DEPARTMENT OF HEALTH CARE SERVICES

2025 MEDI-CAL DENTAL MANAGED CARE PLAN TRANSITION POLICY GUIDE

Version 2.0 – July 2025

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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I. UPDATES

If the requirements contained in this Policy Guide, including any updates or revisions to the Policy Guide or necessitate a change in a DMC plan's' contractually required policies and procedures (P&Ps), the DMC plan must submit its updated P&Ps to its Medi-Cal Dental Services Division (MDSD) Contract Manager within 90 days of the release of the Policy Guide or its updates at DMCdeliverables@dhcs.ca.gov.

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

Policies are effective upon release of the Policy Guide and its updates, regardless of status of P&P refinements.

ORIGINAL – Version 1:

- Includes introduction and policies related to protections for American Indian and Alaska Native members
- Includes Continuity of Care Data Sharing policy
- Includes Member Enrollment and Noticing policy
- Includes the Continuity of Care policy specific to the 2025 DMC Transition , including:
  - Extension of some Continuity of Care protections
  - Addition of members who are residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD) to Special Populations
- Updates to the Continuity of Care Data Sharing policy including updates to reporting templates: two accompanying Excel Attachments for Previous DMC plan Provided Data, *Continuity of Care (CoC) Data Template - 1) Data Elements for All Members* and *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data*
- Updates to the Data Sharing section clarifying the Plan Transfer Status Report layout and file naming convention

- Dates for Previous DMC plan data sharing and Receiving DMC plan submission of baseline DMC plan member call center data
- Technical updates in the Appendix
- Updates to the Transition Policy for Assessments and Screening Tools

Version 2 (July 2025):

- Updates to Continuity of Care policy in alignment with APL 25-002 (Revised)
- Updates to the Transition Deliverable Schedule to streamline and align with monitoring template
- Published All Plan Letter (APLs) references and footnotes
    - APL 25-002 (Revised): Continuity of Care for DMC Members on or after July 1, 2025
    - APL-25-004: 2024-2025 Medi-Cal Dental Managed Care Plan MEDS 834 Cutoff and Processing Schedule
    - APL 25-005: 2025 Deliverable Schedule and Attachment of the Deliverable Schedule
    - APL 25-006: Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, and Alternative Formats (Supersedes APL 21-001) and attachments:
        - Threshold and Concentration Language for All Counties
        - Notice of Nondiscrimination Template
        - Notice of Availability Template
        - Statement of Nondiscrimination for Small Sized Notices Template
- Updates to formatting and presentation of information in this Transition Policy Guide
- The DHCS website for the DMC plan Transition can be found here: https://www.dhcs.ca.gov/Pages/Dental-Transition-Member-Notices.aspx

DMC Plans should contact their Contract Manager regarding any questions on the Policy Guide.

Additional questions regarding the Policy Guide should be sent to: Dental@dhcs.ca.gov.

II. INTRODUCTION

The California Department of Health Care Services (DHCS) is transforming Medi-Cal to ensure that Californians have access to the care they need to live healthier lives.

Beginning July 1, 2025, DHCS is expanding on relationships with Medi-Cal dental managed care (DMC) plans to redefine how care is delivered across the state. DHCS' top priority is ensuring managed care Members have access to DMC plans that provide timely and high-quality care, and that DMC plans are focused on delivering on the state's health system transformation goals. Those goals are the focus of the California Advancing and Innovating Medi-Cal (Cal AIM) initiative, namely, to drive quality of care improvements, streamline and reduce complexity, and build on access-focused, data-driven and whole person care approaches. DMC plans will be subject to new requirements to rigorously advance quality, access, accountability and transparency to improve the Medi-Cal health care delivery system, ensuring that Members have the care and support they need to live healthier, more fulfilling lives. As part of this transformation, the changes are described below. Collectively, these changes comprise the July 1, 2025, DMC Plan Transition (referred to in this Policy Guide as the DMC Transition).

- New DMC plan contracts;
- New subcontractor relationships;
- Terminating or expiring DMC plan contracts;
- Mandatory enrollment from Dental Fee-for-service (FFS) to DMC in Sacramento County;
- Voluntary enrollment into DMC in Los Angeles County;

DHCS Guiding Principles

DHCS is working proactively to minimize disruptions to members during the DMC Transition, including by developing this 2025 DMC Transition Policy Guide (Policy Guide), and will continue partnering with DMC Plans and stakeholders leading up to and after transition. DHCS' principles guiding the planning, implementation and oversight of the 2025 DMC Transition are to:

- Minimize service interruptions for all members, especially for vulnerable groups most at risk for harm from disruptions in care.

- Provide outreach, education and clear communications to members, providers, DMC plans, and other stakeholders.
- Proactively measure and ensure accountability of DMC plans' transition responsibilities.

Purpose and Scope of the DMC Transition Policy Guide

This Policy Guide contains DHCS policy and related DMC requirements related to member transitions among Medi-Cal DMC plans that take effect on July 1, 2025, including:

- **Member Enrollment and Noticing,** including member noticing requirements and member enrollment policies applicable to transitioning and new members.
- **Continuity of Care (CoC)** requirements for members transitioning due to DMC plan contracting changes effective July 1, 2025.
- **Data Sharing,** including sharing from DHCS to DMC Plans and between DMC Plans, required to minimize transitioning member disruptions and to implement related CoC, noticing and enrollment policies.
- **Monitoring and Oversight** of DMC Plans' compliance with requirements in the Policy Guide.

Dental All Plan Letter (APL) 25-003[1] establishes the binding nature of this Policy Guide as the DHCS authority specific to the 2025 DMC Plan Transition. The Policy Guide contains guidance for DMC plans' transition-related activities rooted in existing applicable APLs and contract requirements, as well as new DMC plan requirements. DMC plan transition requirements addressed in this Policy Guide also apply to DMC plans' fully delegated subcontractors. DMC plans should use this Policy Guide to develop their policies and procedures required to implement member transitions. While DMC plans are the primary audience for the Policy Guide, DHCS envisions that a wide range of stakeholders will find it useful in supporting smooth member transitions.

The policies and requirements in the Policy Guide do **not** apply to routine member- initiated transitions between DMC plans. The Policy Guide does not include guidance related to exiting DMC plan phase-out requirements or DMC plan operational readiness.

The Policy Guide will be updated throughout calendar year 2025 to keep DMC plans informed of new and developing guidance. Updates to this Policy Guide are effective upon publication

[1] APL 25-003 Dental Managed Care Plan Transition Policy Guide can be found here: https://www.dhcs.ca.gov/services/Documents/MDSD/APL-25-003-Transition-Policy-Guide.pdf

on the DHCS website, which will be announced to DMC plans via standard communication channels.

Key Terms

Throughout the Policy Guide, DMC plans will be referred to with various terminology as applicable to the policy at hand. Specifically, DMC plans may be referred to as:

- Previous DMC plans, which includes Exiting DMC plans
- Receiving DMC plans, which includes Continuing DMC plans and Entering DMC plans

Please refer to the Glossary for a list of key terms and their definitions.

III. PROTECTIONS FOR AMERICAN INDIAN AND ALASKA NATIVE MEMBERS

The 2025 Dental Managed Care (DMC) Plan Transition does not change existing protections for the American Indian and Alaska Native (AI/AN) population voluntarily enrolled in managed care. Under both Federal and State Medi-Cal policy, DMC plans must provide for AI/AN members enrolled in dental managed care to receive services from an Indian Health Care Provider (IHCP) of their choice regardless of whether the IHCP is a Network or Out- of-Network (OON) provider. DMC plans are required to make payments[2] to Network and OON IHCPs for services provided to eligible AI/AN members as follows:

- For IHCPs that are enrolled in Medi-Cal as Tribal Health Programs DMC plans are directed to reimburse these providers at the applicable All- Inclusive Rate (AIR) set by the Office of Management and Budget (OMB). The AIR is published annually by the Federal Register with a retroactive effective date and DMC plans are required to pay the most current applicable payments. DMC plans shall ensure interim payments are reconciled to the applicable updated AIR for that calendar year.
- For Urban Indian Organizations participating in Medi-Cal as a Federally Qualified Health Center (FQHC), DMC plans will pay applicable rates and the FQHC is required to submit a claim to the DHCS Fiscal Intermediary for the remainder of their Prospective Payment System rate.

AI/AN members are exempt from enrollment fees, premiums, and cost sharing provisions such as deductibles and co-payments.[3] All of these protections remain in effect for AI/AN members in dental managed care, regardless of whether or not they are required to transition to a new DMC plan on July 1, 2025. AI/AN members of DMC plans who are accessing care from non-IHCPs are subject to the same Continuity of Care protections as all DMC members. Members of DMC Plans who are not AI/AN and who are accessing care from IHCPs are also subject to the same Continuity of Care protections as all DMC members. Please see Section V, Continuity of Care for more information.

In Sacramento county, members will be mandatorily enrolled into dental managed care effective July 1, 2025. As a result, members with a currently approved Non-Medical Exemption request and, beginning in Q2 2025, newly eligible members, will be automatically enrolled into

[2] Tribal Federally Qualified Health Centers (Tribal FQHCs): Billing Codes

[3] Title 19 SSA section 1916(j); 42 U.S.C. §1396o(j); 42 CFR Sections 447.56 and 457.535

a DMC plan in their county, effective July 1, 2025. Members have the right to be seen at a THP regardless if that THP is contracted with the DMC plan and the DMC plan must pay the AIR.

In Los Angeles county, members may voluntarily enroll in a dental managed care plan effective July 1, 2025; otherwise, they will remain in Dental FFS. Members voluntarily enrolled in a DMC plan have the right to be seen at the THP regardless if that THP is contracted with the DMC plan and the DMC plan must pay the AIR.

IV. MEMBER ENROLLMENT AND NOTICING

A. Introduction

This Section includes information and policies related to member enrollment and noticing in Sacramento and Los Angeles counties that are affected by the DMC transition effective July 1, 2025. These changes are outlined by county on the DHCS and detailed in the Appendix to this Policy Guide. This Section applies to member enrollment and noticing policy related to DMC plan transitions.

This information is primarily intended to enable plans, providers and other stakeholders to understand transition-related enrollment and noticing processes and timing so that they may plan for effective transitions and support of Medi-Cal members. It includes DMC plan requirements related to noticing, data transfer to DHCS, and member assignment to subcontractors that are transitioning to a DMC plan in 2025. As most of the content in this section is intended to provide broader context, DMC plan requirements are flagged throughout for ease of reference.

Some policies are contingent on State or federal approval, and all are subject to change.

Specifically, this Section includes:

- Transition Noticing policies for:
  - Members of exiting DMC plans and dental fee-for-service (FFS)
  - Members with "automatic" transitions
- Transition Enrollment policies for:
  - Exiting DMC Plan members
- Exiting DMC plan New Enrollment Freeze Policy

B. Transition Noticing Policy

1. Noticing for Members of Exiting DMC plans and Dental FFS

DHCS' Fiscal Intermediary – Dental Business Operations (DBO), Gainwell Technologies, will send a "90-day" notice to members enrolled as of April 2025 month of enrollment (MOE), with limited exceptions noted below. The "90-day" notices will inform members of their DMC plan's or Dental FFS' upcoming exit from their county and indicate that additional information is forthcoming from DHCS regarding their DMC plan enrollment options for July 2025.

DHCS' enrollment broker, Medi-Cal Health Care Options (HCO), will send "60- day" notices (no later than May 1) and "30-day" notices (no later than June 1) to members of exiting DMC plans or Dental FFS.

- In **Sacramento County** — the "60-day" and "30-day" notices will include information on:
  - Transitioning members' default DMC plan and other available DMC plan option(s); and
  - Actions members need to take to make an active DMC plan choice.
- In **Los Angeles County**, the "60-day" and "30-day" notices will inform members of newly available DMC plans in their county, but enrollment in a DMC plan is voluntary. They can remain in Dental FFS.
- In all counties with exiting DMC plans, the DHCS/HCO "60-day" and "30-day" notices will also provide members with contact information for questions or complaints and a link to a Notice of Additional Information (NOAI) that will be posted on the DHCS and HCO website and accessible through a Quick Reference (QR) code included in the notices. The NOAI will include additional information on Medi-Cal Dental Managed Care, how to make an active DMC plan choice, and how to access continuity of care protections.

DHCS/HCO must provide the NOAI as a print copy by mail or in an alternative format for any member who requests it.[4]

2. Noticing for Members with Dental Exemption Requests

In **Sacramento County**, members with a dental exemption on file will remain in Dental FFS until their dental exemption expires, even though the DMC Transition is implemented.

Members enrolled in Dental FFS due to an approved dental exemption request, will remain in FFS until their dental exemption expires and will receive a choice packet 45 days before their dental exemption expires allowing them the opportunity to choose one of the newly available DMC plans or file another dental exemption request.

[4] For overview of alternative format options, please refer to APL 22-011.

