DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: September 27, 2024

ALL PLAN LETTER 24-014

TO: ALL MEDI-CAL MANAGED CARE PLANS IN SINGLE PLAN COUNTIES

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL MEMBERS WHO ARE FOSTER YOUTH AND FORMER FOSTER YOUTH IN SINGLE PLAN COUNTIES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) in Single Plan counties with guidance on enhanced continuity of care protections for Foster Youth and Former Foster Youth Medi-Cal members who live in a Single Plan county and are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care.

BACKGROUND:
Assembly Bill (AB) 118 (Committee on Budget, Chapter 42, Statutes of 2023 - SEC.157), amended Welfare and Institutions Code (W&I) section 14184.200 mandating Foster Youth and Former Foster Youth[1] Medi-Cal members living specifically in Single Plan counties (i.e., Alameda, Contra Costa and Imperial) to transition from Medi-Cal FFS to enroll as Members in an MCP on or after January 1, 2025.[2] January 1, 2025, will be referred to herein as the "Transition Date". The impacted Foster Youth and Former Foster Youth Medi-Cal members will be referred to herein as the "Transitioning Population".

POLICY:
MCPs are required to provide enhanced continuity of care protections to the Transitioning Population. The enhanced continuity of care protections are time-bound to the Transition Date. MCP compliance with the policy stated herein will be monitored via pre- and post-transition monitoring activities and requirements. This APL does not limit an MCP's obligations to fully comply with the requirements of the MCP Contract, APL 23-022, or any superseding APL.[3] APL 23-022 outlines member notifications, additional continuity of care protections and timelines for specified conditions, and members' ability to request an additional 12

[1] Transitioning population includes current foster youth, former foster youth, adoption, and child welfare cases. For the full list of foster youth aid codes for this transition, see the Master Aid Code Chart, which can be found at: https://www.dhcs.ca.gov/services/Documents/MMCD/Aid-Code-Chart-2024.pdf.
[2] California state law and legislation are searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

months of continuity of care.
The Contract and APL 23-029, requires MCPs to build partnerships with County Child Welfare agencies including good faith efforts to execute Memorandum of Understanding for the purpose of clarifying roles and responsibilities among parties, supporting local engagement, facilitating care coordination and the exchanging of information necessary to enable care coordination and improve the referral processes between parties.

In addition, the MCP Contract and APL 24-013, requires each MCP to designate a Child Welfare Liaison to serve as the point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member's care coordination, including ECM Lead Care Managers for the Children and Youth Involved in Child Welfare Population of Focus and county child welfare staff, among others.

1. **Continuity of Care Requests**
   MCPs must be able to initiate, accept, and process continuity of care requests from the Transitioning Population, Providers, and Authorized Representatives[4] beginning 60 calendar days prior to the Transition Date. MCPs must begin to process all continuity of care requests within five Working Days of receipt. Additionally, each continuity of care request must be completed within the following timelines from the date the MCP received the request:[5]
   - 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).[6]

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[4] Per the 2024 DHCS Managed Care Contract "authorized representative" means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member. The Contract is available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[5] These continuity of care request timelines do not modify timely access to appointment standards under H&S section 1367.03, Title 28 California Code of Regulations (CCR) section 1300.67.2.2, and the MCP Contract. CCRs are searchable at: https://govt.westlaw.com/calregs/Search/Index.
[6] For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the Member.

2. **Continuity of Care for Providers**
   Continuity of care for Providers enables the Transitioning Population to continue receiving health care, including medical and behavioral health care from their existing Providers for up to 12 months.[7] This continuity of care for Providers protection is intended to maintain trusted Member/Provider relationships until the Member can transition to a Network Provider with the MCP. Upon receipt of Medi-Cal member level detailed transition data from the Department of Health Care Services (DHCS) for the Transitioning Population, or at least 30 calendar days prior to the Transition Date, the MCP must conduct outreach to out-of-Network eligible Providers[8] with whom Medi-Cal members have pre-existing relationships to initiate a Network Provider Agreement or continuity of care for Providers agreement. MCPs must review all available data within 30 calendar days of receiving data for the Medi-Cal member, including but not limited to the Medi-Cal member level detailed transition data from DHCS, to identify the eligible Providers who provided services to Medi-Cal members prior the Transition Date. MCPs must complete outreach to eligible out-of-Network Providers within 60 calendar days of the Transition Date. Outreach is defined as at least three separate attempts made to the eligible out-of-Network Provider to achieve positive contact. These outreach attempts must include at least two different modes of communication, such as, phone calls, emails, mailers, etc. DHCS reserves the right to request materials from the MCP documenting its outreach attempts. After achieving positive contact with the out-of-Network Provider(s), MCPs must engage in good faith negotiations to achieve agreement.

