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EDMUND G. BROWN JR.  
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DATE: OCTOBER 4, 2013

ALL PLAN LETTER 13-013  
(SUPERSEDED BY ALL PLAN LETTER 17-007)

TO: ALL TWO-PLAN MODEL AND GEOGRAPHIC MANAGED CARE  
MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR NEW ENROLLEES TRANSITIONED TO  
MANAGED CARE AFTER REQUESTING A MEDICAL EXEMPTION

### PURPOSE

The Department of Health Care Services (DHCS) is issuing this All Plan Letter (APL) to inform Medi-Cal managed care health plans (MCPs) operating under the Two-Plan and Geographic Managed Care models that they must ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care. This APL also provides MCPs with access to a new data file through which DHCS will notify MCPs of beneficiaries who are transitioning from FFS Medi-Cal to a MCP, and have submitted a Medical Exemption Request (MER) and/or an Emergency Disenrollment Exemption Request (EDER).

### BACKGROUND

State law requires MCPs to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving from a non-participating provider or from a terminated provider, subject to certain conditions. Those services must be provided for up to 12 months for the following: an acute condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn child, and the performance of certain previously planned surgeries.<sup>1</sup>

In addition, State regulations allow certain beneficiaries to request a medical exemption from MCP enrollment for up to 12 months to complete a treatment with their current Medi-Cal FFS provider(s).<sup>2</sup> This treatment must be for a complex medical condition and must be provided by a physician, certified nurse midwife, or licensed midwife who is participating in FFS Medi-Cal and is not contracted with any of the MCPs available in an eligible beneficiary's county of residence.

<sup>1</sup> Health & Safety Code § 1373.96.

<sup>2</sup> Exemptions from enrollment in Two-Plan Model health plans are governed by Title 22 of the California Code of Regulations (CCR), Section 53887. Exemptions from enrollment in Geographic Managed Care health plans are set forth in Title 22 CCR 53923.5.

A beneficiary who has been granted a medical exemption from MCP enrollment may remain with the FFS Medi-Cal provider until his or her medical condition has stabilized to a level that would enable him or her to change to a MCP physician without deleterious medical effects, as determined by the beneficiary's FFS Medi-Cal provider. At any time, including during the exemption verification process, DHCS may verify the complexity, validity, and status of the beneficiary's medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a MCP in the beneficiary's county of residence. DHCS may deny a request for exemption from MCP enrollment or revoke an approved exemption if a provider fails to fully cooperate with DHCS's verification process.

If a beneficiary files a MER that is denied, the beneficiary may still be entitled to continuity of care as further explained below.

## **POLICY**

MCPs are required to consider a request for exemption from MCP enrollment that is clinically denied as a request to complete a course of treatment with an existing FFS provider under Health and Safety Code (H&S Code) Section (§) 1373.96, and in compliance with the MCP's contract with DHCS and any other continuity of care APL issued by DHCS. MCPs must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. Continuity of care timeframes are established under H&S Code §1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities (SPDs) established under APL 11-019.<sup>3</sup>

MCPs must treat every exemption listed on the "Exemption Transition Data" report (see Attachment A for data file format details) as an automatic continuity of care request for the identified beneficiary. Once a MCP is notified that a beneficiary is on the Exemption Transition Data report, the MCP must make every effort to ensure that the beneficiary is allowed to continue to receive ongoing medical care through his or her FFS provider(s) for the period specified in H&S Code §1373.96 for a particular illness or condition.

MCPs must begin processing requests for extended continuity of care within five working days from their receipt of the requests. In this case, receipt of the Exemption Transition Data report constitutes such a request. MCPs must complete their responses to each request within 30 calendar days from the date the MCP receives it, or sooner if the beneficiary's medical condition requires more immediate attention. If a beneficiary voluntarily chooses to change MCPs, the completion of covered services

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<sup>3</sup> APL 11-019 and all APLs are available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

MCPs must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out of network) about the requirements set forth in this APL. MCPs must, at a minimum, include information about continuity of care in provider training and new member orientation materials.

MCPs must oversee and remain accountable for the requirements in this APL even if they subcontract with an independent physicians association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this APL. If the beneficiary's FFS provider is not in the MCP's provider network, DHCS strongly encourages the MCP to secure a letter of agreement, memorandum of understanding, or contract with the provider to assure continuity of care under this APL and to enable the provider to join the MCP's network.

For coordination of care and care transition efforts required under H&S Code §1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

MCPs must immediately refer SPDs for a health risk assessment, as is required under Policy Letter 12-004<sup>4</sup>, and an individual care plan must be developed within ten days of enrollment in the MCP, including authorization for 30 days of continuity of prescription drugs, as required by Welfare and Institutions Code (W&I Code) §14182(b)(22). MCPs must permit a beneficiary to continue the use of a single-source drug that was prescribed immediately prior to his or her date of enrollment, whether or not that drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the contracting physician, as required by W&I Code §14185(b) or until a new care plan is established by the MCP that does not include the drug. There is no limit to the number of drugs that may be subject to this requirement, as long as the drug(s) is part of a prescribed therapy in effect for the beneficiary prior to the date of enrollment.

### **Exemption Transition Data Report**

DHCS has created a data file to notify MCPs of beneficiaries who have submitted a MER and are transitioning into a MCP. The exemption transition data file will be accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: <http://healthcareoptions.maximus.com/sdes/>.

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<sup>4</sup> Policy Letter 12-004 is available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>.

The exemption transition data file will be posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The 2013 file posting schedule is available for download from the SDES website by clicking on the [2013 File Posting Schedule link](#). Authorized MCP representatives who have access to the WPF will also have access to the exemption file.

MCPs will receive exemption transition data if the beneficiary has been enrolled in a MCP within one year of the date on which the exemption was denied. Once the beneficiary is enrolled in the MCP, the exemption transition data will remain in the report for four consecutive weekly reports. When a beneficiary is enrolled in a MCP, a record of the exemption denial will also be present in the WPF. If there is no exemption denial activity for beneficiaries enrolling in a particular MCP, an empty exemption file will not be posted to the SDES.

The record layout for the exemption transition data file is provided as Attachment A to this letter. Sample exemption data files have been posted on the SDES in the individual plan folders. MCPs should download and review the files and submit any technical questions to MAXIMUS at: [cahcohelpdesk@maximus.com](mailto:cahcohelpdesk@maximus.com). Please use "MER/EDER Data File" in the subject line of the email.

## **REQUIREMENTS**

MCPs must submit a quarterly Exemption Denial and Continuity of Care report to DHCS using the reporting template and instructions that are provided with this APL in Attachments B and C. The quarterly reports must be submitted in the required format and emailed to: [pmp.monitoring@dhcs.ca.gov](mailto:pmp.monitoring@dhcs.ca.gov) no later than 45 calendar days after the end of the quarter.

If you have any questions regarding this APL, please contact your contract manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar, Chief  
Medi-Cal Managed Care Division

Attachments