in this APL.
2. The provider is willing to accept the higher of the DMC plan's contract rates or Medi-Cal Dental FFS rates;
3. The provider meets the DMC plan's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this APL, a quality of care issue means a DMC plan 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 DMC plan members);
4. The provider is a California State Plan approved provider; and
5. The provider supplies the DMC plan with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

DMC plans are not required to provide continuity of care for services not covered by Medi-Cal dental benefits.

If a member changes their DMC plan, the 12-month continuity of care period may start over one time. When members change DMC plans a second time (or more), the continuity of care period does not start over, meaning that members do not have the right to a new 12 months of continuity of care. If a member returns to Medi-Cal Dental FFS and later re-enrolls in a DMC plan, the continuity of care period does not start over. If a member changes DMC plan, this continuity of care policy does not extend to providers that the member accessed through their previous DMC plan.

#### DMC Processes

Members, their authorized representatives on file with Medi-Cal, or their providers, may make a direct request to a DMC plan for continuity of care. When this occurs, the DMC plan must begin to process the request within five working days following the receipt of the request. However, as noted below, the request must be completed in three calendar days if there is a risk of harm to the member. For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the member's health. The continuity of care process begins when the DMC plan starts the process to determine if the member has a pre-existing relationship with the provider.

DMC plans must refer members requesting continuity of care to appropriate providers of services that are in the network.

Consistent with federal and state law, the member's new provider(s) must be able to obtain copies of the member's medical records, as appropriate.

The Medi-Cal Dental FFS provider or the DMC plan that was previously serving the member must fully and timely comply with requests from the new DMC plan for historical utilization data in compliance with federal and state law.

DMC plans must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the DMC plan may take any necessary information from the requester over the telephone.

DMC plans shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above numbered 1-5 on page 2, and also in 1-3 below. The services that are the subject of the request must have occurred after the member's enrollment into the DMC plan, and the DMC plan must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the DMC plan. DMC plans shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after February 1, 2018;

2. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
3. Are submitted within 30 calendar days of the first date of service for which retroactive continuity of care is being requested.

The DMC plan should determine if a relationship exists through use of data provided by DHCS to the DMC plan, such as Medi-Cal Dental FFS utilization data. A member or his/her provider may also provide information to the DMC plan, which demonstrates a pre-existing relationship with a provider. A member may not attest to a pre-existing relationship (instead, actual documentation must be provided) unless the DMC plan makes this option available to the member.

Following identification of a pre-existing relationship, the DMC plan must determine if the provider is an in-network provider. If the provider is not an in-network provider, the DMC plan must contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a continuity of care relationship for the member.

Request Completion Timeline:

Each continuity of care request must be completed within the following timeline:

- 30 calendar days from the date the DMC plan received the request;
- 15 calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing dental care needs; or,
- Three calendar days if there is risk of harm to the member.

The DMC plan must notify the member of the outcome of the continuity of care request, within the timeframes specified above.

A continuity of care request is considered completed when:

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

Requirements after the Request Process is Completed:

If a DMC plan and the out-of-network Dental FFS provider are unable to reach an agreement because they cannot agree to a rate or the DMC plan has documented quality of care issues with the provider, the DMC plan will offer the member an in-network alternative. If the member does not make a choice, the DMC plan will refer or

assign the member to an in-network provider. If the member disagrees with the result of the continuity of care process, the member maintains the right to pursue a grievance and/or appeal.

If a provider meets all of the necessary requirements including concurring with a letter of agreement or contract with the DMC plan, the DMC plan must allow the member to have access to that provider for the length of the continuity of care period unless the provider is only willing to work with the DMC plan for a shorter timeframe. In this case, the DMC plan must allow the member to have access to that provider for the shorter period of time.

At any time, members may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the DMC plan must work with the provider to establish a care plan for the member.

Upon approval of a continuity of care request, the DMC plan must notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the DMC plan's provider network.

