DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: December 20, 2023

ALL PLAN LETTER 23-031

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: MEDI-CAL MANAGED CARE PLAN IMPLEMENTATION OF PRIMARY CARE PROVIDER ASSIGNMENT FOR THE AGE 26-49 ADULT EXPANSION TRANSITION

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care plans (MCPs) with guidance on the Age 26-49 Adult Expansion to ensure individuals transitioning from restricted scope Medi-Cal or are otherwise uninsured to full-scope Medi-Cal maintain their existing Primary Care Provider (PCP) assignments to the maximum extent possible to minimize disruptions in services. PCPs include the following: general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, obstetrician-gynecologist, specialists, medical homes, and clinics. MCPs must coordinate with county uninsured programs and public health care systems to share data for the Adult Expansion Population and use that data to effectuate PCP assignment.

BACKGROUND:
Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code (W&I) section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS) as required by W&I section 14011.2.[1] This new coverage is referred to as the Age 26-49 Adult Expansion. SB 184 will take effect on January 1, 2024.

Much of the Adult Expansion Population is currently served through county programs for the uninsured and low-income populations and public health care systems. As these individuals transition to full scope Medi-Cal, California has prioritized two goals:

1) Maintain PCP assignment to the maximum extent possible; and
2) Support and strengthen traditional county health providers who treat a high volume of uninsured and Medi-Cal patients.

[1] State law is searchable at: https://leginfo.legislature.ca.gov/

POLICY:

IMPACTED POPULATIONS:
New Enrollee Population: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.

Transition Population: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or are unable to establish SIS for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.

Collectively, these populations will be referred to as the “Adult Expansion Population”.

DATA SHARING AND COORDINATION POLICY:
MCPs are required to maintain PCP assignment to the maximum extent possible for Adult Expansion Population Members. To support this PCP assignment, the Department of Health Care Services (DHCS) is requiring MCPs to effectuate a data sharing process with the county uninsured programs and public health care systems that currently serve the Adult Expansion Population. MCPs are required to accept data from, transmit data to, and coordinate with, the county uninsured programs and public health care systems serving the Adult Expansion Population. MCPs must designate a point of contact for the county uninsured programs and public health care systems and engage with all such organizations that are able and willing to share data per the requirements detailed in this APL. MCPs are required to review and use the data provided by the county uninsured programs and public health care systems to effectuate PCP assignments for these Members.

DATA SHARING AUTHORITY AND REGULATIONS
Health care providers, health plans, and health care clearinghouses are considered covered entities and must comply with the data sharing limitations of the Health Insurance Portability and Accountability Act (HIPAA).[2] Covered entities are permitted to share health care data with other covered entities for treatment, payment, or healthcare

[2] Title 45 Code of Federal Regulations (CFR) sections 160.103 and 164.502. The CFR is searchable at: https://www.ecfr.gov/

operations purposes.[3] If the county uninsured program or the public health system is a HIPAA covered entity, then data sharing with the MCP is permitted by HIPAA for this purpose.[4] A covered entity may share data for payment or healthcare operations with a business associate as defined in HIPAA provided in accordance with the Business Associate Agreement in place.[5] DHCS requires MCPs to coordinate with healthcare providers and county uninsured programs as part of their obligations to coordinate services. Such responsibilities authorize health care providers to share Protected Health Information (PHI) with MCPs without patient authorization for payment or health care operations purposes.[6] DHCS has determined that data sharing for the Adult Expansion Population is required by the authority of law.[7,8,9]

DATA SHARING PROCESS:

MCPs will receive data for the Adult Expansion Population from county uninsured programs and public health care systems to match PCP assignments for transitioned Members. MCPs will receive the Member PCP Assignment File from the county uninsured program or the public health care system, review the data file, and use the data elements provided to complete a Member match and PCP assignment. The MCP must send back the PCP Assignment Return File confirming which Members were successfully assigned a PCP match as outlined in the Data Transmission Requirements section below. This data sharing process does not absolve MCPs of the standard contractual requirements to notify providers of PCP assignment present in the MCP Contract.[10,11]

In the course of this transition, MCPs may receive data for individuals who do not ultimately enroll into the MCP. Throughout the data transmission processes outlined in this APL, MCPs must have processes for receiving, storing, using, or transmitting PHI and sharing data in accordance with applicable laws, MCP Contract requirements, and DHCS data privacy and security standards. MCPs must ensure compliance with the HIPAA privacy and security rules. MCPs must establish process and procedures to securely destroy data for individuals who do not ultimately enroll into the MCP in compliance with HIPAA regulations.

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[3] 45 CFR sections 164.502(a) and 164.506(c)
[4] Each entity should define their own business relationship and consult the appropriate legal counsel. This APL does not supersede the agreed upon relationships.
[5] 45 CFR section 164.502(e)
[6] 45 CFR sections 164.502(a) and 164.506(c)(3)
[7] W&I section 14007.8(a)(2)(B)
[8] W&I section 14184.102 (d)
[9] W&I section 14184.102 (j)
[10] MCP Contract: Exhibit A, Attachment III, Subsection 5.1.4 Primary Care Provider Selection
[11] Boilerplate MCP Contracts are available at:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

MATCHING POLICY
In many cases, individuals will need to be matched to MCP records without the use of a unique identifier such as Client Index Number (CIN). To the extent feasible, MCPs should develop matching processes to identify unique individuals in the county uninsured programs or public health care systems, for example by using data elements such as name, date of birth, and address. MCPs must coordinate with the county uninsured programs and public health care systems to develop methodologies allowing for flexibility in the matching algorithm used by the MCPs to accomplish the policy goals laid forth in this APL.

