CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: May 23, 2025

ALL PLAN LETTER 25-002 *(REVISED)*
SUPERCEDES ALL PLAN LETTER 17-011E

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL DENTAL MANAGED CARE MEMBERS WHO NEWLY ENROLL FROM MEDI-CAL DENTAL FEE-FOR-SERVICE, AND FOR MEDI-CAL DENTAL MANAGED CARE MEMBERS WHO TRANSITION INTO A NEW MEDI-CAL DENTAL MANAGED CARE PLAN ON OR AFTER JULY 1, 2025

PURPOSE:
The purpose of this Dental All Plan Letter (APL) is for the Department of Health Care Services (DHCS) to provide Dental Managed Care (DMC) plans with guidance on Continuity of Care for Members who mandatorily transition from Medi-Cal Dental Fee-for-Service (FFS) to enroll as Members in a DMC plan, or transition from DMC plans with contracts expiring or terminating to a new DMC plan, on or after July 1, 2025. This APL supersedes APL 17-011E.[1] *This APL has been revised. Revised language is noted in Italics.*

BACKGROUND:
Members who mandatorily transition from Medi-Cal Dental FFS to enroll as Members in a DMC plan, or transition from DMC plans with contracts expiring or terminating to a new DMC plan, on or after July 1, 2025, have the right to request Continuity of Care with Providers in accordance with federal and state law and the DMC contract, with some exceptions.[2,3,4,5,6] Consistent with federal law, Members must (a) have access to services consistent with the access they previously had, (b) be permitted to have continued access to services during a transition from dental FFS to DMC, or a transition from DMC plan to DMC plan, and (c) be permitted to retain their current Provider for a period of time if that Provider is not in the DMC plan's Network when the Member, in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization.[7]

[1] APL 17-011E: Errata to Transition of Care Policy
[2] HSC § 1367(d) and §1373.96 are searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml
[3] Title 28 of the California Code of Regulations (CCR) §1300.67.1 is searchable at: https://govt.westlaw.com/calregs/Search/Index
[4] Dental Managed Care Boilerplate Contracts can be found at: DMC Contracts and All Plan Letters
[5] Title 42 Code of Federal Regulations (CFR) § 438.62 is searchable at: https://www.ecfr.gov/
[6] Further implementation guidance applicable for 2025 transitions is forthcoming.
[7] 42 CFR §438.62

Members may request up to 12 months of Continuity of Care with a Provider if a verifiable pre-existing relationship exists with that Provider.[8] Continuity of Care with a Provider will be referred to as Continuity of Care in this APL. Additionally, consistent with Health and Safety Code (HSC) §1373.96[9], the DMC plan must provide Continuity of Care for the completion of a course of treatment for that specific condition by a terminated Provider or by a nonparticipating Provider at the Member's request. Members also have the right to Continuity of Care for Covered Services and active prior treatment authorizations for Covered Services.

In addition to the requirements in this APL, DMC plans must comply with the requirements in APL 17-011E, or any subsequent APLs on these topics.

POLICY:

I. Continuity of Care Requirements

If a Member is mandatorily transitioning from Medi-Cal Dental FFS or transition from DMC plans with contracts expiring or terminating, to enroll as a Member in a DMC plan on or after July 1, 2025, the Member may request Continuity of Care for up to 12 months after the enrollment date with the DMC plan if a pre-existing relationship exists with that Provider, regardless of the Member having a condition listed in HSC §1373.96.

DMC plans shall honor Continuity of Care situations in which a Member's treatment will need to be completed by the treating Provider beyond 12 months, through the duration of treatment completion, such as in orthodontia cases.

Continuity of Care protections extend to Primary Care Dentists, Specialists, Registered Dental Hygienists in Alternative Practice (RDHAP's), and select ancillary Providers, including Community Health Workers (CHWs). These protections are subject to the Continuity of Care requirements outlined below in this section.

Continuity of Care protections do not extend to all other ancillary Providers such as Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT), other ancillary services, and non-enrolled Medi-Cal Providers.

DMC plans are only required to provide Continuity of Care for covered benefits. Plans must process Continuity of Care requests by following the requirements outlined below:

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[8] A pre-existing relationship means the Member has seen an OON Primary Care Dentist, specialist, or select ancillary Provider including CHWs for a non-emergency visit, at least once during the 23 months prior to the date of their initial enrollment in the DMC plan, unless otherwise specified in this APL.
[9] California Code, HSC 1373.96

A. Processing Continuity of Care Requests

1. Acceptance of Requests

DMC plans must accept Continuity of Care requests from the Member, authorized representative, or Provider over the telephone with a live agent, according to the requester's preference, and must not require the requester to complete and submit a paper or online 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 with a live agent.