C. Transition Enrollment Policy

1. Enrollment for Exiting DMC plan and Dental FFS Members in Sacramento County

In Sacramento county, members enrolled in Continuing DMC plans will remain in their current DMC plan, unless they opt to change DMC plans (as is their right under current member choice policies). Members of Exiting DMC plans and Dental FFS will receive a choice packet from HCO with their "60- day" notice no later than April 1, 2025, including all 2025 DMC plan options. Members will have until approximately June 24, 2025 to make an active DMC plan choice. If they do not make an active choice by the cut-off date, they will be enrolled into the default DMC plan as indicated in their "60-day" and "30-day" notices, effective July 1, 2025.

Consistent with current DHCS practice during a transition, default assignment will be based on the following assignment hierarchy:

- **Provider Linkage** The member is default-assigned to the DMC plan which has the member's primary care dentist (PCD) of record within their network, if only one DMC plan has this provider in network.

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- **Plan Linkage**: If there is no provider linkage, or if more than one DMC plan has the member's current PCD in-network, the member is assigned to the DMC plan in which they were most recently enrolled, if applicable;

⬇

- **Family Linkage**: If there is no provider or prior plan linkage, or if the member has provider or Plan linkage to more than one DMC plan, the member is assigned to the DMC plan in which a family member is currently enrolled, if applicable.

⬇

- **Auto-Assignment:** If a member does not meet any of the "linkage" criteria above, their default DMC plan will be based on **the Auto-Assignment algorithm**, which uses quality and other adjustments for an annually-defined ratio of members for auto-assignment among DMC plans in Sacramento county.

2. Enrollment for Exiting DMC Plan Members in Los Angeles County

In Los Angeles county, **members enrolled in Continuing DMC plans** will

remain in their current DMC plan, unless they opt to change DMC plans or join Dental FFS (as is their right under current member choice policies).

Members of the Exiting DMC plan will receive a choice packet from HCO with their "60- day" notice no later than April 1, 2025, including all 2025 DMC plan options. Members will have until approximately June 24, 2025 to make an active DMC plan choice. If they do not make an active choice by the cut-off date, they will be enrolled into Dental FFS as indicated in their "60-day" and "30-day" notices, effective July 1, 2025.

3. Enrollment for Children or Youth Enrolled in the Foster Care System and Identified With a Foster Care Aid Code, As Well As Members in a Former Foster Care Aid Code

Children or youth enrolled in the foster care system and identified with a foster care aid code, as well as members in a former foster care aid code, remain voluntary and can choose either a managed care plan or Medi-Cal Dental FFS. See above Section on "Noticing for Members of Exiting DMC plans or Dental FFS" for member noticing information.

D. Enrollment Freeze for Exiting DMC Plans in Quarter 2 (Q2) 2025

Consistent with other recent DHCS managed care transitions exits, DHCS will stop **new** enrollment into exiting DMC plan (both for active choice and default assignment) three months prior to the DMC plan's exit from a county. The last enrollment into an exiting DMC plan in a county will occur during March 2025 MOE, with the new enrollment freeze taking effect for April 2025 effective enrollments. This policy applies to new enrollment only for exiting DMC plans – inclusive of newly eligible members and existing members who decide to enroll with a new DMC plan. Exiting DMC plans will retain their existing membership though June 30, 2025, unless the member makes an active choice to choose a different DMC plan or Dental FFS before then.

The exiting DMC plan new enrollment freeze has implications for choice and enrollment options for new Medi-Cal members in Q2 2025. In Sacramento and Los Angeles counties, DHCS/HCO will issue new DMC choice packets for newly eligible Medi-Cal members beginning May 1, 2025, that:

- Exclude exiting DMC plan; and
- Include all new 2025 DMC plan options, including those that are not yet operating in the county ("Entering DMC plans") as well as DMC plans that currently operate in the

county and will continue operations after the DMC Transition is implemented ("Continuing DMC plans").

Default assignment for new members in Q2 2025 will also exclude Exiting DMC plans and include all new 2025 DMC plan options. In Los Angeles county, members who actively choose a Continuing DMC will be enrolled into the Continuing DMC plan on the first of the following month. In Sacramento county, members who actively choose a currently available Continuing DMC plan (a DMC plan that has not been suspended based on Parity[5] or enroll into a Continuing DMC plan based on default assignment will be enrolled into the Continuing DMC plan on the first of the following month. The DMC plan enrollment effective date for members who enroll in an Entering DMC plan (by choice or default assignment) or a Continuing DMC plan that is currently suspended will be July 1, 2025. These members will remain in Dental FFS until their DMC plan enrollment is effective on July 1, 2025.

[5] Dental Provider Bulletin: Volume 39, Number 24

V. CONTINUITY OF CARE

The Continuity of Care (CoC) Policy for the 2025 DMC plan Transition (Transition) provides guidance to Previous and Receiving DMC plans, and their Subcontractors, about their obligations to ensure CoC for members required to change DMC plans on July 1, 2025. Per this policy contains details of DMC plans' contractual requirements to ensure CoC for transitioning members.

The 2025 CoC Policy applies to members who change DMC plans on July 1, 2025, for the following reasons:

- The member's DMC plan exits the market
- The Subcontractor Agreement between the member's DMC plan and the Subcontractor ends
- A new DMC plan enters the market
- Mandatory enrollment from Dental Fee-for-service (FFS) to DMC in Sacramento County;
- Voluntary enrollment into DMC in Los Angeles County;

Leading up to and during the Transition, DHCS will work with DMC plans to facilitate continued member access to high-quality, coordinated care. DHCS has established a robust CoC Policy for the 2025 DMC plan Transition that aims to minimize:

- Service interruptions, especially for members living with complex or chronic conditions (i.e., Special Populations)
- Member, provider, and DMC plan confusion
- Unnecessary administrative burden for members, providers, and DMC plans

To accomplish these goals, the 2025 DMC plan CoC Policy aligns with and builds upon CoC protections under the Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96) and upon CoC protections for members who transitioned from Medi-Cal Dental Fee-for-Service (FFS) to Dental Managed Care in July 2025.[6,7]

Achievement of these goals will also necessitate that DMC plans engage in Transition activities during 2025, in advance of the July 1, 2025 effective date. Interaction with transitioning

[6] State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.

[7] APL 25-002 (Revised) can be found at: https://www.dhcs.ca.gov/services/Documents/MDSD/APL-25-002-Continuity-of-Care-for-DMC-Members-on-or-after-July-1-2025.pdf

members who are not yet enrolled and out-of-network (OON) providers is expected to the extent necessary to curtail members' service disruptions and enhance access to care.

Transitioning members with other health coverage (OHC), such as Medicare or other private insurance, may continue to see a provider with whom they have a Pre-Existing Relationship, and may have their Medi-Cal DMC plan billed as secondary to their OHC, even if the provider is OON with the DMC plan. Providers will need to adhere to the DMC plan's billing requirements. Continuation of services from the OON provider for members with OHC without a CoC for Providers agreement in place (see Section V.C, Continuity of Care for Providers) is allowable since the OON provider will coordinate benefits and submit crossover billing when necessary.

The 2025 DMC plan CoC Policy applies to all Medi-Cal members who must change DMC plans on July 1, 2025, including:

- Members who actively choose a DMC plan
- Members who are assigned to a DMC plan (Note: All transitioning members will have the opportunity to choose a new DMC plan. If the member is in Sacramento county and they do not choose a new DMC plan by the established deadline, DHCS will assign them to a DMC plan. If the member is in Los Angeles county and they do not choose a new DMC plan by the established deadline, the member will remain in Dental FFS .)

The 2025 DMC plan CoC Policy does **not** apply to members who change DMC plans by choice after July 1, 2025.

In addition to issuing this Policy, DHCS will develop and implement a robust plan for communicating with members, advocates, and providers about CoC protections and other critical policies leading up to and during the 2025 DMC plan Transition.

A. What is Continuity of Care?

"Continuity of Care" (CoC) refers to a set of coordination policies that are designed to protect member access to care after the 2025 DMC plan Transition. Robust CoC policies help members maintain trusted relationships with providers and access to needed services as they transition between DMC plans, promoting positive health outcomes. CoC protections are foundational in the Medi-Cal system. These protections are in place today (see Figure 1, *Summary of Existing Continuity of Care Protections Applicable to 2025*, below) and have been tested in prior member transitions. Due to the size and scope of the 2025 DMC plan Transition, DHCS is both expanding CoC protections and extending those protections to all transitioning

members.

Figure 1. Summary of Existing Continuity of Care Protections Applicable to 2025

Knox-Keene Act (H&S section 1373.96)

According to the Knox-Keene Act, health plan enrollees living with certain conditions who are actively undergoing certain services have the right to continue receiving covered services as a newly covered enrollee or from a terminated or non- participating provider. The duration of that continued care varies but generally ends when the specific care or condition ends, and certain exceptions apply.

The Knox-Keene Act specifies the following services or conditions as eligible for CoC:

- An acute condition
- A serious chronic condition
- A pregnancy, including postpartum and maternal mental health condition
- The care of a newborn child between birth and age 36 months
- Performance of a surgery or another procedure to occur within 180 days from the contract termination date or new coverage's effective date that is authorized by the plan as part of a documented course of treatment

The Knox-Keene Act applies to the 2025 DMC plan Transition. The policies in this Policy Guide align with and build upon the Knox-Keene Act.

Existing CoC Policy for Transitions from Dental Fee-for-Services (FFS) to Dental Managed Care

Existing CoC policy for transitions from Dental FFS to Dental managed care offers additional member protections beyond those set forth in the Knox-Keene Act. This existing policy primarily addresses a transitioning member's right to request CoC with an OON provider for 12 months when a Pre-Existing Relationship exists, regardless of the member having a condition listed in the Knox-Keene Act, H&S section 1373.96. This policy also requires DMC plans to honor transitioning members' active Prior Authorizations for Covered Services. Specific provisions apply for both non-emergency

Existing CoC Policy for Transitions from Dental Fee-for-Services (FFS) to Dental Managed Care
medical and non-medical transportation (NEMT and NMT).

This 2025 DMC plan CoC Policy includes three key protections for Medi-Cal members:

1. **Continuity of Care for Providers:** A member may continue seeing a provider with whom they have a Pre-Existing Relationship, even if the provider is OON with the Receiving DMC plan. See Section V.C, Continuity of Care for Providers.
2. **Continuity of Care for Covered Services:** A member may continue an Active Course of Treatment as well as receive services previously authorized by the Previous DMC plan. See Section V.D, Continuity of Care for Covered Services.
3. **Continuity of Care Coordination and Management Information:** The Previous DMC plan and the Receiving DMC plan must work together to share supportive information important for members' care coordination and management. See Section V.E, Continuity of Care Coordination and Management Information.

Each protection is described in detail below, first as it applies to all transitioning members and second as it applies to members who will need enhanced protections to access CoC protections and minimize interruptions in their care.

Receiving DMC plans may offer added protection to transitioning members that are more expansive than the requirements contained in this CoC Policy for the 2025 DMC plan Transition. Receiving DMC plans may consider if there are other members who have unique circumstances and who would benefit from extra DMC plan attention during the Transition, such as historically marginalized populations and members with culturally appropriate needs. Such considerations should be based on the local needs of each community in which the Receiving DMC plan is contracted.

B. Special Populations

All transitioning members have CoC protections, but some transitioning members – referred to in this 2025 DMC plan CoC Policy as Special Populations – will need enhanced protections leading up to and throughout the 2025 DMC plan Transition. Transitioning members in Special Populations are generally individuals living with complex or chronic conditions (Figure 2, List of Special Populations).

Under this 2025 DMC plan CoC Policy, DHCS is requiring both Previous and

Receiving DMC plans to focus attention and resources on transitioning members in Special Populations to minimize the risk of harm from disruptions in their care as detailed below. This Section of the 2025 DMC plan CoC Policy identifies members who will be considered Special Populations. Enhanced CoC protections for Special Populations are detailed in subsequent Sections of this 2025 DMC plan CoC Policy.

Transitioning members in the following Special Populations will be identified using DHCS or Previous DMC plan data, including program enrollment, screening and diagnostic codes, procedure codes, or aid codes. Data for these members will be provided to the Receiving DMC plan in advance of the 2025 DMC plan Transition. See Section V.G, CoC Data Sharing, for more details regarding data sharing requirements.

Figure 2. List of Special Populations

Members Who Are:
» Children and youth enrolled in California Children's Services (CCS)/CCS Whole Child Model
» Living with an intellectual or developmental disability (I/DD) diagnosis
» Residing in Skilled Nursing Facilities (SNF)
» Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)

C. Continuity of Care for Providers

If a member's current provider is a network provider in both the Previous DMC plan and the Receiving DMC plan, the member may continue to see their provider when the member transitions to the Receiving DMC plan on July 1, 2025. No action is required by the member to continue seeing their provider in this case.

Some members who transition to a new DMC plan on July 1, 2025, will be receiving care from providers who are OON providers for the Receiving DMC plan. Some other members, transitioning to a new provider on July 1, 2025, may disrupt their care. Continuity of Care for Providers enables transitioning members to continue receiving care from their existing providers for 12 months (exceptions explained below in this Section), if certain requirements are met. This CoC for Providers protection is intended to maintain trusted member/provider relationships until the member can transition to a network provider with the Receiving DMC plan.

All transitioning members may request CoC for Providers with an eligible provider for up to 12 months.[8] Eligible provider types are listed in Figure 3. Provider Types Eligible for Continuity of Care for Providers. All other provider types are not eligible for CoC for Providers.

