



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



EDMUND G. BROWN JR.  
GOVERNOR

DATE: October 25, 2018

MHSUDS INFORMATION NOTICE NO.: 18-051

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS  
COUNTY DRUG & ALCOHOL ADMINISTRATORS  
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA  
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES  
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS  
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.  
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES  
CALIFORNIA OPIOID MAINTENANCE PROVIDERS  
CALIFORNIA STATE ASSOCIATION OF COUNTIES

SUBJECT: DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM TRANSITION OF CARE POLICY

**PURPOSE:**

Pursuant to 42 CFR 438.62(b), the Department of Health Care Services (DHCS) shall effectuate a transition of care policy and require all Drug Medi-Cal Organized Delivery System (DMC-ODS) counties implement a transition of care policy consistent with DHCS' policy.

Specifically, 42 CFR 438.62(b) requires that DHCS' transition of care policy ensures continued access to services during a transition from State Plan Drug Medi-Cal (DMC) to DMC-ODS or transition from one DMC-ODS county to another DMC-ODS county when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

DHCS' transition of care policy must provide continued access to services by ensuring that:

- The beneficiary has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of

time if that provider is not in the DMC-ODS county's network, subject to certain conditions; and

- The beneficiary is referred to appropriate providers of services that are in the network.

This information notice sets forth the DHCS transition of care policy and provides guidance to DMC-ODS counties on implementation of the policy.

**POLICY:**

DHCS' transition of care policy requires that a DMC-ODS county allow the beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. DMC-ODS treatment services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months.

DMC-ODS counties shall provide a beneficiary with transition of care with an out-of-network provider when all of the following criteria are met:

1. The DMC-ODS county determines through its assessment that moving a beneficiary to a new provider would result in a serious detriment to the health of the beneficiary, or would produce a risk of hospitalization or institutionalization;
2. The DMC-ODS county is able to determine that the beneficiary has an existing relationship with an out-of-network provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
  - a. An existing relationship means the beneficiary was receiving treatment from the out-of-network provider prior to the date of his or her transition to the DMC-ODS county.
3. The out-of-network provider is willing to accept the higher of the DMC-ODS county's contract rates or DMC rates for the applicable DMC-ODS service(s);
4. The out-of-network provider meets the DMC-ODS county's applicable professional standards and has no disqualifying quality of care issues (for the purposes of this information notice, a quality of care issue means the DMC-ODS county 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-ODS beneficiaries);

5. The provider is verified as a current DMC certified provider; and
6. The out-of-network provider supplies the DMC-ODS county with all relevant treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations. Additionally, the provider supplies the DMC-ODS county with all relevant outcomes data.

### **Transition of Care Request Process**

Beneficiaries, their authorized representatives, or their current provider, may submit a request to the DMC-ODS county to retain their current provider for a period of time. Upon receipt of the request, the DMC-ODS county shall send the beneficiary written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

The DMC-ODS county shall assess the risk of serious detriment to the health of the beneficiary, or a risk of hospitalization or institutionalization. If a DMC-ODS county determines, based on their assessment of the beneficiary, that either risk exists, the DMC-ODS county shall identify whether the beneficiary has a pre-existing relationship with a provider.

Following identification of a pre-existing relationship, the DMC-ODS county shall determine if the provider is a qualified out-of-network provider. If the provider is qualified, the DMC-ODS county shall contact the provider and make a good faith effort to enter into an arrangement to establish a transition of care relationship for the beneficiary.

### **Retroactive Transition of Care Request Process**

DMC-ODS counties shall retroactively approve a transition of care request and reimburse out-of-network providers for services that were provided if the request meets all transition of care requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member's enrollment into the DMC-ODS; and
- Have dates of service that are within thirty (30) calendar days of the first service for which the provider requests retroactive continuity of care reimbursement.

Retroactive continuity of care reimbursement requests shall be submitted in writing within thirty (30) calendar days of the first service to which the request applies.