2. Retroactive Requests

DMC plans must retroactively approve a Continuity of Care request and reimburse Providers for services that were already provided if the request meets all Continuity of Care requirements outlined below in subsection A.3, including the Provider being willing to accept the Plan's contract rates or Medi-Cal Dental FFS rates, and the services that are the subject of the retroactive request meet the following requirements:

- Occurred after the Member's enrollment into the DMC plan.
- Have dates of service that are within 30 calendar days of the first service for which the Provider requests retroactive reimbursement (i.e., the first date of service is not more than 30 calendar days from the date of the reimbursement request).

3. Completion of Requests

The Continuity of Care process begins when the DMC plan receives the Continuity of Care request. The DMC plan must first determine if the Member has a pre-existing relationship with the Provider. DMC plans must request from an Out-of-Network (OON) Provider 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 regulation. DMC plans must provide Continuity of Care when the following requirements are met:

- The DMC plan is able to determine that the Member has a pre-existing relationship with the Provider;
- The Provider is willing to accept the DMC plan's contract rates or Medi-Cal Dental FFS rates;

- The Provider meets the DMC plan's applicable professional standards and has no disqualifying quality of care issues;[10] and
- The Provider is a Medi-Cal approved Provider.[11]

4. **Validating Pre-Existing Relationship**
   The DMC plan must determine if a relationship exists through use of data provided by DHCS (such as Medi-Cal Dental FFS utilization data), or claims data from a DMC plan. A Member, authorized representative, or Provider may also provide information to the Plan that demonstrates a pre-existing relationship with the Provider. A Member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the DMC plan makes this option available to the Member.

   Following identification of a pre-existing relationship, DMC plans must determine if the Provider is a Network Provider. If the Provider is a Network Provider, then the DMC plan must allow the Member to continue seeing the Provider. If the Provider is not a Network Provider, the 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 Continuity of Care for the Member.

5. **Timeline**
   DMC plans must begin to process non-urgent requests within five (5) *business* days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request must be completed within the following timelines from the date the DMC plan received the request:
   - 30 calendar days for non-urgent requests;
   - 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   - As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the Member).[12]

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[10] For the purposes of this APL, a quality of care issue means the 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 Members.
[11] The Provider must be enrolled and participating in the Medi-Cal program. A list of suspended or ineligible Providers is available here: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/
[12] For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the Member.

6. Member Notifications

DMC plans must provide acknowledgment of the Continuity of Care request within the timeframes specified below, advising the Member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. DMC plans must notify the Member by using the Member's known preference of communication or by notifying the Member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:

- For non-urgent requests, within seven (7) calendar days of the decision;
- For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three (3) calendar days of the decision.

A Continuity of Care request is considered complete when a DMC plan notifies the Member of the DMC plan's decision. The DMC plan must attempt to notify the Member of the Continuity of Care decision via the Member's preferred method of communication or by telephone at least two (2) times. DMC plans must also send a notice by mail to the Member within seven (7) calendar days of the Continuity of Care decision, or if urgent, within the shortest applicable timeframe thit is appropriate for the member's condition, but no longer than three (3) calendar days. Receiving DMC plans must comply with the HIPAA Privacy Rule in all notifications.

a. Member Notification of Denial

For Continuity of Care requests that are denied, the DMC plan must include the following information in the notice:

- A statement of the DMC plan's decision;
- A clear and concise explanation of the reason for denial;
- The Member's right to file a grievance or appeal. For additional information on grievances and appeals, refer to APL 22-006[13] or subsequent iterations of this APL.

If the DMC plan and the OON 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 must offer the Member a Network Provider alternative. If the Member does not make a choice, the Member must be referred to a Network

[13] APL 22-006: Grievance and Appeals Requirements Notice

Provider. If the Member disagrees with the Continuity of Care determination, the Member maintains the right to file a grievance.

b. Member Notification of Approval

For Continuity of Care requests that are approved, the DMC plan must include the following information in the notice:

- A statement of the DMC plan's decision;
- 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;
- The Member's right to choose a different Network Provider.

If a Provider meets all of the necessary requirements, including entering into 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 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.

When the Continuity of Care agreement has been established, the DMC plan must work with the Provider to establish a plan of care for the Member. At any time, Members may change their Provider to a Network Provider regardless of whether or not a Continuity of Care relationship has been established.

The DMC plan must notify the Member sixty (60) calendar days before the end of the Continuity of Care period two (2) times, using the Member's preferred method of communication, and following up with a letter in the mail, about the process that will occur to transition the Member's care to a Network Provider 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.

7. Provider Referral Outside of the DMC Plan Network

The DMC plan must work with the approved OON Provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the OON Provider does not refer the Member to another OON Provider without authorization from the DMC plan. In such

cases, the DMC plan will make the referral, if medically necessary, if the DMC plan does not have an appropriate Provider within its Network.