Figure 3. Provider Types Eligible for Continuity of Care for Providers

Eligible Provider Types
» Primary Care Dentists (PCD)
» Specialists
» RDHAPs
» Select Ancillary Providers – Community Health Workers

Figure 4. Examples of Provider Types Ineligible for Continuity of Care for Providers[9]

Examples of Ineligible Provider Types
» All other Ancillary Providers such as:
» Non-emergency medical transportation (NEMT)
» Non-medical transportation (NMT)
» Other ancillary services
» Non-enrolled Medi-Cal Providers

For coordination of care and care transition efforts required under HSC section 1373.96, DHCS strongly encourages DMC plans to allow non-contracted providers to continue a member's treatment plan for ineligible provider types shown in Figure 4 that are delivering non-contracted services.

[8] Health and Safety code section 1373.96 protects longer durations of treatment time for Members with certain conditions specified in Figure 7.

[9] Members with conditions specified in Health and Safety Code section 1373.96 may request to continue care with any provider type in accordance with Health and Safety Code section 1373.96

To access CoC for Providers, the member, Authorized Representative, or provider (i.e., the requester) must request CoC for Providers by contacting the Receiving DMC plan. The requester may contact the Receiving DMC plan prior to the date of service up until June 30, 2025. If the services were rendered prior to the CoC request, the requester must contact the Receiving DMC plan within 30 calendar days after the date of service. Upon receiving the request, the Receiving DMC plan must confirm whether the request meets the following requirements:

- the provider is providing a service that is eligible for Continuity of Care for Providers (see Figure 3);
- the member has a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding July 1, 2025;
- the provider is willing to accept the Receiving DMC plan's contract rates or Medi-Cal FFS rates;[10] [11]
- the provider meets the Receiving DMC plan's applicable professional standards and has no disqualifying quality of care issues;[12] and
- the provider is a California Medicaid State Plan approved provider.[13]

1. Expectations of the Receiving DMC plan

The Receiving DMC plan must process CoC for Providers requests and notify members according to the following timelines. When processing a CoC for Provider's request, the

[10] Applicable to SNF services that are exclusive of the SNF per diem rate.

[11] Per Welfare and Institutions code (W&I) section 14184.201(b)(2), each DMC plan must reimburse a Network Provider furnishing Skilled Nursing Facility (SNF) services to a Member, and each Network Provider of SNF services must accept, the payment amount the Network Provider would be paid for those services in the FFS delivery system, as defined by the Department in the Medi-Cal State Plan and as authorized by W&I section 14184.102(d).

[12] For purposes of this Policy Guide, "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 plan Members.

[13] The Provider must be enrolled and participating in Medi-Cal dental. A list of suspended or ineligible Providers is available at: Provider Suspended and Ineligible List (S&I List) - California Health and Human Services Open Data Portal. Provider types that do not have an enrollment pathway must be vetted by the Receiving DMC plan.

Receiving DMC plan will confirm whether the request meets the requirements in Section V.C, Continuity of Care for Providers.

The Receiving DMC plan must accept requests made over the telephone, electronically, or in writing, according to the requester's preference. The Receiving DMC plan must ensure that transitioning members are able to access assistance from the Receiving DMC plan's call center with a live agent starting April 1, 2025 prior to their enrollment with the Receiving DMC plan before July 1, 2025. The Receiving DMC plan must confirm whether or not the requirements in Section V.C, Continuity of Care for Providers are met. If requirements are met, the Receiving DMC plan must contact the eligible provider and make a good faith effort to either enter into a Network Provider Agreement with the eligible provider or enter into a CoC for Providers agreement for the member's care within the timeframe listed in Figure 5. Timeframes for CoC for Providers Process that is appropriate for the member's condition. A CoC for Providers agreement must extend through June 30, 2026, unless the eligible provider and the Receiving DMC plan agree to a shorter or longer duration.[14] [15]

a.) Timeframes for Processing CoC for Providers Requests

The Receiving DMC plan must resolve the CoC for Providers request and notify the member and provider of the outcome of the CoC for Providers request within the following timeframes from the date of the request.

Figure 5. Timeframes for CoC for Providers Process*

Request	Description	Timeframe for Processing Request**	Timeframe for Notifying Member and Provider After Processing the Request
Urgent	There is identified risk of harm to the	As soon as possible, but no longer than 3 calendar days	Within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than 3 calendar days

[14] Per the Knox-Keene Act, Receiving DMC plans must provide more than 12 months of Continuity of Care for Providers as needed for members living with a terminal illness, acute condition, or a pregnancy (including the three trimesters of pregnancy, the immediate postpartum period, and 12 months past the end of the pregnancy as defined by the American Rescue Plan Act Postpartum Care Expansion.)

[15] For the purposes of this Policy Guide, "risk of harm" is defined as an imminent and serious threat to the health of the Member or if the Member is identified as a Special Population.

Request	Description	Timeframe for Processing Request**	Timeframe for Notifying Member and Provider After Processing the Request
	member[16]		
Immediate	The member's dental condition requires more immediate attention, such as a provider appointment or other pressing services	15 calendar days	7 calendar days
Non-Urgent	The member's condition does not qualify for immediate or urgent status	30 calendar days	7 calendar days

*These timeframes apply to requests made prospectively. If the prospective request is made in advance of July 1, 2025, then the Receiving DMC plan must complete processing the request by July 1, 2025 or according to these timeframes, whichever is later. Retroactive requests cannot be considered urgent or immediate.
**Receiving DMC plans must confirm whether the request meets requirements in Section V.C, Continuity of Care for Providers and must execute a Network Provider Agreement or Continuity of Care for Providers agreement.

b.) Member notifications

The Receiving DMC plan must notify the member of the date the request was received, whether the request was considered 'urgent,' 'immediate', or 'non-urgent' and why, and provide a statement of the DMC plan's decision using the

[16] For the purposes of this Policy Guide, "risk of harm" is defined as an imminent and serious threat to the health of the Member or if the Member is identified as a Special Population.

member's preferred form of communication or, if not known, by telephone call, text message, or email according to the timeframes listed in Figure 5. In addition, the Receiving DMC plan must send a notice by mail to the member within seven (7) calendar days of the decision, or if urgent, within the shortest applicable timeframe that 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.

In cases where the member's provider is now in the Receiving DMC plan's network, the notification must also state that the member may continue receiving Covered Services from the provider.

In cases where the member's eligible provider is OON, and the DMC plan and the eligible provider enter into a CoC for Providers agreement, the notification must also state that the member may continue receiving Medi-Cal services from the eligible provider for the specified timeframe agreed upon with the eligible provider, after which the member must transition to a network provider.

In cases where the requirements in Section V.C, Continuity of Care for Providers are not met, the member notification must also include:

- A statement that the member must switch from the eligible provider to a network provider to continue receiving Covered Services, and information on how to do so.
- A clear and concise explanation of the reason for the denial and why the Receiving DMC plan did not enter into a CoC for Providers agreement with the eligible provider.
- Information regarding the member's right to file a grievance or appeal, and how to do so. For additional information on grievances and appeals, refer to APL 22-006[17] or subsequent iterations of APL 22-006.

If the member disagrees with the Receiving DMC plan's CoC determination, the member has the right to file a grievance.

c.) If a CoC for Providers agreement is established

When a CoC for Providers agreement is established, the Receiving DMC plan must work with the eligible provider to ensure no disruption in services for the member. In addition, the Receiving DMC plan must direct the eligible provider

[17] APL 22-006

not to refer the member to other OON providers without prior approval from the Receiving DMC plan. If referral is needed for another OON provider, the Receiving DMC plan will approve the referral to the OON provider. At any time, the member may transfer care to a network provider.

After establishing a CoC for Providers agreement with the eligible provider, the Receiving DMC plan must reimburse the provider for Covered Services for the appropriate duration in accordance with the Knox-Keene Act and this Policy Guide, and as agreed upon with the provider.

As the end of the agreed-upon CoC period approaches, the Receiving DMC plan must establish a process to transition the member to a network provider. Within sixty (60) calendar days before the end of the CoC for Providers period, the Receiving DMC plan must notify the member using the Member's preferred method of communication two (2) times, and following up with a letter in the mail to the member and the eligible provider about the process for transitioning the member's care. The Receiving DMC plan must identify a network provider, engage and the member, eligible provider, and the member's new network provider, and ensure the member's record is transferred within sixty (60) days to ensure continuity of Covered Services through the Transition to the network provider.

d.) If a CoC for Providers agreement is not established

If the Receiving DMC plan and the eligible provider are unable to reach a CoC for Providers agreement, the Receiving DMC plan must offer the member an alternative network provider in a timely manner so the member's service is not disrupted.[18] If the member does not actively choose an alternative network provider, the Receiving DMC plan must refer the member to a network provider. If there is no network provider to provide the Covered Service, the Receiving DMC plan must arrange for an OON provider.

2. Enhanced CoC for Providers Protections for Special Populations

For Special Populations, established and trusted relationships with their providers, and frequent appointments and follow-ups, are often essential to managing members' care needs. If a member's current provider is a network provider in both the Previous DMC plan and the Receiving DMC plan, DHCS expects the provider to continue seeing the member with no disruption to the member's care when the

[18] DMC Plans regulated by the Knox-Keene Act must comply with timely access standards.

member transitions to the Receiving DMC plan.

If a member's current provider is not in the Receiving DMC plan's network, DHCS requires Receiving DMC plans to proactively contact all eligible providers with whom Special Population members have Pre-Existing Relationships to initiate a Network Provider Agreement or a Continuity of Care for Providers agreement. This outreach effort will minimize disruptions in care and risk of harm for transitioning Special Populations.

As explained in Section V.G, CoC Data Sharing, DHCS and Previous DMC plans will identify members who meet the criteria for Special Populations for the Receiving DMC plan. Upon receiving data for Special Populations, the Receiving DMC plan must proactively begin the Continuity of Care for Providers process. Receiving DMC plans must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding July 1, 2025 by July 1, 2025 or within 30 calendar days of receiving data for Special Populations, whichever is sooner. Receiving DMC plans must contact identified eligible providers and negotiate a Network Provider Agreement or a CoC for Providers agreement, if requirements in Section V.C, Continuity of Care for Providers are met. DHCS encourages the Receiving DMC plan to streamline outreach to and communication with eligible providers for Special Populations to the greatest extent possible to minimize DMC plan and provider administrative burden.

The Receiving DMC plan must notify the member and the member's Care Manager, when applicable, in accordance with the following requirements:

- If the member's provider is in Network, or is brought in Network as a result of the Receiving DMC plan's outreach, then the Receiving DMC plan must send notification that the member may continue with his or her provider.
- If the member's provider is OON and the Receiving DMC plan establishes a CoC for Providers agreement, then the Receiving DMC plan must notify the member that the length of time that they can stay with their provider.
- If the provider is OON and cannot establish a CoC for Providers agreement, the Receiving DMC plan must send notification that the member must change to a network provider, and assign the member a new network provider.

In all cases, the notification must include that the member may choose to change providers, and comply with the notification requirements in Section V.C, Continuity of Care for Providers. Expectations of the Receiving DMC plan with the timeline are in Figures 5 and 6.

Figure 6. Timeframes for Processing CoC for Providers for Special Populations

	Timeframe for Processing CoC for Providers	Timeframe for Notifying Member After Processing CoC for Providers
Special Population	30 calendar days from receipt of Special Populations data	7 calendar days

DHCS requires Receiving DMC plans to closely monitor Special Population members' care utilization, especially during the first 3 months of the 2025 DMC plan Transition, to understand members' care needs and minimize gaps in care caused by the Transition.

a.) Extended Duration of CoC for Providers

The duration of the CoC for Providers period extends beyond 12 months for certain Special Populations governed by the Knox-Keene Act. Figure 7 summarizes these extended timeframes.

D. Continuity of Care for Covered Services

It is critical that transitioning members continue to receive care during the 2025 DMC plan Transition. Continuity of Care for Covered Services enables all transitioning members to continue receiving Covered Services (Services) without seeking a new authorization from the Receiving DMC plan during the 3-month CoC for Services period from July 1, 2025 to September 30, 2025.

Continuity of Care for Services requires the Receiving DMC plan to honor active prior Authorizations when data are received from the Previous DMC plan and/or when requested by the member, Authorized Representative, or provider and the Receiving DMC plan obtains documentation of the Prior Authorization before or within the 6-month CoC for Services period[19]. It is expected that many of these requests will be directed to the Receiving DMC plan before transitioning members are enrolled with their Receiving DMC plan on July 1, 2025. The DMC plan must be able to accept and

[19] The Member, Authorized Representative, or Provider may request for the Receiving DMC plan to honor an existing Prior Authorization via telephone, electronically, or in writing, according to the requestor's preference.

process requests in those instances beginning May 1, 2025. Upon receipt of Prior Authorization data, the Receiving DMC plan and the member must work together to continue the member's authorized service with a network provider if the member's provider is OON and does not enter a CoC for Providers agreement. If the member needs to continue the service after 3 months, the provider should request a new authorization from the Receiving DMC plan.[20]

Because DMC plans can have different authorization protocols, CoC for Services also requires the Receiving DMC plan to allow members to continue an Active Course of Treatment without Prior Authorization for the 3-month CoC for Services period. The Receiving DMC plan and the member must work together to continue the member's Active Course of Treatment with a network provider if the member's provider is OON and does not enter a CoC for Providers agreement.
Active Course of Treatment is defined as a course of treatment in which a member is actively engaged with a provider prior to July 1, 2025 and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.[21] An Active Course of Treatment to be honored by the Receiving DMC plan should be documented in utilization or authorization data transferred to the Receiving DMC plan or other documentation.

