2024 Medi-Cal Managed Care Plan Transition Policy Guide FAQs

The below frequently asked questions (FAQs) are a companion resource to the 2024 Medi-Cal MCP Transition Policy Guide (Policy Guide). While this technical FAQ document is primarily geared toward Medi-Cal managed care plans (MCPs) as the audience, it is also useful for other stakeholders including advocates, providers, counties, and others who may be working with members during the transition. The FAQs are organized by Policy Guide section and will be updated on a regular basis. Questions on the Policy Guide should be sent to MCPTransitionPolicyGuide@dhcs.ca.gov.

Member Enrollment and Noticing 1
Continuity of Care 3
Transition Policy for Enhanced Care Management 14
Continuity of Care Data Sharing Policy 15
Transition Monitoring and Related Reporting Requirements 16

Member Enrollment and Noticing

1. For transitioning members, how will members be notified of changes to their Managed Care Plan?

   Members transitioning Managed Care Plans (MCPs) due to the 2024 MCP Transition will have a January 1, 2024, effective enrollment date. Transitioning members will receive notification prior to the transition. Additional details on notification can be found on the Medi-Cal Managed Care Plan Transition Member webpage.

2. Will members who are required to exit their current MCP be assigned to MCPs by DHCS after January 1, 2024?

   Transitioning members, eligible for MCP enrollment, will be required to exit their current MCP to join a new MCP (by choice or default assignment) no later than January 1, 2024, as applicable. Some members who are required to exit their current MCP will receive a choice packet no later than November 3, 2023, including all 2024 MCP options in their county.

   Members will have until December 22, 2023, to make an active MCP choice. If the member does not actively choose a new MCP, the member will be enrolled in the

MCP according to their default assignment identified on the notices that they received and will be effective January 1, 2024.

In Single Plan and County Organized Health System (COHS) expansion counties, members who are required to exit their current MCP will be automatically enrolled into the COHS, Single Plan or Kaiser (where applicable) effective January 1, 2024.[1]

Kaiser Enrollment:

3. Since Kaiser will have a direct contract with DHCS in 32 counties beginning in 2024, does that mean Kaiser will no longer have subcontracts with MCPs in California?
   Correct. Kaiser will operate as an MCP in 32 counties and have a direct contract with DHCS beginning 2024, including 22 counties where Kaiser currently participates in Medi-Cal today (either as a prime or subcontracted MCP).

4. What will enrollment look like once Kaiser is added as a MCP in COHS counties?
   Beginning January 1, 2024, members can contact Health Care Options (HCO) for any questions about plan enrollment by visiting the HCO website: www.healthcareoptions.dhcs.ca.gov or calling HCO at
   1-800-430-4263 (TTY 1-800-430-7077), Monday – Friday, 8 a.m. to 6 p.m.

5. Can a Prime MCP enroll newly eligible members in subcontractor Kaiser after September 2023 Month of Enrollment (MOE)?
   No, new enrollment into the Kaiser subcontract ends effective September 2023 MOE. However, per the Policy Guide, exceptions may be made to protect continuity of care, specifically if the member is in active treatment with Kaiser – such as cancer treatment, pregnancy, or other care need - and is requesting assignment to Kaiser prior to January 1, 2024. Exceptions would also apply for newborn babies of existing Kaiser Medi-Cal members.

[1] Note: A small percentage of Medi-Cal members are enrolled in fee-for-service (FFS) Medi-Cal due to a medical exemption request (MER). In COHS and Single Plan model counties, Medi-Cal managed care enrollment is mandatory. In counties transitioning to the COHS or Single Plan model, an estimated 400 Medi-Cal members in FFS have an active MER that is set to expire in CY 2024. These members will remain in FFS until their MER expires before transitioning enrollment to an MCP in CY2024.

Continuity of Care

1. Does the 2024 MCP Transition Continuity of Care policy (CoC) apply to counties with new models, such as Single Plan?
   Yes, the CoC policy applies to members required to transition plans in counties that changed Medi-Cal managed care models, such as Single plan counties.

2. Do members transitioning from Medi-Cal Fee-for-Service (FFS) to Medi-Cal managed care have CoC protections?
   Yes, All Plan Letter 23-022 provides guidance on CoC protections for members transitioning from Medi-Cal FFS to Medi-Cal managed care.