8. **12-Month Continuity of Care Period Restart**
   If a Member changes DMC plans by choice following the initial enrollment in a DMC plan or if a Member loses and then later regains DMC eligibility during the 12-month Continuity of Care period, the 12-month Continuity of Care period for a pre-existing Provider may start over one (1) time. For example, if a Member enrolls in a DMC plan on July 1, 2025, but then later changes plan by choice on October 1, 2025, then the 12-month Continuity of Care may start over one (1) time and the Member may see the Provider until October of the following year.

   If the Member changes DMC plans or loses and then later regains DMC eligibility a second time (or more), the Continuity of Care period does not start over and the Member does not have the right to a new 12 months of Continuity of Care. If the Member returns to Medi-Cal Dental FFS, if applicable, and later re-enrolls in a DMC plan, the Continuity of Care period does not start over.

B. Scheduled Specialist Appointment

At the request of the Member, authorized representative, or Provider, DMC plans must allow transitioning Members to keep authorized and scheduled Specialist appointments with OON Providers when Continuity of Care has been established and the appointments occur during the 12-month Continuity of Care period.

If a Member, authorized representative, or Provider contacts the DMC plan to request to keep an authorized and scheduled Specialist appointment with an OON Provider that the Member has not seen in the previous 12 months and there is no established relationship with the OON Provider, the DMC plan may arrange for the Member to keep the appointment or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider.

If the DMC plan is unable to arrange a Specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider, the DMC plan is encouraged to make a good faith effort to allow the Member to keep their appointment with the OON Provider. However, since the appointment with the OON Provider occurs after the Member's transition to the DMC plan, it does not establish the requisite pre-existing Provider relationship for the Member to submit a Continuity of Care request.

II. Continuity of Covered Services and Prior Treatment Authorizations

All Members have the right to continue receiving Medi-Cal Dental services covered under the DMC plan's Contract or Medi-Cal Dental FFS when transitioning to a DMC plan, even in circumstances in which the Member does not continue receiving services from their pre-existing Provider. The DMC plan must arrange for Continuity of Care for Covered Services without delay to the Member with a Network Provider, or if there is no Network Provider to provide the Covered Service, with an OON Provider. In an instance where a Member would like their OON Provider to provide a service and they have a pre-existing relationship with the OON Provider, they may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal Dental FFS or from DMC plans with contracts expiring or terminating to a new DMC plan, on or after July 1, 2025, or if the conditions in HSC §1373.96 are met. The DMC plan must make a good faith effort to enter an agreement if all Continuity of Care requirements are met.

Following a Member's mandatory transition from Medi-Cal Dental FFS or from DMC plans with contracts expiring or terminating to a new DMC plan on or after July 1, 2025, active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the Member, authorized representative, or Provider. The DMC plan must arrange for services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider. After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the DMC plan, whichever is shorter. If the Plan does not complete a new assessment, the active treatment authorization remains in effect and after 90 days, the DMC plan may reassess the Member's prior treatment authorization at any time.

Additionally, in an instance where a service has been rendered with an OON Provider, and that Provider satisfies the Continuity of Care requirements, the Member, authorized representative, or Provider may request Continuity of Care to retroactively cover the service. See additional information and requirements for retroactive requests under section I.A.2 of this APL.

A. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)

For NEMT and NMT, DMC plans must allow Members to keep the modality of transportation under the previous Prior Authorization with a Network Provider until the new DMC plan is able to reassess the Member's continued transportation needs.

DMC plans must use Treatment Authorization Request (TAR) data or Prior Authorization data to identify prior treatment authorizations, including authorized procedures and surgeries.

III. Member and Provider Outreach and Education

DMC plans must inform Members of their Continuity of Care protections and include information about these protections in Member information packets, handbooks, and on the DMC plan's website. This information must include how a Member, authorized representative, and Provider may initiate a Continuity of Care request with the DMC plan. In accordance with APL 21-001[14] or subsequent iterations of the APL, the DMC plan must translate these documents into 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.

IV. Reporting

DMC plans must continue to report on existing metrics related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents. DHCS may request additional reporting on Continuity of Care at any time and in a manner determined by DHCS.

REQUIREMENTS:
If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a DMC plan's contractually required policies and procedures (P&Ps), the plan must submit its updated P&Ps with and without Track Changes to DHCS' Medi-Cal Dental Services Division (MDSD) at dmcdeliverables@dhcs.ca.gov within 90 days of the release of this APL.

If a DMC plan determines that no P&P changes are necessary, the DMC plan must submit an email confirmation to dmcdeliverables@dhcs.ca.gov within 10 days of the release of this APL, stating that the DMC plan's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DMC plans are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

[14] APL 21-001: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

These requirements must be communicated by each DMC Plan to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact the Medi-Cal Dental Services Division, at dmcdeliverables@dhcs.ca.gov.

Sincerely,

Original signed by

Dana Durham
Chief, Medi-Cal Dental Services Division
Department of Health Care Services