1. Enhanced Coc for Services Protections for Special Populations

To minimize disruptions in care for Special Populations at the end of the 6- month Continuity of Care for Services period, Receiving DMC plans must continue to honor Prior Authorizations and Active Courses of Treatment for the full 3-month Continuity of Care for Services period (until September 30, 2025) and until the Receiving DMC plan assesses clinical necessity for ongoing services.[22] During the 3-month Continuity of Care for Services period, the Receiving DMC plan must examine utilization data of Special

[20] As noted previously, the Continuity of Care policy builds on and aligns with the Knox-Keene Act. Members who have an authorized procedure or surgery scheduled with an OON provider within 180 days of transitioning may contact the Receiving DMC plan to request Continuity of Care for Providers. The Receiving DMC plan must allow for the Member to complete the surgery or procedure if requirements in HSC section 1317.96 are met.

[21] CMS Proposed Ruling: https://public-inspection.federalregister.gov/2022-26956.pdf.

[22] A new assessment is considered complete by the DMC plan if the Member has been seen in-person and/or via synchronous Teledentistry by a Network Provider and this 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 treatment authorization.

Populations to identify any Active Course of Treatment that requires authorization, and must contact those providers to establish any necessary Prior Authorizations. DHCS encourages DMC plans to contact providers as soon as possible to allow for communication with providers as needed.

E. Continuity of Care Coordination and Management Information

Transitioning members are receiving care management services from their Previous DMC plan will change to a new Care Manager on July 1, 2025, upon transitioning to the Receiving DMC plan. In such cases, DHCS recognizes the importance of sharing supportive information to avoid member and provider screening and assessment fatigue as well as to enable the new Care Manager to continue the member's care management services without interruption. The Previous DMC plan must share supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans. Transitioning members receiving Care Management (CM) services are expected to continue receiving these services from their Receiving DMC plan.

To facilitate the sharing of supportive information for these transitioning members, the Previous DMC plan shall designate key staff with appropriate training and experience to serve as the plan-level contact(s). The Previous DMC plan must provide to the Receiving DMC plan, by May 1, 2025 contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members. The Receiving DMC plan must proactively contact the Previous DMC plan's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care. Previous DMC plans must share supportive data for these members before July 1, 2025 or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

F. Additional Continuity of Care Protections for All Transitioning Members

To provide a robust Continuity of Care Policy for the 2025 DMC plan Transition, DHCS is specifying additional protections for all transitioning members related to non-emergency medical transportation (NEMT) and non-medical transportation (NMT), and scheduled specialist appointments.

1. Medical Transportation and Non Medical Transportation

DHCS expects Receiving DMC plans to ensure no disruptions to transitioning members' access to the Non-Emergency Medical Transportation and Non-

Medical Transportation (NEMT/NMT) benefit. To guard against disruptions, Receiving DMC plans must:

- Review data provided by the Previous DMC plan to identify members with scheduled NEMT/NMT services;
- Confirm a network provider to deliver the scheduled NEMT/NMT services. If a network provider is not available to provide the transitioning member's scheduled NEMT/NMT service, then the Receiving DMC plan must make a good faith effort to allow the transitioning member to keep the scheduled transportation service with an Out-of-Network (OON) NEMT/NMT provider;
- Accept and process member requests for NEMT/NMT before July 1, 2025;
- Honor all Prior Authorizations for NEMT/NMT approved by the Previous DMC plan, including the modality of transportation, for 3 months and until the Receiving DMC plan is able to reassess the member's continued transportation needs.

The Previous DMC plan must support continuation of NEMT/NMT services for transitioning members by:

- Providing authorization data as described in Section VIII, Continuity of Care Data Sharing Policy;
- Transmitting all NEMT/NMT schedule data to the Receiving DMC plan initially on May 8, 2025 and refresh weekly beginning in June 2025.

DHCS expects that DMC plans will work with SNFs where members are residing to ensure transportation is coordinated. SNFs are familiar with DMC plan transportation liaisons and work collaboratively to ensure all members can get appropriate and timely transportation to their appointments, such as critical dialysis appointments. DMC plan transportation liaisons should be proactively working with SNFs to address transportation needs.

2. Scheduled Specialist Appointments

DHCS recognizes that some specialists have long waitlists. A member with an initial scheduled appointment to see a specialist who is an OON provider for their Receiving Plan would not qualify for CoC for Providers because the member does not have a Pre-Existing Relationship with that specialist.

Requiring the member to leave an OON specialist waitlist and start at the back of a network specialist's waitlist could significantly delay care.

In such cases, the member should contact the Receiving DMC plan and request a network specialist within the same timeframe as the scheduled appointment. DHCS

encourages the Receiving DMC plan to arrange for the member to either keep the appointment with the OON specialist or schedule an appointment with a network provider on or before the member's scheduled appointment with the OON provider.[23]

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 an appointment with the OON provider.[24]
The Receiving DMC plan must ensure that transitioning members who seek assistance before July 1, 2025 while not yet enrolled in the Receiving DMC plan are offered the same level of support they would receive on and after the July 1, 2025, enrollment date.

G. Continuity of Care Data Sharing

Successful data sharing is critical to effectuating the CoC Policy for the 2025 DMC plan Transition. To implement the required CoC protections, Receiving DMC plans must receive ingestible, accurate, and timely data from Previous DMC plans, Dental FFS and DHCS. The Previous DMC plan and Dental FFS must complete all data sharing activities as described in Section VI, Continuity of Care Data Sharing Policy. DHCS reserves the right to perform audits to confirm successful data sharing according to timeliness and quality expectations. If the Previous DMC plan or Dental FFS does not meet data requirements, the DMC plan or Dental FFS may be subject to enforcement actions.

Receiving DMC plans will receive data from the Previous DMC plan, Dental FFS and DHCS. DHCS will provide Receiving DMC plans with utilization data in May 2025 However, these data will be lagged, and more timely data will aid Receiving DMC plans in achieving Continuity of Care, particularly for Special Populations. To facilitate Receiving DMC plans' Continuity of Care activities, DHCS will require DMC plans to exchange data beginning May 1, 2025.

[23] DMC plans regulated by the Knox Keene Act must comply timely access standards.

[24] 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 Relationship for the Member to submit a Continuity of Care for Providers Request.

VI. CONTINUITY OF CARE DATA SHARING POLICY

Successful data sharing among DHCS, Previous DMC plans, Dental FFS and Receiving DMC plans will be critical to effectuate the CoC Policy for the 2025 DMC Transition. To this end, Receiving DMC plans must have access to ingestible, complete, accurate, and timely data from Previous DMC plans, Dental FFS and DHCS. This Section of the Policy Guide lays out the data that DHCS will provide to Receiving DMC plans, and defines requirements for Previous DMC plans or Dental FFS to share necessary data for Receiving DMC plans to implement CoC protections.

The requirements outlined in this Section apply to both Previous DMC plans and Dental FFS that are exiting the market.

A. Secure Transition of Member-Level Information

Throughout the data transmission processes discussed in this Section of the Policy Guide, DMC plans must have processes for receiving, storing, using, or transmitting Protected Health Information (PHI) and sharing data in accordance with applicable laws, DMC plan contract requirements, and DHCS data privacy and security standards. DMC plans must ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. DMC plans must also abide by applicable state law requirements. DMC plans must have alternative, legally compliant submission processes in place for when standard secure transmission protocols are not available.

B. Overview of All Data Files

As detailed in this chapter, the following data files or reports are relevant to the 2025 DMC plan Transition.

Figure 7. Summary of Data Files

File	Responsible Party for Generating the File	Relevant Subsection
Plan Transfer Status Report	DHCS	Section VI.B.1.a)
Plan Data Feed	DHCS	Section VI.B.1.b)

File	Responsible Party for Generating the File	Relevant Subsection
Special Populations Member File	DHCS	Section VI.B.1.c)
Transitioning Member Identifying Data	Previous DMC plan or Dental FFS	Section VI.B.2.a)
Transitioning Member Utilization Data	Previous DMC plan or Dental FFS	Section VI.B.2.b)
Transitioning Member Authorization Data	Previous DMC plan or Dental FFS	Section VI.B.2.c)
Transitioning Member NEMT/NMT Schedule Data	Previous DMC plan or Dental FFS	Section VI.B.2.d)

1. DHCS Provided Data Files

DMC plans must utilize information provided in the standard monthly *Plan Data Feed* to implement CoC protections. However, these data will not be available for all transitioning members prior to July 1, 2025. To support CoC activities, DHCS will share the data outlined in Figure 8 to DMC plans. DHCS will refresh the files for DMC plans as full replacement files. These data will supplement data shared from the Previous DMC plan or FFS to the Receiving DMC plan described in Section VI.B below.

Figure 8. Summary of DHCS Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Plan Transfer Status Report	Pending DMC plan enrollment for transitioning members	Previous DMC Plans or Dental FFS	Weekly, Beginning May 4, 2025
Plan Data Feed	Utilization information for all enrolled members	Receiving DMC plans	Monthly
Special Populations Member File	Member-level information, specifically CINs for transitioning members who meet Special Populations criteria, indicating the members' Special Population group(s)	Receiving DMC plans	Monthly for All Special Population Members from May 2025 through September 2025[55]

a.) Plan Transfer Status Report

DHCS will prepare the *Plan Transfer Status Report* file to identify a subset of transitioning members. The *Plan Transfer Status Report* file will include transitioning members' pending enrollment into one of the Receiving DMC plans. The Previous DMC plan and Dental FFS will use the *Plan Transfer Status Report* of transitioning members to match on the member's Medi-Cal Client Index Number (CIN) and prepare data files described in this Section for transmission to the Receiving DMC plan. DHCS will transmit the *Plan Transfer Status* Report file to the Previous DMC plan or Dental FFS weekly, beginning in May 2025 (See Section VI.D for more information). DHCS will share these data with the Previous DMC plan and Dental FFS via SFTP.

The DHCS *Plan Transfer Status Report* file will include the data elements outlined in Figure 9 below. To ensure that the most up-to-date member enrollment information is captured in files shared from the Previous DMC plan or Dental FFS to the Receiving DMC plan, DHCS requires the Previous DMC plan or Dental FFS to use the most recently available Plan Transfer Status Report files to prepare required files.

Figure 9. Plan Transfer Status Report Data Elements

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member Date of Birth	MM/DD/YYYY, Date
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Exiting Plan	Alpha-Numeric, Text
Assignment	Alpha-Numeric, Text
Effective Date	MM/DD/YYYY, Date
Choice/Default	Alpha-Numeric, Text

b.) Plan Data Feed

The *Plan Data Feed* includes information for all members enrolled in a DMC plan on the first of each month. Receiving DMC plans will use the information provided in the *Plan Data Feed* in conjunction with data provided by Previous DMC plans. DHCS will notify Receiving DMC plans when the data is posted on their plan specific SFTP sites.

c.) Special Populations Member File

All transitioning members have CoC protections, but some transitioning members – referred to as Special Populations – will need enhanced protections leading up to and throughout the 2025 DMC Transition.

To ensure DMC plans have access to relevant data, DHCS will share monthly *Special Populations Member Files* using existing DHCS data sources from May 2025 through September 2025 for a subset of transitioning members. The monthly *Special Populations Member Files* will consist of Medi-Cal Member Client Index Numbers (CIN) for members who meet the Special Populations criteria and indicators of the members' Special Population group(s). DMC plans will use the provided CIN information to match data provided through the recurring *Plan Data Feed* files provided by DHCS.

Receiving DMC plans must use the DHCS-provided Special Populations Member File to identify Special Populations members' providers and begin outreach, a key tenet of the CoC policies for Special Populations. DHCS expects that any member identified on the DHCS-provided *Special Populations Member File* will be classified as a Special Population member and afforded appropriate CoC protections.

2. Previous DMC Plan and Dental FFS Provided Data Files

In addition to DHCS data sharing with DMC plans, DHCS is requiring Previous DMC plans and Dental FFS to share data with Receiving DMC plans to ensure Receiving DMC plans have access to the most timely, accurate, and comprehensive member-level information to effectuate CoC protections.

The Previous DMC plan or Dental FFS must complete all data sharing requirements outlined below. This Section outlines a standardized set of "minimum necessary" data elements for data shared from the Previous DMC plan or Dental FFS to the Receiving DMC plan, as well as standard file formats, transmission methods, and transmission frequencies.

Previous DMC plans or Dental FFS will transmit the data files in Figure 3 to Receiving DMC plans, in accordance with the requirements outlined in Sections VI.B.1-VI.B.4. Previous DMC plans or Dental FFS will refresh the files for Receiving DMC plans as full replacement files for each refresh. The Previous DMC plan or Dental FFS will transmit copies of data sent to Receiving DMC plans to DHCS to facilitate DHCS' oversight of the transition. DHCS will perform verification checks to confirm successful data sharing according to timeliness and quality expectations. If the Previous DMC plan or Dental FFS does not meet data requirements, the DMC plan or Dental FFS may be subject to enforcement actions.