CONTINUITY OF CARE AND ASSIGNMENT POLICY
Member choice of PCP is paramount and must be prioritized over any auto-assignment processes.[12]

MCPs must not preclude assignment based on a PCP having a closed panel status, or not accepting new Members status as these Adult Expansion Population Members would not represent an increase to the panel size as they are already assigned to this PCP. If the Member is assigned to a federally qualified health center (FQHC) or rural health clinic (RHC) per W&I section 14087.325(b), the Member may be assigned at the clinic site level. Assignment at the clinic site level is encouraged, especially for multi-site FQHCs and RHCs. MCPs are not permitted to exclude assignment for Members assigned to an FQHC or RHC resulting from a lack of a provider-level assignment in the data.

For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, the MCP is required to maintain that assignment. Adult Expansion Population Members are not required to request continuity of care to maintain their PCP assignment With PCPs that are in the MCP's Network. If the PCP is out-of-Network, the MCP is not expected to maintain that assignment; however, the MCP must adhere to all Continuity of Care requirements in accordance with APL 23-022. Not all Adult Expansion Population Members will be represented in the data sharing process.[13]

DATA TRANSMISSION REQUIREMENTS:
Participating county uninsured programs and public health care systems have

[12] Exhibit A, Attachment III: Subsection 5.1.4 Primary Care Provider Selection of the 2024 MCP Contract
[13] For Adult Expansion Population Members not represented in the data sharing process, and for services not provided by PCPs for the entire Adult Expansion, the existing Continuity of Care policy outlined in APL 23-022, or any superseding APL, applies. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

committed to securely share the PCP Assignment File, via secure file transfer protocol (SFTP), and in Comma-Separated Values (CSV) file format to MCPs in their respective counties.[14] MCPs must inform those organizations of the outcome of the assignment using the PCP Assignment Return File. This file must also be transferred via SFTP in CSV file format. In addition, MCPs must send the Member PCP Assignment Return File to the county uninsured program and public health care system to provide verification of the PCP assignment.

FILE NAMING CONVENTION: "PCP Assignment File_Organization name_YYYYMMDD"

DATA ELEMENTS:

The following data elements must be transmitted unless otherwise mutually agreed upon between the MCPs and the county uninsured program or public healthcare system:

a) Patient Last Name
b) Patient First Name
c) Date of Birth
d) Sex
e) Patient Language
f) Patient Physical Address Line 1
g) Patient Physical Address Line 2
h) Patient Physical City
i) Patient Physical State
j) Patient Physical ZIP Code
k) Patient Mailing Address Line 1
l) Patient Mailing Address Line 2
m) Patient Mailing City
n) Patient Mailing State
o) Patient Mailing ZIP Code
p) PCP National Provider Identifier (NPI) (optional if assigned to site)
q) PCP Last Name (optional if assigned to site)
r) PCP First Name (optional if assigned to site)
s) Facility/Site NPI (optional if assigned to provider)
t) Facility/Site Name (optional if assigned to provider)
u) Suffix
v) Phone Number
w) County Code

[14] Any exception to this process must be approved by DHCS.

<u>The following data elements must be transmitted if available:</u>
x) Submitted CIN

FILE NAMING CONVENTION: "PCP Assignment Return File_Organization name_YYYYMMDD"

DATA ELEMENTS:

<u>DHCS only requires MCPs to share the return file for members who retained PCP assignment. The following data elements must be transmitted unless otherwise mutually agreed upon between the MCP and the county uninsured program or public health care system:</u>

a) Patient Last Name
b) Patient First Name
c) Date of Birth
d) Sex
e) Patient Language
f) Patient Physical Address Line 1
g) Patient Physical Address Line 2
h) Patient Physical City
i) Patient Physical State
j) Patient Physical ZIP Code
k) Patient Mailing Address Line 1
l) Patient Mailing Address Line 2
m) Patient Mailing City
n) Patient Mailing State
o) Patient Mailing ZIP Code
p) PCP NPI (optional if assigned to site)
q) PCP Last Name (optional if assigned to site)
r) PCP First Name (optional if assigned to site)
s) Facility/Site NPI (optional if assigned to provider)
t) Facility/Site Name (optional if assigned to provider)
u) Suffix
v) Phone Number
w) County Code

<u>The following data elements must be transmitted if available:</u>
x) Submitted CIN

TIMING:
MCPs must begin accepting data from county uninsured programs and public health care systems immediately upon the publishing of this APL, and continue accepting data through June 30, 2024, as necessary to effectuate assignment.

EXCEPTIONS:
County uninsured programs and public health care systems are expected to strictly adhere to the file transmission requirements, however, MCPs share an obligation in ensuring the data transmitted meets the requirements of this APL. MCPs are expected to work with county uninsured programs and public health care systems to correct data deficiencies. If the MCP does not have an executed contract with the assigned PCP effective before June 30, 2024, the MCP is not required to effectuate the PCP assignment, but must offer continuity of care for provider agreement if all continuity of care for provider agreement requirements are met per APL 23-022.

ASSESSMENT OF COMPLIANCE:
DHCS will assess MCPs' compliance with the requirements laid forth in this APL via post transitional monitoring, coordination with county uninsured programs and public health care systems and other stakeholders, and reviews of regular MCP reporting streams including but not limited to the Primary Care Physician Assignment File.

The requirements contained in this APL will necessitate a change in an MCP's contractually required policies and procedures (P&Ps). If applicable, MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD) Contract manager within 90 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 requirements, and other DHCS guidance, including APLs and Policy Letters.[15] These requirements must be communicated from each MCP to all Subcontractors and Network Providers. 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 iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and other sanctions.

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[15] 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.

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