The MCP must notify the Member or Authorized Representative and the Member's care manager[9] within seven calendar days after processing the continuity of care for Providers, when applicable, if the Member's Provider is in-Network, or is brought in-Network as a result of the MCP's outreach. The MCP must send notification that the Member may continue with their Provider. If the MCP and the Member's out-of-Network

[7] Health and Safety Code (H&S) section 1373.96(c) protects longer durations of treatment time for Members with a serious chronic condition, a pregnancy, a terminal illness, or care of a newborn from birth to 36 months of age.
[8] Provider types eligible for continuity of care for Providers includes PCPs. specialists, ECM providers, Community Support providers, Skilled Nursing Facilities (SNFs), and select ancillary providers such as, dialysis centers, physical therapists, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment providers, speech therapy providers, and community health workers.
[9] For the purposes of this policy, a care manager is inclusive of the Complex Care Management care manager and the Enhanced Care Management (ECM) lead care manager, as well as other care managers.

Provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the Provider, the MCP must offer the Member an in-Network Provider.

3. **Continuity of Care for Covered Services – Prior Authorization and Active Course of Treatment**
   MCPs must honor active Prior Authorizations identified in any data available to the MCP and/or when requested by the Transitioning Population, Provider, or Authorized Representative, and the MCP obtains documentation of the Prior Authorization before or within the six-month period following the Transition Date. DHCS and MCP authorization protocols may differ, therefore MCPs must allow Members to continue an Active Course of Treatment[10] without a Prior Authorization for the six-month period following the Transition Date. Upon receipt of Medi-Cal member level detailed transition data from DHCS, and continually during the six-month period following the Transition Date, the MCP must examine all available data to identify any Active Course of Treatment that requires authorization. If an Active Course of Treatment is identified, the MCP must contact the prescribing and/or ordering Providers within 30 days of discovery to establish any necessary Prior Authorizations. MCPs must continue to honor any Prior Authorization and Active Course of Treatment for the full six-month period following the Transition Date and until reassessment for Medical Necessity of ongoing services.[11,12] If the MCP does not reassess for Medi-Cal Necessity during the six-month period, the MCP must continue to honor Prior Authorizations and Active Courses of Treatment beyond the six-month period and until the MCP reassess Medical Necessity for ongoing services. If the Provider serving the Member is out-of-Network and does not enter into a continuity of care for Provider Agreement with the MCP, the MCP must engage

[10] Active Course of Treatment is defined as a situation when a Member is actively engaged with a Provider and following prescribed or ordered course of treatment as outlined by the Provider for a particular medical condition and identifiable in claims data in the 12-month period preceding the Transition Date.

[11] A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider, and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of Covered Services specified by the pre-Transition Active Course of Treatment authorization.

[12] Per W&I sections 14184.402(d) and (f)(1)(A), a mental health diagnosis is no longer a prerequisite for foster youth to access Specialty Mental Health Services (SMHS), as trauma due to involvement in child or juvenile justice makes children and youth under age 21 eligible for SMHS. Pursuant to Behavioral Health Information Notice (BHIN) 21-073, children and youth involved in child welfare and juvenile justice category meet Medical Necessity criteria for SMHS. BHIN's are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral-Health-Information-Notice-%28BHIN%29-Library.aspx.

the Member to continue the Member's Active Course of Treatment with an in-Network Provider.

4. **Durable Medical Equipment Rentals and Medical Supplies**
   MCPs must allow Members to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing DME Providers without further authorization for the full six-month period following the Transition Date and until a reassessment has been completed, and the new equipment or supplies are in the possession of the Member and ready for use. [13] If the MCP does not complete a reassessment during the six-month period, the MCP must allow Members to keep their existing DME rentals or medical supplies beyond the six-month period and until the MCP completes the reassessment. After six months from the Transition Date, the MCP may reassess the Member's authorization at any time and may require the Member to switch to an in-Network DME Provider. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the original treatment authorization.

Enhanced Care Management
As MCPs are transitioning Medi-Cal members into managed care, MCPs must ensure the Transitioning Population is identified, engaged and referred to ECM (i.e., eligible as a population of focus for children and youth involved in child welfare, including former and current foster youth up to age 26). As for all ECM Populations of Focus, MCPs must establish policies and procedures that allow network providers to refer patients to the MCP for ECM if they suspect eligibility criteria are met and track key performance indicators to monitor and improve the volume of provider referrals. Whenever possible, MCPs should encourage community-based referrals from existing medical and non-medical providers, especially those with which they have made Continuity of Care arrangements.