Figure 10. Summary of Previous DMC plan or Dental FFS Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning members	Receiving DMC plans and DHCS	Initial transfer May 8, weekly refreshes beginning in June
Transitioning Member Primary Care Dentist Data	Identifying Primary Care Dentist for transitioning members	Receiving DMC plans and DHCS	Initial transfer May 8, weekly refreshes beginning in June
Transitioning Member Utilization Data	Claims and encounter information for transitioning members	Receiving DMC plans and DHCS	Initial transfer May 8, weekly refreshes beginning in June

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Authorization Data	Prior authorization information for transitioning members	Receiving DMC plans and DHCS	Initial transfer May 8, weekly refreshes beginning in June
Transitioning Member NEMT/NMT Schedule Data	Scheduled transportation information for transitioning members	Receiving DMC plans and DHCS	Initial transfer May 8, weekly refreshes beginning in June

Accompanying Excel Attachment for Previous DMC Plan Provided Data

DHCS has compiled the outlined data elements into an Excel workbook for Previous DMC plans and Dental FFS to prepare data files to transmit to Receiving DMC plans to enable Receiving DMC plans to implement Continuity of Care policies in Section V, Continuity of Care. The accompanying Excel workbook includes additional guidance for Previous DMC plans and Dental FFS around expected values and file requirements.

- Continuity of Care (CoC) Data Template - 1) Data Elements for All Members
    - Previous DMC plans and Dental FFS must use this template to prepare member level data files for transitioning members in accordance with requirements outlined in Sections VI.B.1-VIII.B.4 below. Receiving DMC plans will utilize the resulting member level data to implement Continuity of Care policies in Section V, Continuity of Care.

a) Transitioning Member Identifying Data

Receiving DMC plans need identifying member information to operationalize CoC policy requirements. Previous DMC plans and Dental FFS will provide the Receiving DMC plan with relevant member information, as identified in Figure 4. The *Transitioning Member Identifying Data* file will allow DMC plans to link to the other required data files using the Medi-Cal Member CIN. Receiving DMC plans will use members' contact information and preferred form of contact to send notifications about Continuity of Care for Special Populations, as appropriate. Primary Care Dentist (PCD) information is particularly important for transitioning members identified as meeting Special Populations criteria since Receiving DMC plans will need to directly contact the PCD in cases in which the PCD is out-of-network (OON).

Previous DMC plans and Dental FFS will share *Transitioning Member Identifying Data* files with the Receiving DMC plan and DHCS in accordance with the required transmission method and frequency outlined in Sections VI.C-VI.D.

i) Required Data Elements

Previous DMC plans and Dental FFS must share *Transitioning Member Identifying Data* files with Receiving DMC plans and DHCS in accordance with the required data elements and format outlined in Figures 4 and 5.

Figure 11. Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code[25]	Numeric 3-digit, Text
Member Homelessness Indicator[26]	Numeric, 1 digit, Text
Member Residential Address[27]	Alpha-numeric, Text
Member Residential City[28]	Alpha-numeric, Text

[25] This will be limited to the Medi-Cal 834 file acceptable values.

[26] Identifier for if the member is experiencing "homelessness." If "homeless," enter "2", if not, enter "1", if unknown, enter "0". Homeless is defined a meeting one or more of the following conditions: lacking a fixed, regular, and adequate nighttime residence; having a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; living in a supervised publicly or privately operated shelter, designed to provide temporary living arrangements (including hotels and motels paid for by federal, state, or local government programs for low income individuals or by charitable organizations, congregate shelters, and transitional housing); exiting an institution into homelessness (regardless of length of stay in the institution); will imminently lose housing in next 30 days; and/or fleeing domestic violence, dating violence, sexual assault, stalking, and other dangerous, traumatic, or life-threatening conditions relating to such violence.

[27] DMC plans or Dental FFS may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[28] DMC plans or Dental FFS may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and Residential City is not available.

Data Element	Format
Member Residential Zip Code[29]	Alpha-numeric, Text
Member Mailing Address[30]	Alpha-numeric, Text
Member Mailing City[31]	Alpha-numeric, Text
Member Mailing Zip Code[32]	Numeric, 5-digit
Member Phone Number[33]	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact[34]	Alpha-Numeric, Text
Description of Member's Selected Alternative Format[35]	Alpha-Numeric, Text
Member's Preferred Language (Spoken)[36]	Alpha-Numeric, Text
Member's Preferred Language (Written)[37]	Alpha-Numeric, Text

[29] DMC plans or Dental FFS may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.

[30] DMC plans or Dental FFS may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[31] DMC plans or Dental FFS may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.

[32] DMC plans or Dental FFS may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available

[33] Numbers only, no dashes, character limit of ten. If number not available, DMC plan or Dental FFS may report "0000000000".

[34] Member's Preferred Form of Contact, as known by DMC plan or Dental FFS (e.g., "CALL", "TEXT", "EMAIL", "MAIL"). If not known, DMC plan or Dental FFS may report "UNKNOWN".

[35] If applicable, member's selected alternative format, as known by DMC plan or Dental FFS (e.g., "LARGE PRINT", "AUDIO CD", "DATA CD", "BRAILLE"). If not known, DMC plan or Dental FFS may report "UNKNOWN".

[36] If available, Member's Preferred Spoken Language (e.g., "ENGLISH", "SPANISH"). If not known, DMC plan or Dental FFS may report "UNKNOWN".

[37] If available, Member's Preferred Written Language (e.g., "ENGLISH", "SPANISH"). If not known, DMC plan or Dental FFS may report "UNKNOWN".

Figure 12. Transitioning Member Primary Care Dentist Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Dentist Name (Assigned PCD)	Alpha-numeric, Text
Dental Provider National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Dentist Phone Number[38]	Numeric, 10-digit
Primary Care Dentist Facility Name	Alpha-numeric, Text
Primary Care Dentist Facility NPI	Numeric, 10-digit, Text
Primary Care Dentist Facility Phone Number	Numeric, 10-digit
Primary Care Dentist Facility Address	Alpha-numeric, Text
Dental Group	Alpha-numeric, Text
Dental Group Taxpayer Identification Number (TIN)	Numeric, 9-digit
Last Visit Date[39]	MM/DD/YYYY, Date

b.) Transitioning Member Utilization Data

Receiving DMC plans need timely utilization information in order to implement CoC for Providers and identify any relevant Active Courses of Treatment pursuant to CoC for Services requirements (See Sections V.C, Continuity of Care, Continuity of Care for Providers and V.D, Continuity of Care, Continuity of Care for Covered Services for more information).

Previous DMC plans and Dental FFS will share *Transitioning Member Utilization Data* files with Receiving DMC plans and DHCS in accordance with the required transmission method and frequency outlined in Sections VI.C-VI.D.

i) Required Data Elements

Previous DMC plans and Dental FFS must share *Transitioning Member Utilization Data* files with Receiving DMC plans and DHCS in

[38] Numbers only, no dashes, character limit of ten. If number not available, DMC plan or Dental FFS may report "0000000000".

[39] As known by the DMC plan or Dental FFS; if no visits on record, DMC plan or Dental FFS will enter "00/00/0000".

accordance with the required data elements and format outlined in Figure 12.

The below data elements are specific to the data transmitted from the Previous DMC plan or Dental FFS.

Figure 13. Transitioning Member Claims/Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code[40]	Alpha-Numeric, Text
Place of Service[41]	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Billing Provider NPI	Numeric, 10-digit, Text
Billing Provider First Name	Alpha-Numeric, Text
Billing Provider Last Name	Alpha-Numeric, Text
Billing Provider Phone Number[42]	Numeric, 10-digit
Billing Provider Tax Identification Number (TIN)	Numeric, 9-digit, Text
Rendering Provider Specialty Type[43]	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text
Rendering Provider First Name	Alpha-Numeric, Text
Rendering Provider Last Name	Numeric, 10-digit
Rendering Provider Phone Number	Alpha-Numeric, Text
Diagnosis Code 1[44]	Alpha-Numeric, Text
Diagnosis Code 2[45]	Alpha-Numeric, Text

[40] Primary procedure code for this line of service, such as current Dental Terminology (CDT) codes. Do not code decimal point.

[41] Required for professional claims only, please leave blank for institutional claims.

[42] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan DMC plan may report "0000000000".

[43] Standard taxonomy codes issued by the NUCC, available here. If number not available to the DMC plan, DMC plan may report "0000000000".

[44] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[45] ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank.

Data Element	Format
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text
Tooth Code[46]	Alpha-Numeric, Text
Surface Code[47]	Alpha-Numeric, Text
Quadrant Code[48]	Alpha-Numeric, Text
Service Office Address 1	Alpha-Numeric, Text
Service Office Address 2	Alpha-Numeric, Text
Service Office City	Alpha-Numeric, Text
Service Office State	Alpha-Numeric, Text
Service Office Zip Code	Alpha-Numeric, Text
Business Tax Identification Number (TIN)	Numeric, 9-digit, Text

c.) Transitioning Member Authorization Data

To honor active Prior Authorizations as required by the CoC for Services policy, the Receiving DMC plan will need accurate, up-to-date data for transitioning members. (See Section V.D, Continuity of Care, Continuity of Care for Covered Services for more information).

Previous DMC plans and Dental FFS will share *Transitioning Member Authorization Data* files with Receiving DMC plans and DHCS in accordance with the required transmission method and frequency outlined in Sections VI.C-VI.D.

i) Required Data Elements

Previous DMC plans and Dental FFS must share *Transitioning Member Authorization Data* files with Receiving DMC plans and

[46] Tooth Code applicable to the submitted Procedure Code. If Procedure Code does not require Tooth information, can be left blank or entered as "FM". If multiple teeth are involved, each procedure code/tooth code can be sent as a separate detail line (duplicate other fields) or a Comma Delimited list of tooth codes can be sent on a single line. Example: 01,02,03

[47] Surface Code applicable to the submitted Procedure Code. If unknown or Procedure Code does not require Tooth information, leave blank.

[48] Quadrant Code applicable to the submitted Procedure Code. If unknown or Procedure Code does not require Tooth information, leave blank.

DHCS in accordance with the required data elements and format outlined in Figure 13.

Figure 14. Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Requesting Provider Name	Alpha-numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number[49]	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text
Requesting Facility Phone Number[50]	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number[51]	Numeric, 10-digit
Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number[52]	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units	Numeric 7-digit, Text
Procedure Code	Alpha-Numeric, 5-digit, Text
Procedure Code Description	Alpha-Numeric, Text
Diagnosis Code[53]	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status[54]	Alpha-Numeric, Text

[49] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "0000000000".

[50] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "0000000000".

[51] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "0000000000".

[52] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "0000000000".

[53] ICD-9-CM or ICD-10-CM. Do not code decimal point.

[54] Indication of authorization status (e.g., "APPROVED", "DENIED", "PARTIAL")

Data Element	Format
Authorization Type	Alpha, 2-digit, Text
Previous DMC Plan or Dental FFS Authorization Number	Alpha-Numeric, Text
Tooth Code[55]	Alpha-Numeric, Text
Surface Code[56]	Alpha-Numeric, Text
Quadrant Code[57]	Alpha-Numeric, Text
Service Office Address 1	Alpha-Numeric, Text
Service Office Address 2	Alpha-Numeric, Text
Service Office City	Alpha-Numeric, Text
Service Office State	Alpha-Numeric, Text
Service Office Zip Code	Alpha-Numeric, Text
Rendering/Billing Provider Tax Identification Number (TIN)[58]	Numeric, 9-digit, Text
Business Tax Identification Number (TIN)	Numeric, 9-digit, Text
Authorization Status of Service Line[59]	Alpha-Numeric, Text

d.) Transitioning Member NEMT/NMT Schedule Data

DHCS expects Receiving DMC plans to ensure no disruptions to Transitioning Members' access to Non-Emergency Medical Transportation and Non-Medical Transportation (NEMT/NMT) benefit. To guard against disruptions, the Receiving DMC plan will need data for Members with scheduled NEMT/NMT services from the Previous DMC plan or Dental FFS. The

[55] Tooth Code applicable to the submitted Procedure Code. If Procedure Code does not require Tooth information, can be left blank or entered as "FM". If multiple teeth are involved, each procedure code/tooth code can be sent as a separate detail line (duplicate other fields) or a Comma Delimited list of tooth codes can be sent on a single line. Example: 01,02,03

[56] Surface Code applicable to the submitted Procedure Code. If unknown or Procedure Code does not require Tooth information, leave blank.

[57] Quadrant Code applicable to the submitted Procedure Code. If unknown or Procedure Code does not require Tooth information, leave blank.

[58] Tax ID of the rendering/billing provider. Do not code punctuation.

[59] Indication of authorization status (e.g., "APPROVED", "DENIED", "PARTIAL"). Required for "Partial Approvals" showing status of each service line. Optional for fully approved or fully denied Authorizations

Receiving DMC plan must identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedule a Network provider or an OON provider to transport the member. See Section V.F.1, Continuity of Care, Additional Continuity of Care Protections for All Transitioning Members, Non-Emergency Medical Transportation and Non-Medical Transportation for more information on CoC for NEMT/NMT.

