DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
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Medi-Cal Managed Care Enrollment and What this Means for Members and Providers

Overview of Mandatory Managed Care Enrollment (MMCE)

Effective January 1, 2022, as part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, mandatory managed care enrollment standardized enrollment processes to ensure populations moving between counties are subject to the same enrollment requirements, thereby eliminating variances in benefits according to aid code, population and geographic location. This will reduce the complexity of the varying plan models of care delivery in California, and beneficiaries moving between counties will have the same experience when receiving services. Mandatory managed care enrollment means that Medi-Cal beneficiaries in a voluntary or excluded from managed care enrollment aid code that are accessing the fee-for-service (FFS) delivery system would be required to choose a Medi-Cal managed care plan (MCP).[1]

MMCE occurred in two phases when beneficiaries who only have Medi-Cal (non-dual) and those who have both Medi-Cal and Medicare (dual) transitioned from FFS to managed care:

Phase I: Effective January 1, 2022	Phase II: Effective January 1, 2023:
• Trafficking and Crime Victims Assistance Program (dual and non-dual) • Individuals granted accelerated enrollment (dual and non-dual) • Breast and Cervical Cancer Treatment Program (BCCTP) (non-dual • Beneficiaries with other health care coverage (non-dual) • Beneficiaries living in rural zip codes (non-dual)	• Newly Eligible Beneficiaries • Dual beneficiaries in non-County Organized Health Systems (COHS), Coordinated Care Initiative (CCI) and non-CCI counties (except those with share of cost (SOC)) in the following aid code groups: Adult Expansion, Aged, BCCPT, Disabled, Non-Disabled Adults (19+ years of age), Non-Disabled Children (<19 years of age), Beneficiaries with other health coverage, Beneficiaries living in rural zip codes, and Non-dual and dual beneficiaries in long term care (LTC) – skilled nursing facilities (SNFs), including LTC SOC

On January 1, 2024, DHCS will carve in non-dual and dual beneficiaries in LTC Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled – Habilitative (ICF/DD-H), Intermediate Care Facilities for the Developmentally Disabled – Nursing (ICF/DD-N) and Subacute Care Facilities (adult and pediatric), including beneficiaries with LTC Share of Cost (SOC).

How Mandatory Managed Care Enrollment Impacts Members and Providers

Other Health Coverage and Medi-Cal Managed Care

- Medi-Cal beneficiaries who have other health coverage (OHC) (Commercial health insurance, Medicare, Tricare, etc.) can keep their OHC when they become mandatorily enrolled into managed care.

[1] Beneficiaries can file a Medical Exemption Request (MER) to request a temporary exemption from enrollment into an MCP only until the member's medical condition has stabilized to a level that would enable the Member to transfer to a network provider of the same specialty without deleterious medical effects. Members may get a medical exemption if a member has a complex medical condition.

- Medi-Cal is the payer of last resort, which means in most cases Medi-Cal will be secondary to the OHC, covering allowable costs not paid by the primary insurance (typically wrap payments or co-pays) up to the Medi-Cal rate.
- Providers enrolled as a Medi-Cal FFS or as a Medicare provider do not need to be contracted with a Medi-Cal MCP in order to see the MCP Member and bill the Medi-Cal MCP for a dual-eligible patient or who has OHC.[2]
- Where a prior authorization is required, the out-of-network provider may leverage a letter of agreement (LOA) or similar mechanism. [3] Without an LOA or similar agreement, the provider may be at risk for billed amounts exceeding the allowable FFS rate.
- To bill the member's Medi-Cal MCP after billing the OHC, provider must present acceptable forms of proof to the MCP that all sources of payment have been exhausted, which may include:
    - A denial letter from the OHC for the service
    - An explanation of benefits indicating that the service is not covered by the OHC
- See All Plan Letter (APL) 22-027 for more information on MCP requirements for coordination of benefits, and for more information on services that can be directly billed to Medi-Cal. For more information on billing Medi-Cal FFS with OHC, please visit Other Health Coverage Provider Manual.

Continuity of Care

Eligible Members transitioning from Medi-Cal FFS to a Medi-Cal MCP may request continuity of care (CoC) from their MCP to remain with their current FFS provider for up to 12 months after the enrollment date with the MCP. The MCP must honor the CoC request if the following conditions are met:

- The Member can establish a pre-existing relationship exists with that provider[4];
- The MCP has no quality concerns with the provider;
- The MCP and provider can agree to a rate.

The MCP must also arrange for CoC for covered cervices with a network provider, or if there is no network provider to provide the covered service, with an out-of-network (OON) provider. If a Member has a pre-existing relationship with the OON provider and want them to provide services, they may make a CoC request. The MCP must make a good faith effort to enter into an agreement if all CoC requirements are met. For more information on CoC, see APL 22-032 and:

- Continuity of Care and Managed Care - Frequently Asked Questions
- Continuity of Care for Medi-Cal Managed Care Members

Dual Eligibility (Medicare and Medi-Cal)

For dual-eligible beneficiaries, enrollment in a Medi-Cal MCP does not impact Medicare benefits or provider access. Dual-eligible Members can continue to see their current Medicare providers, who do not need to be contracted with the MCP, to bill the MCP for any Medicare cost sharing (crossover billing). For duals in Medicare Advantage (MA) plans, providers should bill the MA plan for primary Medicare payment, which include physician and hospital services. For duals in Original Medicare, or Medicare FFS, the crossover billing is an automatic process. Secondary claims will cross to Medi-Cal MCPs or FFS, depending on member eligibility.

Balance Billing

Balance billing the beneficiary is strictly prohibited under federal and state law, so it is important for providers to check Medi-Cal eligibility status.[5] Actions to address payment disputes between the provider and the MCP and the OHC plan must be resolved among the respective parties. For additional information on crossover billing, please see the following resources:

- Crossover Billing Toolkit for Medicare Providers
- Medi-Cal Managed Care Enrollment for Dual-Eligible Beneficiaries in 2023

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[2] Payments are limited to the Medi-Cal FFS reimbursement rate.

[3] Services that require prior authorization are available on the MCPs' websites, accessible via the Medi-Cal Managed Care Health Plan Directory.

[4] A pre-existing relationship means the Member has seen an out-of-network provider primary care provider for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment in the plan.

[5] See The Facts on Balance Billing for more information on balance billing.