   Children and 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 who are transitioning from FFS to a managed care plan in COHS expansion counties or from an exiting MCP to a new MCP effective January 1, 2024, are also covered by the CoC protections present in the Policy Guide.

3. Should the MCP or the provider ever contact the member to resolve a question of payment for services or benefits the member received?
   No, MCPs and providers must work out any questions about payment or payer responsibility; they should not contact the member. In no circumstance should the member be balance billed for covered Medi-Cal services.

4. Are all providers required to be a California Medicaid State Plan approved provider to be eligible for CoC for Providers?
   Yes, the provider must be enrolled and participating in the Medi-Cal program, with the exception of provider types that do not have an enrollment pathway. Examples of providers without an enrollment pathway include Behavioral Health Treatment (BHT) providers, Applied Behavior Analysis (ABA) providers, and many Community Supports providers (e.g., housing agencies, medically tailored meal providers). These providers must be vetted by the Receiving MCP.

5. Is a request from a member, authorized representative, or provider sufficient for the Receiving MCP to honor Prior Authorizations?

No, following a request from a member, authorized representative, or provider, the Receiving MCP must obtain the Prior Authorization from the Previous MCP or the provider in order to honor it.

6. Is the Receiving MCP only required to honor Prior Authorizations if the OON provider agrees to enter into a CoC agreement with the MCP?
   No, the Receiving MCP must honor a Prior Authorization even when the OON provider does not enter into a CoC for Provider agreement. In this case, the Receiving MCP would find a network provider to deliver the previously authorized service(s).

7. Does the 2024 MCP Transition CoC apply to all members who are required to leave their current MCP and transition to a new MCP on January 1, 2024?
   Yes, the 2024 CoC policy applies to all members required to change MCPs on January 1, 2024, including members who actively choose a new MCP as part of the transition as well as members who are default-assigned to a new MCP, due to the following: (1) the member's MCP exits the market, (2) the subcontractor agreement between the member's Prime MCP and the subcontractor ends, and (3) DHCS requires the Prime MCP to transition members to the subcontractor. The CoC policy does not apply to routine member-initiated transitions to a new MCP. (See #8 for more information about routine member-initiated transitions after January 1, 2024.)

8. What does this statement mean? The 2024 MCP CoC Policy does not apply to members who change MCPs by choice after January 1, 2024.
   The CoC Policy applies to members required to transition from their current MCP to a new MCP on January 1, 2024. If a member chooses another MCP for any reason on or after January 1, 2024, the CoC Policy will no longer apply to the member when enrolled in their newly-chosen MCP. (See #7 for more information regarding the requirement to transition MCPs effective January 1, 2024.)

9. How do the requirements for the CoC policy apply to subcontractors, for example, a subcontracted IPA?
   Prime MCPs are ultimately responsible for ensuring the CoC policy is implemented, irrespective of any subcontracting relationship.

10. Are the following provider types eligible for CoC for Providers: speech therapists, occupational therapists, physical therapists, licensed marriage and family therapists (LMFT), developmental pediatricians, and providers of applied behavioral analysis (ABA) services and psychological services?

    Yes, speech therapists, occupational therapists, and physical therapists are eligible for CoC for Providers, and are specified under 'Select Ancillary Providers' as displayed in Figure 3: Provider Types Eligible for Continuity of Care for Providers, in Section V.C. of the Policy Guide. LFMTs, developmental pediatricians, and providers of ABA services and psychological services are included in the provider type 'Specialists' in the same Figure 3.

11. Do members have to be in an active course of treatment at the time of the transition (January 1, 2024) to request CoC for Providers?

    No, members do not have to be in an active course of treatment at the time of the transition to request CoC for Providers. A request for CoC for Providers is only necessary if the provider is not already contracted with the Receiving MCP as a network provider. The member may request CoC for Providers for any eligible provider as indicated in Figure 3: Provider Types Eligible for Continuity of Care for Providers, in Section V.C. of the Policy Guide. Among other requirements (see section V.C. in the Policy Guide), the member must have a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding January 1, 2024.