The DMC plan must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition his/her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

DMC Extended Continuity of Care Option:

A DMC plan may choose to work with the member's out-of-network provider beyond the 12-month continuity of care period, but the DMC plan is not required to do so to fulfill its obligations under this APL.

Beneficiary and Provider Outreach and Education:

DMC plans must inform members of their continuity of care protections and must include information about these protections in member information packets and the member and provider handbooks and manuals. This information must include how the members and providers initiate a continuity of care request with the DMC plan. The DMC plan must translate these documents into all applicable threshold languages and make them available in alternative formats upon request. DMC plans must provide training to call center and other staff who come into regular contact with members about continuity of care protections.

Provider Referral Outside of the DMC Plan Network:

An approved out-of-network provider must work with the DMC plan and its contracted network and must not refer the member to another out-of-network provider without authorization from the DMC plan. In such cases, the DMC plan will make the referral, if medically necessary, and if the DMC plan does not have an appropriate provider within its network.

**COVERED CALIFORNIA TO MEDI-CAL TRANSITION:**

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal coverage due to the Covered California yearly coverage renewal determination or changes in a member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning members.

To ensure that continuity of care and coordination of care requirements are met, the DMC plans must ask these members if there are upcoming dental care appointments or treatments scheduled and assist them, if they choose to do so, in initiating the continuity of care process at that time according to the provider and service continuity rights described below or other applicable continuity of care rights. When a new member enrolls, the DMC plan must contact the member by telephone, letter, or other resources no later than 15 days after enrollment. The requirements noted above in this paragraph must be included in this initial member contact process. The DMC plan must make a good faith effort to learn from and obtain information from the member so that it is able to honor active prior treatment authorizations and/or establish out-of-network provider continuity of care as described below.

The DMC plan must honor any active prior treatment authorizations for up to 60 days or until a new assessment is completed by the DMC plan. A new assessment is considered completed by the DMC plan if the member has been seen by an DMC-contracted provider and this provider has completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. The prior treatment authorizations must be honored without a request by the member or the provider.

The DMC plan must, at the member's or provider's request, offer up to 12 months of continuity of care with out-of-network providers, in accordance with the DHCS policy requirements for other transitioning populations regarding out-of-network continuity of care.

**EXISTING CONTINUITY OF CARE PROVISIONS UNDER CALIFORNIA STATE LAW:**

Additional requirements pertaining to continuity of care are set forth in Health and Safety (H&S) Code § 1373.96 and require health plans in California to, at the request of a beneficiary, provide for the completion of covered services by a terminated or nonparticipating health plan provider. Under §1373.96, health plans are required to complete services for the following conditions: acute, serious chronic, pregnancy,

terminal illness, the care of a newborn child between birth and age 36 months, and surgeries or other procedures that were previously authorized as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's transition date or within 180 days of the effective date of coverage for a newly covered member. This APL does not alter a DMC plan's obligation to fully comply with the requirements of §1373.96. In addition to the requirements set forth in this APL, each DMC plan must allow for completion of covered services as required by §1373.96, to the extent that doing so would allow a beneficiary a longer period of treatment by an out-of-network provider than would otherwise be required under the terms of this this APL. DMC plans must allow for the completion of these services for certain timeframes which are specific to each condition and defined under H&S Code § 1373.96.

**REQUIREMENTS:**

By February 1, 2018, DMC plans must submit a transition of care policy for DHCS review that is consistent with the DHCS policy described above. DMC plans must implement their plan specific policies, including any edits identified by DHCS. DMC plans must submit any changes to their transition of care policies within 10 days of any changes, and annually no later than thirty (30) calendar days after the beginning of every calendar year.

If you have any questions regarding the information in this APL, please contact the Medi-Cal Dental Services Division via email to: [dmcdeliverables@dhcs.ca.gov](mailto:dmcdeliverables@dhcs.ca.gov).

Sincerely,

Original signed by Alani C. Jackson

Alani C. Jackson, Division Chief  
Medi-Cal Dental Services Division  
Department of Health Care Services