Previous DMC plans and Dental FFS will share *Transitioning Member NEMT/NMT Schedule* files with Receiving DMC plans and DHCS in accordance with the required transmission method and frequency outlined in Sections VI.C-VI.D.

i) Required Data Elements

Previous DMC plans and Dental FFS must share *Transitioning Member NEMT/NMT Schedule Data* files with Receiving DMC plans and DHCS in accordance with the required data elements and format outlined in Figure 15.

Figure 15. Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service[60]	Numeric, 1 digit, Text
Date of Scheduled Transportation Service	MM/DD/YYYY, Date
Time of Scheduled Transportation Service	hh:mm:ss, Time
Recurring Transportation Service Indicator[61]	Numeric, 1 digit, Text
Member Phone Number[62]	Numeric, 10-digit
Pickup Location[63]	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number [64]	Numeric, 10-digit

[60] Identifier for NEMT and NMT services. If NEMT, enter "0", if NMT, enter "1".

[61] Identifier for if one-time or recurring NEMT/NMT services. If one-time, enter "0", if recurring, enter "1".

[62] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "0000000000".

[63] Indicates NEMT/NMT pickup locations (e.g., "MEMBER HOME", "SNF", "LTC").

[64] If applicable. Numbers only, no dashes, character limit of ten. If number not available to the DMC plan or Dental FFS, DMC plan or Dental FFS may report "0000000000".

Data Element	Format
Mode of Transport[65]	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number[66]	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number[67]	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes[68]	Alpha-Numeric, Text

e.) Transitioning Member Special Populations Information Data

As outlined in Section VI.A.3, DHCS will share a monthly file of Medi-Cal Member Client Index Numbers (CINs) for a subset of transitioning members who meet the Special Populations criteria and are able to be identified using existing DHCS data sources from May 2025 – September 2025.

The Receiving DMC plan is responsible for intaking *Special Populations Member Files* from DHCS. DHCS expects that any member identified on the DHCS- provided *Special Populations Member Files* will be classified as a Special Population member and afforded appropriate CoC protections.

Receiving DMC plans will utilize information from DHCS, Previous DMC plans, and Dental FFS as well as other data the Receiving DMC plan has access to, to begin implementing CoC policy for Special Populations. See Section V.C, Continuity of Care, Continuity of Care for Providers, V.D, Continuity of Care, Continuity of Care for Covered Services and V.E, Continuity of Care, Continuity of Care Coordination and Management

[65] Member's Mode of Transportation, as known by DMC plan (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").

[66] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan or Dental FFS, DMC plan or Dental FFS may report "0000000000".

[67] Numbers only, no dashes, character limit of ten. If number not available to the DMC plan, DMC plan may report "000000000

[68] May include appointment reason (e.g., PCD visit) or member needs (e.g., oxygen, stair chair, attendants).

Information for additional information on how the Receiving DMC plans will use these data to provide enhanced protections for Special Populations.

Figure 16. Special Populations for which DHCS Data is Primary Source of Information

Members Who Are:
• Children and youth enrolled in CCS/CCS Whole Child Model • Living with an Intellectual or Developmental Disability (I/DD) diagnosis • Residing in Skilled Nursing Facilities (SNF) • Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)[69]

C. File Format and Transmission Method Requirements

Previous DMC plans and Dental FFS will share data outlined using the accompanying Excel attachment (C*ontinuity of Care (CoC) Data Template - 1) Data Elements for All Members*) and saved as comma-separated value (csv) files. Each tab in the accompanying Excel attachment must be transmitted as a separate csv file in accordance with the required file naming conventions outlined in Figure 17. DHCS will share data as txt files.

Previous DMC plans, Dental FFS and DHCS will share files with Receiving DMC plans via Secure File Transfer Protocol (SFTP) transmission. Previous DMC plans will share data directly with the Receiving DMC plan and share copies of files with DHCS via the SFTP folders outlined in Figure 18. Dental FFS will share data with DHCS via the Medi-Cal Dental Document Management System (DMS) and DHCS will share copies of files with the Receiving DMC plans via the SFTP folders outlined in Figure 18.

See Section VI.D for more information regarding the required reporting frequency.

[69] The 2025 DMC plan Transition CoC policy applies to members residing in ICF/DD who are in dental managed care or Dental FFS as of June 30, 2025.

Figure 17. Required File Naming Convention for Data Outlined in Continuity of Care (CoC) Data Template- 1) Data Elements for All Members

File	Data Elements	Required File Naming Convention
Transitioning Member Identifying Data	Member Identifying Data (See Figure 4)	C01_INFO_RECEIVING HCP
Transitioning Member Identifying Data	Primary Care Dentist Information (See Figure 5)	C02_PCD_RECEIVING HCP
Transitioning Member Utilization Data	Transitioning Member Claims / Encounter Information (See Figure 6)	C03_CLAIMS_RECEIVING HCP
Transitioning Member Authorization Data	Transitioning Member Authorization Information (See Figure 7)	C04_PA_RECEIVING HCP
Transitioning Member NEMT/NMT Schedule Data	Transitioning Member NEMT/NMT Schedule Data (See Figure 8)	C05_NEMTNMT_RECEIVING HCP

Figure 18. DHCS SFTP Folder Information

File	Responsible Party for Generating the File	SFTP Folder Name*
Plan Transfer Status Report	DHCS	DHCS-MDSD-*planname*-Plan Transfer Report
Plan Data Feed	DHCS	TBD
Special Populations Member File	DHCS	DHCS-MDSD-*planname*-Special Populations
FFS Transitioning Member Identifying Data	Dental FFS	DHCS-MDSD-*planname*-FFS Identifying Data

File	Responsible Party for Generating the File	SFTP Folder Name*
FFS Transitioning Member Primary Care Dentist Data	Dental FFS	DHCS-MDSD-*planname*-FFS PCD
FFS Transitioning Member Utilization Data	Dental FFS	DHCS-MDSD-*planname*–FFS Utilization
FFS Transitioning Member Authorization Data	Dental FFS	DHCS-MDSD-*planname*–FFS Authorizations
FFS Transitioning Member NEMT/NMT Schedule Data	Dental FFS	DHCS-MDSD-*planname*-FFS NEMT NMT
DMC Plan Transitioning Member Identifying Data	Previous DMC plan	DHCS-MDSD-*planname*-DMCTran 2025 P2P
DMC Plan Transitioning Member Primary Care Dentist Data	Previous DMC plan	DHCS-MDSD-*planname*-DMCTran 2025 P2P
DMC Plan Transitioning Member Utilization Data	Previous DMC plan	DHCS-MDSD-*planname*-DMCTran 2025 P2P
DMC Plan Transitioning Member Authorization Data	Previous DMC plan	DHCS-MDSD-*planname*-DMCTran 2025 P2P
DMC Plan Transitioning Member NEMT/NMT Schedule Data	Previous DMC plan	DHCS-MDSD-*planname*-DMCTran 2025 P2P

D. File Transmission Frequency

It is essential for Receiving DMC plans to receive accurate, timely data from DHCS, Previous DMC plans, and Dental FFS in order to implement the required CoC protections. Figure 19 Data Sharing Timeline below describes the required data sharing timeline and refresh requirements.

Figure 19. Data Sharing Timeline

File	DHCS Data Obligations	Previous DMC Plan / Dental FFS Data Obligations	Receiving DMC Plan Data Obligations
Plan Transfer Status Report	Send to Previous DMC plan and Dental FFS weekly on Fridays, beginning May 2, 2025 and September 5, 2025.	Ingest	N/A
Transitioning Member Identifying Data	Intake Transitioning Member Identifying Data from the Previous DMC plan and Dental FFS upon each refresh. Provide monitoring and oversight.	Share Transitioning Member Identifying Data with Receiving DMC plans and DHCS on May 8, 2025 and refresh weekly starting June 3, 2025 and ending September 30, 2025.	Ingest Transitioning Member Identifying Data from the Previous DMC plan and Dental FFS upon each refresh. See Section V.C for additional information on how the Receiving DMC plans will use these data.

File	DHCS Data Obligations	Previous DMC Plan / Dental FFS Data Obligations	Receiving DMC Plan Data Obligations
Transitioning Member Primary Care Dentist Data	Intake Transitioning Member Primary Care Dentist Data from the Previous DMC plan and Dental FFS upon each refresh. Provide monitoring and oversight.	Share Transitioning Member Primary Care Dentist Data with Receiving DMC plans and DHCS on May 8, 2025 and refresh weekly starting June 3, 2025 and ending September 30, 2025.	Ingest Transitioning Member Primary Care Dentist Data from the Previous DMC plan and Dental FFS upon each refresh. See Section V.C for additional information on how the Receiving DMC plans will use these data.
Transitioning Member Utilization Data	Intake Transitioning Member Utilization Data from the Previous DMC plan and Dental FFS upon each refresh. Provide monitoring and oversight.	Share Transitioning Member Utilization Data with Receiving DMC plans and DHCS on May 8, 2025 and refresh weekly starting June 3, 2025 and ending September 30, 2025.	Ingest Transitioning Member Utilization Data from Previous DMC plan and Dental FFS upon each refresh. See Section V.C for additional information on how the Receiving DMC plans will use these data.

File	DHCS Data Obligations	Previous DMC Plan / Dental FFS Data Obligations	Receiving DMC Plan Data Obligations
Transitioning Member Authorization Data	Intake Transitioning Member Authorization Data from the Previous DMC plan and Dental FFS upon each refresh.	Share Transitioning Member Authorization Data with Receiving DMC plans and DHCS on May 8, 2025, and refresh weekly starting June 3, 2025 and ending September 30, 2025. Work with Receiving DMC plans to fill data gaps.	Ingest Transitioning Member Authorization Data from the Previous DMC plan and Dental FFS upon each refresh. See Section V.D for additional information on how the Receiving DMC plans will use these data. Work with Previous DMC plan, Dental FFS and providers to address missing data.
Transitioning Member NEMT/NMT Schedule Data	Intake Transitioning Member NEMT/NMT Schedule Data from the Previous DMC plan upon each refresh. Provide monitoring and oversight.	Share Transitioning Member NEMT/NMT Schedule Data with Receiving DMC plans and DHCS on May 8, 2025 and refresh weekly starting June 3, 2025 and ending September 30, 2025.	Ingest Transitioning Member NEMT/NMT Schedule Data from the Previous DMC plan and Dental FFS upon each refresh. See Section V.F.1 for additional information on how the Receiving DMC plans will use these data.

File	DHCS Data Obligations	Previous DMC Plan / Dental FFS Data Obligations	Receiving DMC Plan Data Obligations
Transitioning Member Special Populations Information Data	Share Special Populations Member Files in May 2025 and refresh monthly from June 2025 through September 2025.[70]	N/A	Ingest Special Populations Member Files from DHCS upon each refresh. See Section V.C. for additional information on how the Receiving DMC plans will use these data.

[70] Data will not include information for "Adults and children receiving Care Management," as DHCS does not have access to CIN-level data for these members.

VII. TRANSITION MONITORING AND OVERSIGHT REPORTING REQUIREMENTS

This Section presents DHCS' approach to monitoring the transition of members between DMC plans on July 1, 2025. The monitoring approach encompasses both Previous and Receiving DMC plans, and allows DHCS to determine whether DMC plans are meeting mandated requirements relative to the transition including, but not limited to, adherence to DHCS' Guiding Principles in Section II, Introduction and the Continuity of Care (CoC) requirements in Sections V – VI.

DHCS has established a multi-pronged monitoring approach for the 2025 DMC plan Transition:

1. Receiving DMC plans (and Previous DMC plans to a limited extent) will submit Continuity of Care performance data via DHCS provided template related to:
    a. CoC for all transitioning members and Special Populations members
    b. Member issues
        - This Section of the Policy Guide focuses primarily on monitoring via DMC Plan- submitted performance data, which is explained in more detail below. In addition to DMC plan-submitted performance data, DHCS will use approaches 2 – 3 below to monitor the 2025 DMC plan Transition.
2. DHCS will proactively outreach to Receiving DMC plans and require detailed reporting on samples of transitioning members related to CoC for Special Populations.
3. Previous DMC plans will submit copies of all data files shared with Receiving DMC plans to DHCS for validation. More information regarding these shared files is found in Section VI, Continuity of Care Data Sharing Policy.

DHCS will solicit and track feedback from stakeholders, including members. Receiving DMC plans will also track and trend stakeholder input, and ensure that a feedback loop within the DMC plan keeps its leadership and relevant units of its organization apprised of this critical input. DMC plans will utilize stakeholder feedback to improve on topics of concern. For example, tracking calls to the Receiving DMC plan's member call center identifies that numerous members expressed concern about loss of access to a large dental group. This information should be shared with the DMC plans' provider network team to determine if the DMC plan is seeking to contract or enter into a CoC for Providers agreement with the dental group.

DHCS will conduct monitoring and oversight activities leading up to and after the July 1, 2025, transition from May 2025 through June 2026. The reporting cadence fluctuates throughout the period, as noted in A.2. below. DHCS has made efforts to ensure that transition monitoring is not duplicative of existing data reporting. DMC plans are expected to comply with all other performance monitoring and data reporting requirements in accordance with their contract and DHCS policy.