12. How does continuity of care work as it relates to providers? For example, if a member needs physical therapy for a shoulder injury in February 2024, can the member request CoC for Providers to see the same physical therapist the member saw in August 2023 for an unrelated knee injury?

    Yes. A request for CoC for Providers is only necessary if the provider is not already contracted with the Receiving MCP as a network provider. The member may request CoC for Providers for any eligible provider (a physical therapist is an eligible provider type, as indicated in Figure 3: Provider Types Eligible for Continuity of Care for Providers, in Section V.C. of the Policy Guide). Among other requirements (see Section V.C. in the Policy Guide), the member must have a Pre-Existing Relationship with the eligible provider, defined as at least one non-emergency visit during the 12 months preceding January 1, 2024. The visit from August 2023 for an unrelated service would fulfill this requirement.

13. Are members receiving substance use disorder (SUD) services included in Special Populations?

    Not all members receiving SUD services are included in Special Populations. Members who are "Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality" are included in Special Populations, as displayed in Figure 2: List of Special Populations, in Section V.C. of the Policy Guide. This population will be identified via National Drug Codes (NDCs), which include drugs used for substance use disorder treatment, such as Buprenorphine.

14. What are some examples of the Receiving MCP streamlining outreach to and communication with eligible providers for Special Populations to minimize MCP and provider administrative burden?

    Receiving MCPs could streamline their communications to eligible providers by:

    - Identifying all Special Population members with Pre-Existing Relationships with an eligible provider (based on utilization data provided to the Receiving MCP);
    - Sharing the file of Special Population members with the eligible provider at one time; and
    - Executing one CoC for Provider agreement covering all identified Special Population members.

    DHCS encourages its MCP partners to collaborate with one another and share best practices to reduce administrative burden and create efficiencies.

15. Will Receiving MCPs be allowed to reassess members living with chronic conditions such as serious mental illness (SMI), serious emotional disturbance (SED), or medical conditions eligible for California Children's Services (CCS)?

    These members are Special Populations and, as such, the Receiving MCP must continue to honor prior authorizations and active courses of treatment for a full 6-month CoC for Services period (until July 1, 2024) and until reassessment.

16. Can Receiving MCPs identify an alternate DME provider for the member if the OON provider does not agree to enter into a CoC for Provider agreement with the Receiving MCP?

    No, the Receiving MCP must allow members to keep their existing DME rentals and medical supplies from their existing DME providers without further authorization for

6 months after the January 1, 2024 MCP transition and until reassessment, and the new equipment or supplies are in possession of the member and ready for use. This includes DME or medical supplies that have been arranged for but not yet delivered, in which case the Receiving MCP must allow the delivery and permit the member to keep the equipment or supplies for a minimum of 6 months and until reassessment.

17. Do the same CoC requirements defined in APL 23-022 apply?
All Plan Letter 23-022 provides guidance on Continuity of Care protections for members transitioning from Medi-Cal FFS to Medi-Cal managed care. All Plan Letter 23-018 and the 2024 Medi-Cal Managed Care Plan Transition Policy Guide provide guidance for members in Medi-Cal managed care who are required to change MCPs on January 1, 2024. Children and 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 who are transitioning from FFS in COHS expansion counties or from managed care effective January 1, 2024 are also covered by the CoC protections present in and the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

18. How does the CoC policy apply to members who are transitioning to Kaiser? Which portions of the CoC policy apply to members transitioning to Kaiser?
The 2024 MCP Transition CoC policy, including the transition policies for ECM and Community Supports, applies to members who are required to transition from their current MCP and are either default assigned to Kaiser or who choose Kaiser by December 22, 2023. CoC protections are particularly important for members who have providers outside the Kaiser network and who will transition to Kaiser as a Prime MCP effective January 1, 2024. The CoC policy does not apply to routine member-initiated transitions to a new MCP, including Kaiser.

19. What are some examples of how Receiving MCPs can offer added protection that is more expansive than the CoC policy for the 2024 MCP Transition?
Receiving MCPs are permitted, but not required, to establish more generous CoC protections than what are outlined in the CoC Policy. Examples of additional protections Receiving MCPs could offer to transitioning members include:

    - An MCP could choose to include additional members as Special Populations members based on cultural and linguistic needs that may be prevalent in the community in which the MCP operates, and/or based on diagnosis codes or

health conditions not already defined in Figure 2: List of Special Populations, in Section V.C. of the Policy Guide.