Beginning January 1, 2025, MCPs must implement presumptive authorization arrangements with select ECM Providers to allow the provision of ECM for up to 30 days while a formal referral is made and adjudicated. Some of the ECM Providers covered by presumptive authorization requirements for children and youth involved in child welfare include: County-contracted and County-operated Specialty Behavioral Health Providers, High Fidelity Wraparound Providers, Health Care Program for

[13] A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider, and the Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of Covered Services specified by the pre-Transition Active Course of Treatment authorization.

Children in Foster Care Providers, Department of Social Services (DSS) offices, Foster Family Agencies, Transitional Housing Programs for Current and Former Foster Youth, and Children's Crisis Residential Programs).[14] MCPs must follow the standard Member notification guidelines outlined in APL 21-011.

MCPs designated Child Welfare Liaison provides assistance to staff responsible for the Member's care coordination, including ECM Lead Care Managers. Assistance provided by the MCP Child Welfare Liaison may include but is not limited to providing assistance with benefits and services navigation and coordination throughout the MCPs service area, including but not limited to ECM, Community Supports, Behavioral Health, Transitional Care Services, Health Education, Home and Community Based Services, California Children's Services (CCS), tribal health care, and other local service area resources, etc., to provide full-spectrum services to Members, as well as collaborating with MCP ECM staff to ensure that robust and effective referral pathways exist to ensure the Transitioning Population are referred to ECM.

Behavioral Health
Given that a proportion of transition Foster Care Children and Youth are likely to be receiving behavioral health care services, MCPs must have well-defined protocols that ensure that Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption in accordance with No Wrong Door policies. This includes concurrent service provision, whereby the MCP must cover Medically Necessary Non-Specialty Mental Health Services for a Member concurrently receiving SMHS covered by the county Mental Health Plan, and ensure those services are coordinated and not duplicative. The MCP must ensure compliance with No Wrong Door for Mental Health Services policy pursuant to W&I section 14184.402.[15] as well as timely access standards under H&S section 1367.03 and Title 28 CCR section 1300.67.2.2.

Member and Provider Outreach and Education
MCPs must follow the Member notification guidelines for continuity of care requests outlined in APL 23-022, or any superseding APL.[16] MCPs must inform Members of their

[14] For more information please see the ECM Policy Guide which is available at: https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx
[15] For more information about No Wrong Door, see APL 22-005, or any superseding APL as well as BHIN 22-011.
[16] Per APL 23-022, Member noticing must include a statement of the MCP'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, and the member's right to choose a different Network Providers.

continuity of care protections and include information about these protections in Member information packets, handbooks, and on the MCP's website.[17] This information must include how a Member, Provider, and Authorized Representative may initiate a continuity of care request with the MCP. In accordance with APL 21-004, or any superseding APL, the MCP must translate these documents into threshold languages and make them available in alternative formats upon request. MCPs must provide training to call center and other staff who come into regular contact with Members about continuity of care protections. The MCP Child Welfare Liaison provide support and technical assistance to staff for resolving escalated case specific, systematic, and operational obstacles for accessing services. The MCP Child Welfare Liaison(s) is expected to assist with benefits and services navigation and coordination throughout the MCPs service area, including with other local service area resources and is also required to collaborate and participate in local quarterly meetings with County Child Welfare agencies, as outlined in the MOU between the MCP and the County Child Welfare agencies, as required by the MCP Contract and APL 23-029.

Reporting
MCPs 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.[18] DHCS may request additional reporting on continuity of care for pre- and post-transition monitoring purposes at any time and in a manner as determined by DHCS.

Assessing Compliance
DHCS will assess MCP compliance with the requirements in this APL via pre- and post-transition monitoring, coordination with FFS Medi-Cal, reviews of regular MCP reporting streams, and any other means deemed appropriate by DHCS.

The requirements contained in this APL will necessitate a change in an MCP's contractually required policies and procedures (P&Ps). MCPs must submit their updated P&Ps through the Managed Care Operations Division (MCOD) Oversight SharePoint Submission Portal[19] within 60 days of the release of this APL.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract

[17] H&S sections 1363(a)(15) and 1373.96(m).
[18] 2024 DHCS Managed Care Contract, Program Data Reporting Section 2.1.5B
[19] The MCOD Oversight SharePoint Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Contract%20Oversight.aspx.

requirements, and other DHCS guidance, including APLs and Policy Letters.[20] These requirements must be communicated from each MCP to all Subcontractors and Network Providers. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions, as appropriate, to ensure compliance with this APL. MCPs must follow all Grievance and Appeals guidelines per APL 21-011, or any superseding APL, when MCPs deny, terminate, or reduce/modify services requested or already authorized. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent guidance on this topic. Any failure to meet the requirements of this APL may result in a CAP and other sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[20] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.