### **Transition of Care Request Denial Process**

A DMC-ODS county may deny a beneficiary's request to retain their current provider under the following circumstance:

- The DMC-ODS county has documented quality of care issues with the DMC provider

If a DMC-ODS county denies a beneficiary's request to retain their current provider based on one of the above reasons, then the DMC-ODS county shall notify the beneficiary of the denial in writing, offer the beneficiary at least one in-network alternative provider that offers the same level of services as the out-of-network provider, and inform the beneficiary of their right to file a grievance if they disagree with the denial. If a DMC-ODS county offered the beneficiary multiple in-network provider alternatives and the beneficiary does not make a choice, then the DMC-ODS county shall refer or assign the beneficiary to an in-network provider and notify the beneficiary of that referral or assignment in writing.

### **Transition of Care Request Approval Process**

If the DMC-ODS county and out-of-network provider are able to enter into a suitable arrangement for transitioning care for a given beneficiary, then the DMC-ODS county shall allow a beneficiary to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the beneficiary for a shorter timeframe. In this case, the DMC-ODS county shall allow the beneficiary to have access to that provider for the shorter period of time, as established by the out-of-network provider.

Within seven (7) calendar days of approving a transition of care request, the DMC-ODS county shall notify the beneficiary of the following in writing:

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

Additionally, the DMC-ODS county shall submit the required DMC-ODS Provider Form to the Master Provider File unit (<http://www.dhcs.ca.gov/provgovpart/Pages/Master->

[Provider-File.aspx](#)) to ensure reimbursements for claims submitted by the out-of-network provider.

At any time, beneficiaries 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 county shall work with the provider to establish a care plan for the beneficiary.

### **Transition of Care Request Completion Timeline**

Each transition of care request shall be completed within thirty (30) calendar days from the date the DMC-ODS county received the request. Retroactive claims for services from the date of request shall be processed as described above.

A transition of care request is considered completed when:

- The DMC-ODS county notifies the beneficiary, in the manner outlined above, that the request has been approved; or
- The beneficiary has either selected or been assigned to an in-network provider after the DMC-ODS county notified the beneficiary, in the manner outlined above, that the request was denied.

### **Termination of Transition of Care Process**

The DMC-ODS county shall notify the beneficiary in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition the beneficiary's care to an in-network provider at the end of the transition of care period. This process includes engaging with the beneficiary and affected provider(s) before the end of the transition of care period to ensure continuity of services through the transition to an in-network provider.

### **Member and Provider Outreach and Education**

The DMC-ODS county shall inform beneficiaries of their transition of care protections and shall include information about these protections in beneficiary information packets and handbooks. This information shall include how the beneficiary and provider initiate a transition of care request with the DMC-ODS county. The DMC-ODS county shall translate these documents into threshold languages and make them available in alternative formats, upon request. The DMC-ODS county shall provide training to call

center and other staff who come into regular contact with beneficiaries about transition of care protections.

### **Prohibition of Provider Referral Outside of the DMC-ODS County Network**

An out-of-network provider that has been approved to continue to provide care to a beneficiary as described above, shall work with the DMC-ODS county and its contracted network and shall not refer the beneficiary to another out-of-network provider without authorization from the DMC-ODS county. In such cases, the DMC-ODS county shall make the referral, if medically necessary, and if the DMC-ODS county does not have an appropriate provider within its network.

### **Reporting**

The DMC-ODS county shall report every request to retain a current out-of-network provider, including approved and refused requests, in the quarterly Grievance and Appeals log. This submission must be sent to the [ODSSubmissions@dhcs.ca.gov](mailto:ODSSubmissions@dhcs.ca.gov) inbox.

### **Questions**

Please submit any questions regarding this Information Notice to <https://www.dhcs.ca.gov/services/adp/Pages/DMC-Answers.aspx>.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director  
Mental Health & Substance Use Disorder Services