- An MCP could include additional provider types to qualify for CoC for Provider agreements, such as some or all of the types included in Figure 4: Examples of Provider Types Ineligible for Continuity of Care for Providers in Section V.C. of the Policy Guide.
- An MCP could extend the CoC for Services period beyond the 6 month requirement in the CoC Policy.
- An MCP could honor an upcoming scheduled appointment with an OON specialty provider with whom the member does not have a pre-existing relationship.

20. Are members living with autism-related diagnoses included in Special Populations?
Yes, members living with autism-related diagnoses are included in Special Populations. These members are included in Figure 2: List of Special Populations, in Section V.C. of the Policy Guide, as members who are "Living with an intellectual or developmental disability (I/DD) diagnosis." ICD-10 codes will be used to identify members in this Special Population including F84.0 – Autism Spectrum Disorder – and are included in the Excel template accompanying the Policy Guide entitled "Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications." The data template was shared with MCPs. Email MCPTransitionPolicyGuide@dhcs.ca.gov to obtain a copy of the data template.

21. How should Receiving MCPs balance the CoC requirements for members residing in Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD) in the 2024 Medi-Cal Managed Care Plan Transition Policy Guide versus the CoC requirements in APL 23-023?
For members residing in ICF/DDs, MCPs are subject to one set of CoC requirements, as follows:

- The Policy Guide applies to members in managed care before January 1, 2024.
- APL 23-023 applies to members in FFS before January 1, 2024.

MCPs should refer to APL 23-023 for more information about the ICF/DD transition to managed care occurring on January 1, 2024.

22. What is DHCS' intent for requiring Receiving MCPs to include the date of the CoC request in the member notice pertaining to the CoC for Provider request?
    The intention for requiring the date of the CoC request in the member notice is to provide clear tracking of the length of time the MCP took to process the request. The member notification should show both the date the request was received and the date the MCP notified the member. If the length of time between these dates is out of compliance with the requirements in the CoC policy, the letter will aid the member's ability to file a grievance.

23. Are MCPs required to contract with providers serving Special Population members, or are MCPs 'encouraged?'
    MCPs are not required to contract with providers serving Special Population members. However, DHCS strongly encourages contracting with providers serving transitioning members at the Previous Plan as contracts are the most effective solution to minimize disruptions to care for Special Population members. DHCS does require Receiving MCPs to proactively **contact** all eligible OON providers with whom Special Population members have Pre-Existing Relationships to initiate Network Provider Agreements or Continuity of Care for Providers agreements. Receiving MCPs are required to enter into continuity of care agreements with Special Populations providers in the event all requirements from Section V.C are met:

    - The provider is providing a service that is eligible for CoC 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 January 1, 2024;
    - The provider is willing to accept the Receiving MCP's contract rates or Medi-Cal FFS rates;
    - The provider meets the Receiving MCP's applicable professional standards and has no disqualifying quality of care issues; and
    - The provider is a California Medicaid State Plan approved provider.

    If the Receiving MCP cannot establish a network agreement or a CoC for Providers agreement with a member's provider, the Receiving MCP must assign the member a new network provider.

24. Is the MCP required to contact all providers who provided services to Special Populations members in the last 12 months, even if the member has no need for continuity with some of the providers?
    Yes. To minimize disruptions in care and risk of harm for transitioning Special Populations members, the Receiving MCP is required to contact all eligible OON providers serving Special Populations members to initiate a Network Provider Agreement or a CoC for Providers agreement when the requirements outlined in Section V.C. of the Policy Guide are met. If the provider does not believe there is a need for continuity (e.g., a member has no upcoming scheduled appointments), the provider can decline to enter into an agreement with the Receiving MCP.