A. DMC plan Data Submission via DHCS Approved Excel Template

1. Submission Requirements and Interface

Data related to the July 1, 2025, DMC plan transition will be reported by Receiving DMC plans and Previous DMC plans and FFS will have limited submission requirements. Receiving and Previous DMC plans and FFS will report required data elements at the county level, as noted in the Data Element Detail in A.3. below. Some data elements will require DMC plans to submit baseline data as noted in A.3. below.

A DHCS approved Excel template will be the interface for DMC plans to submit each transition data element. The interface will include submission of narrative fields to allow DMC plans to include additional detail regarding the data submitted.

2. DMC plan Reporting Cadence and Deadlines

DMC plan reporting will begin with baseline reporting in May 2025 for select data elements, pre-transition reporting in May 2025, and post-transition reporting continuing through June 2026. Reporting timeframes vary by measure and are subject to change at DHCS' discretion. The reporting cadence for all data elements is indicated in the table below.

Figure 20. Data Element Reporting Cadence and Deadlines

Month(s)	Data Elements	Cadence
May 21, 2025	Baseline for select data elements	One-time reporting
May 1, 2025 – June 30, 2025	Select data elements	Bi-weekly reporting
July 1, 2025 – September 30, 2025	All data elements	Bi-weekly reporting
October 1, 2025 – December 31, 2025	Select data elements	Monthly reporting
January 1, 2026 – June 30, 2026	Select data elements	Quarterly reporting

DMC plans will report data to DHCS with up to a (3) three-business day lag from the end of the reporting period, as noted below:

Cadence	Reporting Period	Deadline
Bi-weekly	July 1-15, 2025	Friday, July 18, 2025
Bi-weekly	July 16-31, 2025	Wednesday, August 6, 2025
Bi-weekly	August 1-15, 2025	Wednesday August 20, 2025
Bi-weekly	August 16-31, 2025	Wednesday, September 3, 2025
Bi-weekly	September 1-15, 2025	Wednesday, September 17, 2025
Bi-weekly	September 16-30, 2025	Friday, October 3, 2025
Monthly	October 1-31, 2025	Wednesday, November 5, 2025
Monthly	November 1-30, 2025	Wednesday, December 3, 2025

Cadence	Reporting Period	Deadline
Monthly	December 1-31, 2025	Monday, January 5, 2026
Quarterly	January 1-March 31, 2026	Friday, April 3, 2026
Quarterly	April 1-June 30, 2026	July 3, 2026

3. Data Element Detail

The tables below provide details regarding the data elements that DMC plans will be required to submit to DHCS via the DHCS approved Excel template interface.

To assist DMC plans, immediately below is a key to the table layouts.

Figure 21. Table Layout Key

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(DMC plans will report for each county unless indicated)*
1	Brief description of data element DMC plan will electronically report to DHCS	Entity responsible for reporting	Date range during which data will be reported[71]	Detailed description of data element to assist DMC plan with submission

[71] The end date is subject to change as DHCS reserves the right to extend the data reporting period if DMC performance indicates a need for continued monitoring.

Figure 22. CoC for Dental Providers – All Members*

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
1	Cumulative number of Continuity of Care for Providers requests received from transitioning members, providers, or authorized representatives	Receiving DMC plan	5/1/25-6/30/26	Cumulative count Q1 should equal the sum of Q2, Q3, Q7 and Q8
2	Status of CoC for Providers Requests: Cumulative number of requests approved that result in a contract or a CoC agreement	Receiving DMC plan	5/1/25-6/30/26	Cumulative count
3	Status of CoC for Providers Requests: Cumulative	Receiving DMC plan	5/1/25-6/30/26	Cumulative count

[72] The data element numbering aligns with the DHCS template numbering.

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
	number of requests denied			
4	Status of CoC for Providers Requests: Cumulative number of provider requests denied due to the provider being unresponsive	Receiving DMC plan	5/1/25 – 6/30/26	Cumulative count
5	Status of CoC for Providers Request: Cumulative number of provider requests denied due to the provider declining to contract	Receiving DMC plan	5/1/25 – 6/30/26	Cumulative count
6	Status of CoC for Providers Requests: Cumulative number of requests for Providers who are already in the	Receiving DMC plan	5/1/25-6/30/26	Cumulative count: Of the total denials reported for Data Element 6, the DMC plan must report the number of denials for providers who are already in the Receiving DMC plan's network

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
	Receiving DMC Plan's network			
7	Status of CoC for Providers Requests: Cumulative number of requests pending	Receiving DMC plan	5/1/25-6/30/26	Cumulative count
8	Status of CoC for Providers Requests: Cumulative number of requests cancelled by requester	Receiving DMC plan	5/1/25-6/30/26	Cumulative count
9a	Reason for denials of CoC for Providers request	Receiving DMC plan	5/1/25-6/30/26	Attestation Y/N: The DMC plan attests that the following are the only reasons for which the DMC plan denied the CoC for Provider request. Reasons: No relationship between

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
				member and provider; Provider refused to work with DMC plan; Provider not State approved; Quality of care issues; Provider and DMC plan did not agree to a rate; Provider is in the DMC plan's Network; Provider type is not protected by Continuity of Care for Providers
9b	Reason for denials of CoC for Providers request: Explanation	Receiving DMC plan	5/1/25-6/30/26	Narrative: If the DMC plan selected No to Data Element 9a, a request was denied for a reason not listed, the DMC plan must report each denial and the reason for each denial.
9c	Status of CoC for Providers Requests: Continuation with In- Network Provider	Receiving DMC plan	5/1/25-6/30/26	Attestation Y/N: The DMC plan attests that members with CoC for Providers Requests for providers who are already in the Receiving DMC plan's network were permitted to continue with the requested,

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
				in- network provider without disruption.
9d	Status of CoC for Providers Requests: Discontinuation explanation	Receiving DMC plan	5/1/25-6/30/26	Narrative: If the DMC plan selected No to Data Element 9c, a member's Continuity of Care with the requested provider was disrupted and/or was not permitted to continue, the DMC plan must report each disruption and/or discontinuation and provide an explanation.
10	Timeliness: Cumulative number of CoC for Providers requests that took more than 30 days to complete.	Receiving DMC plan	5/1/25-6/30/26	Cumulative count

Data Element Number[72]	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
12	Optional: DMC plans may provide additional information about CoC for Providers – All Members – data elements if pertinent.	Receiving DMC plan	7/1/25-6/30/26	Narrative

*Includes requests made by or on behalf of transitioning members who meet Special Population criteria

Figure 23. CoC Primary Care Dentist or Specialist

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
13	Cumulative number of transitioning members who requested to keep their Primary Care Dentists (PCD) or specialist	Previous DMC plan	One Time 5/1/25	Cumulative count

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
14	Cumulative number of transitioning members who retained their PCD or specialist	Receiving DMC plan	5/1/25-9/30/25	Cumulative count
15	Cumulative number of transitioning members who were denied CoC for PCD/specialist because the PCD/specialist was unavailable	Receiving DMC plan	5/1/25-9/30/25	Cumulative count

Figure 24. Member Issues Via Receiving DMC plan Member Call Centers

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(DMC plans will report for each county unless indicated)*
16	Total call volume to DMC plan member call centers	Receiving DMC plans	5/1/25-9/30/25	Total count
17	Total transition-related calls to DMC plan member call centers	Receiving DMC plans	5/1/25-9/30/25	Total count DMC plans will flag member calls as related to the "2025 Transition" and categorize by call types listed in Figure 25

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification *(DMC plans will report for each county unless indicated)*
18	Optional: DMC plans may provide additional information about Member Issues via Receiving DMC Plan Member Call Centers data element if pertinent.	Receiving DMC plans	5/1/25-9/30/25	Narrative

Figure 25. Transition-Related Categorization of Member Calls to DMC plan Member Call Centers

Category	Type
Access to Care	» General category that includes access to care types: geographic access, physical access, language access, timely access, rural member denied Out of Network request.
Continuity of Care	» Provider
	» Case management/care coordination
	» Treatment/Authorization
	» Transportation
	» Other Continuity of Care
General Transition	» General category which would include other issues such as enrollment, quality of service, referrals, confusion with plan change, information seeking or transition-related complaint (not leading to a formal grievance)

Figure 26. Member Issues Via Receiving DMC plan Grievances and Appeals

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	DMC Element Specification (DMC plans will report for each county unless indicated)
19	Total transitioning member grievances filed for all transitioning Members during the reporting period	Receiving DMC plans	7/1/25 – 12/31/25	Total count* of all grievances
20	Total transitioning member grievances filed with DMC plans for the top five grievance types	Receiving DMC Plans	7/1/25 – 12/31/25	Total count* for each of the top five grievance types
21	Total number of Timely Access grievances	Receiving DMC Plans	7/1/25 – 12/31/25	Total count* of Timely Access grievances
22	Total number of Provider Availability grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count* of Provider Availability grievances
23	Total number of Continuity of Care grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count* of Continuity of Care grievances
24	Total number of Transportation grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count*of all Transportation grievances

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	DMC Element Specification (DMC plans will report for each county unless indicated)
25	Total number of Quality of Care grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count* of all Quality of Care grievances
26	Total number of Case Management/Care Coordination grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count* of all Case Management/Care Coordination grievances
27	Total number of all other grievances	Receiving DMC Plans	7/1/25 - 12/31/25	Total count*of all other grievances
28	Total number of member appeals filed for all transitioning Members	Receiving DMC Plans	7/1/25 - 12/31/25	Total count* for each appeal type
29	Total transitioning member appeals filed with DMC plan by appeal type	Receiving DMC Plans	7/1/25 - 12/31/25	Total appeal count* for select appeal types as indicated in DHCS approved Excel template
30	Optional: DMC plans may provide additional information about Member Issues via Receiving DMC plan	Receiving DMC Plans	7/1/25 - 12/31/25	Narrative

*Total count should be limited to the total data collected during the data reporting

period**.** For example, during the bi-weekly reporting period, the total count would equal the number of grievances or appeals received/categorized over those two weeks**.**

Figure 27. Data Files Transmitted From Previous DMC plans

Data Element Number	**Data Element**	**Responsible for Reporting**	**Dates of Reporting**	**Data Element Specification** (DMC plans will report for each county unless indicated)
31	Data files transmitted from Previous DMC plans	Receiving DMC plan	5/1/25-9/30/25	Y/N: The DMC plan received all required CoC data files from Previous DMC s on the required refresh date, and data files were complete and of expected quality
32	Data files transmitted from Previous DMC plans	Receiving DMC plan	5/1/25-9/30/25	If No to 32, the DMC plan must provide a written explanation for each Previous DMC plan with which the Receiving DMC plan has a data sharing concern, with the following information: 1) Previous DMC plan(s) name and HCP code(s) 2) File name(s) that had the issue 3) Specific data element name(s) in each file 4) Description of the issue with each data element

Data Element Number	Data Element	Responsible for Reporting	Dates of Reporting	Data Element Specification (DMC plans will report for each county unless indicated)
33	Optional: DMC Plans may provide additional information about data file transmitted from Previous DMC plans if pertinent.	Receiving DMC plan	5/1/25-9/30/25	Narrative

B. Monitoring and Oversight Progression to Enforcement Action

Through monitoring and oversight activities, DHCS may determine that DMC plan enforcement action becomes necessary to address transition performance issues. DHCS will apply administrative and/or monetary sanctions in accordance with Welfare and Institutions Code (WIC) 14197.7, Title 42 of the Code of Federal Regulations (CFR) section 438.700 et seq., the DHCS DMC plan contract, and APL 22-009[73]. DHCS may take any one or a combination of enforcement actions including, but not limited to, require a CAP, assess a monetary sanction, or impose a non-monetary sanction.

In alignment with the Transition Guiding Principles in Section II, Introduction, DMC plans must work proactively to minimize disruptions to members during the Transition, particularly for vulnerable populations when the disruption can lead to member harm. For example, if a member is unable to access a medically necessary dental treatment due to a missed Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) service, DHCS may sanction the DMC plan for causing harm to the member and its failure to comply with the CoC policy outlined in this Transition Policy Guide and APL 25-002[74]. Pursuant to state and federal laws and regulations, DHCS may impose financial sanctions on DMC plans in the event of any harm caused to members. For a compliance issue that impacts members, each

[73] APL 22-009: Enforcement Actions: Administrative and Monetary Sanctions can be found here: https://www.dhcs.ca.gov/services/Documents/APL-22-009.pdf

[74] APL 25-002 Continuity of Care for DMC Members on or after July 1, 2025 can be found here: https://www.dhcs.ca.gov/services/Documents/MDSD/APL-25-002-Continuity-of-Care-for-DMC-Members-on-or-after-July-1-2025.pdf

member impacted constitutes a separate violation, and DHCS may impose sanctions for every violation.