25. What are some examples of the types of things Receiving MCPs should closely monitor in Special Population members' care utilization leading up to and during the first 90 days of the 2024 MCP Transition (January 1, 2024 – March 31, 2024), to understand the members' care needs and minimize gaps in care?
    Examples of activities that Receiving MCPs could perform to monitor Special Population members' care utilization leading up to and during the transition include, but are not limited to:
    - Reviewing utilization data and authorization requests for services from Previous MCPs that might indicate gaps in care or the need to follow up with members and their providers, such as:
        - Recent emergency department (ED) visits *(e.g., has the member completed appropriate follow up after the ED visit?)*
        - Recent inpatient hospital stays *(e.g., has the member completed appropriate follow up after the hospital stay?)*
    - Reviewing premature prescription refills of high-risk medications like insulin, respiratory medications, oxygen
    - Monitoring member call center activity
    - Examining member grievances

26. What documentation does the Receiving MCP need to continue a member's active course of treatment?

    The 2024 MCP transition defines active course of treatment as "a course of treatment in which a member is actively engaged with a provider prior to January 1, 2024." The Previous MCP should have utilization or authorization data for the course of treatment and is required to transfer that data to the Receiving MCP to provide the necessary documentation.

27. There are requirements to be met if a member wants to retain a prior provider under CoC (e.g., prior relationship can be verified, provider agrees to reimbursement rates). In CoC for Covered Services, are there similar thresholds a member must meet?

    The only requirements for CoC for Services are that, between November 2, 2023 and June 30, 2024, the Receiving MCP is provided the following:

    - Documented evidence of a prior authorization; and/or
    - Documented evidence that a member is engaged in an active course of treatment.

    The Previous MCP should have the authorization data as well as utilization and/or authorization data to verify the member's active course of treatment, and is required to transfer that data to the Receiving MCP.

28. To whom does CoC of Care Coordination and Management Information apply? Does this apply to members who are authorized for care management, but not receiving those services as of January 1, 2024?

    CoC of Care Coordination and Management Information applies to members who are receiving care management services and must change to a new Care Manager on January 1, 2024, upon transitioning to their Receiving MCP.

    CoC for Care Coordination and Management Information also applies to transitioning members discharged from an inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023, and transitioning members accessing the transplant benefit.

    It is unlikely that members receiving ECM will be impacted since members receiving ECM services do not receive care management directly from the MCP, and since mandatory overlap of the Previous MCP's and Receiving MCP's ECM Providers to the

maximum extent possible is required. However, if the Receiving MCP is unable to contract with a member's ECM provider, the MCP must follow the CoC for Providers requirements in Section V.C. and CoC for Care Coordination and Management Information applies.

29. How will MCPs store non-member data and interactions in compliance with HIPAA before January 1, 2024 when the Receiving MCP's call center must assist transitioning members?
    The Receiving MCP should work with its privacy and security experts to establish a system to intake and store transitioning member data prior to January 1, 2024 in compliance with HIPAA regulations. The Receiving MCP should also establish a mechanism to track any calls or requests pertaining to transitioning members and detail how those requests are adjudicated.

30. Will members be notified if their provider is a network provider in both the Previous MCP and the Receiving MCP? Are members required to take action if their provider is in both networks?
    No, members are not notified if their provider is in both the Previous MCP's and Receiving MCP's networks. Members should contact their new MCP or Health Care Options (HCO) to determine if their provider is a network provider. No action is required by the member if the provider is in both networks.

31. How and when are members notified about their right to CoC and who to contact?
    In October 2023, members enrolled in an exiting MCP received notice from their exiting MCP to inform them of their MCP's upcoming exit from their county and indicate that additional information would be forthcoming from DHCS regarding their MCP enrollment for 2024. In November, members received a 60-day notice (in-hand 11/1) and in December members will receive a 30-day notice (in-hand 12/1) from DHCS. These member notices provide members with information on CoC and direct them to call their new MCP or Medi-Cal HCO to find out more information. All notices also provide members with contact information for questions or complaints and a link to the Notice of Additional Information (NOAI) posted on the DHCS website and accessible through a Quick Response (QR) code. The NOAI includes more detailed information about how members can request CoC for their providers and services (e.g., appointments, DME, etc.). Members can also request a printed

NOAI to be sent by mail at Medi-Cal HCO Monday – Friday, 8 a.m. to 6 p.m. at 1-800-430-4263 (TTY: 1-800-430-7077).

32. How will the Receiving MCP pay for a member's covered services (e.g., DME), whether prior authorized by the Previous MCP or as part of an active course of treatment, when the Receiving MCP requires an authorization for the service and there is none in the Receiving MCP's system?

The Receiving MCP is required to use data transferred from the Previous MCP to ensure CoC for Services and pay members' providers* for covered services on dates of service when members are enrolled with the Receiving MCP. Receiving MCPs should use the following data to carry out CoC for Services requirements as outlined in the Policy Guide:

- Prior authorization data
- Utilization data demonstrating an active course of treatment
- Other documentation demonstrating an active course of treatment

The Receiving MCP is responsible to ensure that previously authorized services are paid.

*Note: MCPs must follow Policy Guide requirements regarding in-network and OON providers.

Transition Policy for Enhanced Care Management

1. Who is included in the Special Population category "Adults and children authorized to receive Enhanced Care Management services?"
   This Special Population includes adult and children transitioning members with authorizations to receive Enhanced Care Management (ECM) services; members do not have to be actively receiving ECM on December 31, 2023 to qualify for the Special Population designation. See the ECM Policy Guide for more information as to how members are authorized for ECM services.

2. Is 100% network overlap of ECM providers between the previous and receiving MCP expected in COHS counties?
   Yes, the Transition policies in their entirety, including the mandatory network overlap of ECM providers to the maximum extent possible, apply in all counties impacted by the January 1, 2024 transition.

Continuity of Care Data Sharing Policy

1. Are Subcontractors, such as IPAs that are delegated risk for a subpopulation, required to share data with Receiving MCPs or DHCS to support the 2024 MCP Transition?
   Section VIII of the Policy Guide contains requirements for Previous Prime MCPs to share data with DHCS and Receiving Prime MCPs. Unless otherwise specified by DHCS, Prime MCPs are responsible for ensuring that subcontractors, including those IPAs that are delegated risk for a subpopulation, share and receive all data elements outlined in Section VIII on a timely basis in accordance with existing subcontractor agreements.

2. What are the expectations for the Previous MCP to work with the Receiving MCP to fill data gaps for CoC data sharing?
   It is essential that Receiving MCPs receive accurate, timely data from Previous MCPs to implement the required CoC protections for transitioning members. While the Previous MCP is required to capture all necessary data elements through the data transfer process and timeline outlined in Section VIII of the Policy Guide, there may be data lag or data quality issues that require the Previous MCP to resubmit files or communicate with the Receiving MCP. As noted in the timeline in the Policy Guide, Previous MCPs are required to share data with Receiving MCPs through the first quarter of 2024. DHCS will perform verification checks to confirm successful data sharing according to timeliness and quality expectations. If the Previous MCP does not meet data requirements, the MCP may be subject to enforcement actions.

Transition Monitoring and Related Reporting Requirements

1. What oversight is happening to reinforce that MCPs comply with CoC requirements? If CoC is not upheld, what can members do?
   Section IX of the Policy Guide outlines the transition monitoring and oversight requirements that will allow DHCS to ensure that MCPs comply with transition mandates, particularly with continuity of care. The same Section notes that DHCS may take administrative and/or monetary sanctions to address MCP transition performance as necessary. Members retain their standard rights to file grievances and/or appeals including, for example, if a member disagrees with a Receiving MCP's CoC determination. Members can call or email the Medi-Cal Office of the Ombudsman or the Department of Managed Health Care (DMHC) Help Center for help understanding these rights and how to file grievances and appeals.[2] Members can contact:

   Medi-Cal Ombudsman

   1-888-452-8609.
   TTY

   California State Relay at 711
   Hours

   Monday – Friday, 8 a.m. to 5 p.m.
   Email

   MMCDOmbudsmanOffice@dhcs.ca.gov

   Department of Managed Health Care Help Center

   1-888-466-2219

   Hours

   Monday – Friday, 6 a.m. to 6 p.m.
   Email

   helpline@dmhc.ca.gov

[2] Medi-Cal MCPs under the purview of DMHC include all MCPs *except* County Organized Health Systems (with the exception of Health Plan of San Mateo).