VIII. TRANSITION POLICY FOR ASSESSMENTS AND SCREENING TOOLS

Dental Managed Care Plans (DMC plans) are required to provide assessments and screenings for new members. This section explains requirements for two (2) assessment and screening tools in the context of the 2025 DMC plan transition:

- Oral Health Information (OHIF)
- Initial Health Appointments(s)

A. Oral Health Information (OHIF)

The Oral Health Information Form (OHIF) is a screening tool that is required to be completed within 90 days of DMC plan enrollment for new members. It fulfills the federal initial screening requirement.[75] Receiving DMC plans must complete the OHIF for transitioning members within 90 days of July 1, 2025 regardless of whether the Previous DMC plan completed a OHIF for the member. DMC plans may fulfill the OHIF requirement in one of two ways:

1. The DMC plan contracts with a provider to complete the OHIF. The provider is responsible for following up on screening results. If the OHIF is not contracted to be done by providers, the DMC plan must either directly follow up on screening results or contract with the provider to complete the follow-up (and share relevant information with the provider to do so).
2. A provider completes the Initial Health Appointment(s) requirement for a transitioning member after the member transitions to the Receiving DMC plan and shares the completed Initial Health Appointment(s) with the Receiving DMC plan within 90 days of the member joining the DMC plan.

B. Initial Health Appointment(s)

Receiving DMC plans must ensure that a member has an Initial Health Appointment(s) within 90 days of the member transitioning to the Receiving DMC plan. The Initial Health Appointment(s) must include a history of the transitioning member's physical and behavioral health, an identification of risks, an assessment of needs for preventive screens or services and health education,

[75] 42 CFR 438.208(b)(3)-(4)

and the diagnosis and plan for treatment of any diseases. The Initial Health Appointment(s) requirement can be completed over the course of multiple visits.

The Receiving DMC plan is not required to complete the Initial Health Appointment(s) requirement within 90 days if the member's primary care dentist (PCD) determines that the member's dental record contains complete information, updated within the previous 12 months. The conclusion of the PCD's assessment must be documented in the member's dental record. Even if the member's PCD determines that the member's record contains complete information such that an Initial Health Appointment(s) does not need to be conducted within 90 days, the receiving DMC plan still needs to complete a OHIF for members within 90 days of a member transitioning.

Other reasons a member may not complete the Initial Health Appointment(s) are the following: Member disenrolled before 90 days; Member refuses Initial Health Appointment(s) completion; and reasonable attempts by the DMC plan or delegated provider to contact the member were unsuccessful. All Initial Health Appointment(s) attempts should be documented in the member's medical record. The following also applies:

1. For children and youth (i.e., individuals under age 21), Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings will continue to be covered in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule.
2. DMC plans should continue to hold network providers accountable for providing all preventive screenings for adults and children as recommended by the first visit so long as members receive all required screenings in a timely manner.

IX. GLOSSARY

2025 DMC plan Transition: Refers to changes to the Medi-Cal Dental Managed Care Plans (DMC plans) operating in specific counties slated to take effect on July 1, 2025,

Active Course of Treatment: A course of treatment in which a member is actively engaged with a provider and following the prescribed or ordered course of treatment as outlined by the provider for a particular medical condition.

Authorized Representative: 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 fair hearings, independent medical reviews, or in any other capacity, as specified by the member or potential member.

Care Manager: For the purposes of this policy, a Care Manager is inclusive of the Care Management (CM) Care Manager, as well as other care managers.

Care Management Plan: A written plan that is developed with input from the member and/or their family members, parents, legal guardians, Authorized Representatives, caregivers, and/or other authorized support person(s), as appropriate, to assess strengths, risks, needs, goals, and preferences, and to make recommendations for clinical and non-clinical service needs.

Care Management (CM): A service for DMC plan members who need extra support to avoid adverse outcomes

Continuing DMC plan: A DMC plan that operates within a county today and will continue to operate as a DMC plan within the county effective July 1, 2025. A Continuing DMC plan is one type of Receiving DMC plan.

Continuity of Care for Providers Agreement: A single case agreement (for a specific, named member) or letter of agreement (for multiple members) between a Receiving DMC plan and OON provider, intended to maintain trusted member/provider relationships until a member can transition to a network provider with the Receiving DMC plan. A Continuity of Care for Providers agreement enables transitioning members to continue receiving care from their existing providers for a period of time, if certain requirements are met.

Covered Services: Those health care services, set forth in Welfare and Institutions (W&I) Code sections 14000 *et seq*. and 14132 *et seq*., 22 California Code of Regulations (CCR) section 51301 *et seq.*, 17 CCR section 6800 *et seq.*, the Medi-Cal Provider Manual, the California Medicaid State Plan, the California section 1115 Medicaid Demonstration Project, the DMC plan Contract, and All Plan Letters (APLs), that are made the responsibility of the DMC plan pursuant to the

California section 1915(b) Medicaid Waiver authorizing the Medi-Cal dental managed care program or other federally approved managed care authorities maintained by DHCS.

Default Assignment: Process of assigning a member to an DMC plan to be enrolled into in the event that they do not make an active choice of DMC plan, where applicable; default assignment is inclusive of provider, plan and/or family "linkage" – by which a member is default assigned to an DMC plan that will maximize member continuity if one is available – and the Auto-Assignment algorithm, which assigns remaining members equally among the three DMC plans in the county.

Entering DMC plan: A DMC plan that does not operate as a DMC plan within Sacramento or Los Angeles counties today but will operate as a DMC Plan within Sacramento and Los Angeles counties starting July 1, 2025. An Entering DMC plan is one type of Receiving DMC plan.

Exiting DMC plan: A DMC plan that operates as a DMC plan within Sacramento and Los Angeles counties today and is exiting the market in those counties effective July 1, 2025, due to changes for the county. An Exiting DMC plan is one type of Previous DMC plan.

Member: A person eligible for Medi-Cal and enrolled in a dental managed care plan or Dental FFS.

Network Provider: Any provider or entity that has a Network Provider Agreement with the DMC plan, Subcontractor, or downstream Subcontractor and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to members. A network provider is not a Subcontractor or downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement: A written agreement between a network provider and

the DMC plan, the DMC plan's Subcontractor, or the DMC plan's' Downstream Subcontractor.

Out-of-Network (OON) Provider: A provider that is not a network provider (i.e., does not have a contract to participate in an DMC plan network).

Pre-Existing Relationship: When a member had at least one non-emergency visit with the provider during the 12 months preceding July 1, 2025. This Pre-Existing Relationship does not limit the Continuity of Care protections for members who have a health condition listed in the Knox-Keene Health Care Service Plan Act, California Health and Safety Code (H&S) section 1373.96.

Previous DMC plan: A DMC plan or Subcontractor DMC plan that a member is required to leave effective July 1, 2025, for one of the following reasons: (1) the DMC plan exits the market (i.e., an Exiting DMC plan), (2) the Subcontractor and the DMC plan terminate their Subcontractor Agreement, or (3) DHCS requires the DMC plan to

transition members to a Subcontractor DMC plan.

Prior Authorization: A formal process requiring a provider to obtain advance approval of the amount, duration, and scope of non-emergent Covered Services.

Primary Care Dentist (PCD): A dental provider responsible for supervising, coordinating, and providing initial and primary care to members, for initiating referrals, for maintaining the continuity of member care, and for serving as the Medical Home for members. The PCD is a general dentist.

DMC plan: A DMC plan that directly contracts with DHCS to provide Covered Services to members within the county or counties specified in their contract.

Prior Authorization: A formal process requiring a Provider to obtain advance approval of the amount, duration, and scope of non-emergent Covered Services.

Provider: Any individual or entity that is engaged in the delivery of Covered Services, or in ordering or referring for those services, and is licensed or certified to do so.

Receiving DMC plan: A DMC plan or Subcontractor DMC plan that a member joins by choice or default after being required to leave a Previous DMC plan effective July 1, 2025. Receiving DMC plans may be Continuing DMC plans or Entering DMC plans in a county.

Special Populations: Members most at risk for harm from disruptions in care or who are least able to access CoC protections by request and who are identifiable in DHCS data or Previous DMC plan data.

Subcontractor: An individual or entity that has a Subcontractor Agreement with an DMC plan that relates directly or indirectly to the performance of the DMC plan's obligations under the DMC plan Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement: A written agreement between the DMC plan and a Subcontractor. The Subcontractor Agreement must include a delegation of the DMC plan's duties and obligations under the contract.

Subcontracted DMC plan: A DMC plan that contracts with the DMC plan to assume full or partial risk of a portion of the DMC plan's membership.

Transitioning Member: A member of a Previous DMC plan or Dental FFS who enrolls in a Receiving DMC plan on July 1, 2025, due to the Previous DMC plan exiting the county or another required transition to a DMC plan or Subcontractor. The term "transitioning member" excludes those members who opt to change DMC plan by choice.

X. APPENDIX: COUNTY-LEVEL DMC PLAN TRANSITIONS

Background

The following table lists Medi-Cal dental managed care (DMC) plan changes slated to take effect July 1, 2025. The changes are the result of DMC plan contracting agreements. The table also outlines relevant transition-related policies as applicable to each Sacramento and Los Angeles counties' Medi-Cal members. Updates may be made on an ongoing basis to this appendix as relevant.

The following Key Terms are defined as follows for the purpose of this appendix::

- **DMC plan:** A DMC plan that directly contracts with DHCS to provide Medi-Cal services to members within the county or counties specified in their contract.
- **Exiting DMC plan:** A DMC plan that operates as a DMC plan within a Los Angeles and Sacramento counties today and is exiting the counties effective July 1, 2025 due to changes in DMC plan contracts for the counties
- **Continuing DMC plan:** A DMC plan that operates within Sacramento and Los Angeles counties today and will continue to operate as a DMC plan within the counties in 2025.
- **Entering DMC plan:** A DMC plan that does not operate as a DMC plan within Sacramento and Los Angeles counties today and will operate as a DMC plan within the county starting July 1, 2025.
- **Default Assignment:** The process of assigning a member to a DMC plan to be enrolled into. In the event that the member does not make an active choice of DMC plan, the member is default assigned to a DMC plan that will maximize member continuity if one is available based upon provider, plan and/or family "linkage". If no "linkage" exists, the Auto-Assignment Algorithm, assigns remaining members, equally among the three DMC plans in the county.

Figure 28: Transition-Related Enrollment and Noticing Policy for Los Angeles County

DMC Plan Changes	Transition-Related Enrollment & Noticing Policy
Los Angeles County – Voluntary DMC Enrollment	
Exiting DMC Plan » Access Dental Plan (Access) **Continuing Dental Options** » Dental FFS » Health Net of California (Health Net) » Liberty Dental Plan (Liberty) **Entering DMC Plans** » California Dental Network (CDN)	**Existing Access Members** » Gainwell will send "90-day" notices to members (no later than April 1, 2025) indicating forthcoming DMC Plan changes effective July 1, 2025 » Medi-Cal Health Care Options will send members a DMC plan choice packet and a "60-day" notice (no later than May 1, 2025), which will indicate a member's default assigned DMC plan, followed by a "30-day" notice (no later than June 1, 2025) » Members may voluntarily choose between CDN, Health Net, or Liberty for July 1, 2025 effective enrollment » Exiting DMC plan (Access) members that do not make an active choice by June 24, 2025 will be automatically enrolled into Dental FFS **Existing Health Net and Liberty Members** » Health Net and Liberty members will not receive transition notices and will not be compelled to change DMC plans **New Medi-Cal Members Beginning in Q2 2025** » After March 24, 2024, newly eligible Medi-Cal members will no longer be able to enroll with the exiting DMC Plan (Access Dental Plan) » Medi-Cal Health Care Options will send all other new members a DMC plan choice packet at the time of initial eligibility; members may actively choose between CDN, Health Net, or Liberty. Members that do not make an active choice will be automatically enrolled into Dental FFS.

Figure 29: Transition-Related Enrollment and Noticing Policy for Sacramento County

DMC Plan Changes	Transition-Related Enrollment & Noticing Policy
Sacramento County – Mandatory DMC Enrollment	
Exiting Dental Options » Access » Dental FFS **Continuing DMC Plans** » Health Net » Liberty **Entering DMC Plans** » CDN	**Existing Access and Dental FFS Members** » Gainwell will send "90-day" notices to members (no later than April 1, 2025) indicating forthcoming DMC Plan changes effective July 1, 2025 » Medi-Cal Health Care Options will send members a DMC plan choice packet and a "60-day" notice (no later than May 1, 2025), which will indicate a member's default assigned DMC plan, followed by a "30-day" notice (no later than June 1, 2025) » Members may actively choose between CDN, Health Net, or Liberty for July 1, 2025 effective enrollment » Exiting DMC plan (Access) members that do not make an active choice by June 24, 2025 will be automatically enrolled into CDN, Health Net, or Liberty based on default assignment **Existing Health Net and Liberty Members** » Health Net and Liberty members will not receive transition notices and will not be compelled to change DMC plans **New Medi-Cal Members Beginning in Q2 2025** » After March 24, 2025, newly eligible Medi-Cal members will no longer be able to enroll with the exiting DMC Plan (Access Dental Plan) » Medi-Cal Health Care Options will send all other new members a DMC plan choice packet at the time of initial eligibility; members may actively choose between CDN, Health Net, or Liberty

DMC Plan Changes	Transition-Related Enrollment & Noticing Policy
	» Members that do not make an active choice will be automatically enrolled into a DMC plan based on default assignment

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