State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

DATE: *APRIL 3, 2014*

ALL PLAN LETTER 13-013 *(REVISED)*

TO: *ALL NON-COUNTY ORGANIZED HEALTH SYSTEM MEDI-CAL MANAGED CARE HEALTH PLANS*

SUBJECT: CONTINUITY OF CARE FOR NEW ENROLLEES TRANSITIONED TO MANAGED CARE AFTER REQUESTING A MEDICAL EXEMPTION

PURPOSE:
The Department of Health Care Services (DHCS) revised All Plan Letter (APL) 13-013, originally dated October 4, 2013, to address not only Two-Plan and Geographic Managed Care health plans, but all non-County Organized Health System (COHS) Medi-Cal managed care health plans (MCPs) and to update the File Posting Schedule for calendar year 2014.

DHCS is issuing APL 13-013 *(Revised)* to inform *all non-COHS model* MCPs that they must ensure continuity of care for Medi-Cal beneficiaries who transition from fee-for-service (FFS) Medi-Cal into Medi-Cal managed care. This APL also provides MCPs with access to a new data file through which DHCS will notify MCPs of beneficiaries who are transitioning from FFS Medi-Cal to a MCP, and have submitted a Medical Exemption Request (MER) and/or an Emergency Disenrollment Exemption Request (EDER).

BACKGROUND:
State law requires MCPs to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving from a non-participating provider or from a terminated provider, subject to certain conditions. Those services must be provided for up to 12 months for the following: an acute condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn child, and the performance of certain previously planned surgeries.[1]

In addition, State regulations allow certain beneficiaries to request a medical exemption from MCP enrollment for up to 12 months to complete a treatment with their current Medi-Cal FFS provider(s).[2] This treatment must be for a complex medical condition and must be

[1] Health & Safety Code § 1373.96.
[2] Exemptions from enrollment in Two-Plan Model and Rural Model health plans are governed by Title 22 of the California Code of Regulations (CCR), Section 53887. Exemptions from enrollment in Geographic Managed Care health plans are set forth in Title 22 CCR 53923.5.

provided by a physician, certified nurse midwife, or licensed midwife who is participating in FFS Medi-Cal and is not contracted with any of the MCPs available in an eligible beneficiary's county of residence.

A beneficiary who has been granted a medical exemption from MCP enrollment may remain with the FFS Medi-Cal provider until his or her medical condition has stabilized to a level that would enable him or her to change to a MCP physician without deleterious medical effects, as determined by the beneficiary's FFS Medi-Cal provider. At any time, including during the exemption verification process, DHCS may verify the complexity, validity, and status of the beneficiary's medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a MCP in the beneficiary's county of residence. DHCS may deny a request for exemption from MCP enrollment or revoke an approved exemption if a provider fails to fully cooperate with DHCS's verification process.

If a beneficiary files a MER that is denied, the beneficiary may still be entitled to continuity of care as further explained below.

POLICY:
MCPs are required to consider a request for exemption from MCP enrollment that is clinically denied as a request to complete a course of treatment with an existing FFS provider under Health and Safety Code (H&S Code) Section (§) 1373.96, and in compliance with the MCP's contract with DHCS and any other continuity of care APL issued by DHCS. MCPs must ensure that all beneficiaries continue to receive medically necessary Medi-Cal services and ensure new enrollees are entitled to receive continuity of care with their existing providers for the completion of those services to the extent authorized by law. Continuity of care timeframes are established under H&S Code §1373.96. This continuity of care policy is in addition to the extended continuity of care policy for Seniors and Persons with Disabilities (SPDs) established under APL 11-019.[3]

MCPs must treat every exemption listed on the "Exemption Transition Data" report (see Attachment A for data file format details) as an automatic continuity of care request for the identified beneficiary. Once a MCP is notified that a beneficiary is on the Exemption Transition Data report, the MCP must make every effort to ensure that the beneficiary is allowed to continue to receive ongoing medical care through his or her FFS provider(s) for the period specified in H&S Code §1373.96 for a particular illness or condition.

MCPs must begin processing requests for extended continuity of care within five working days from their receipt of the requests. In this case, receipt of the Exemption Transition Data report constitutes such a request. MCPs must complete their responses to each request within 30 calendar days from the date the MCP receives it, or sooner if the beneficiary's medical condition requires more immediate attention. If a beneficiary

[3] APL 11-019 and all APLs are available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

voluntarily chooses to change MCPs, the completion of covered services shall be continued by the new MCP for a period of up to 12 months from the date of enrollment into Medi-Cal managed care.

MCPs must provide information to beneficiaries about their continuity of care rights as well as to providers (both in and out of network) about the requirements set forth in this APL. MCPs must, at a minimum, include information about continuity of care in provider training and new member orientation materials.

MCPs must oversee and remain accountable for the requirements in this APL even if they subcontract with an independent physicians association, medical group, or other entity. In addition, MCPs must monitor subcontractors to ensure compliance with this APL. If the beneficiary's FFS provider is not in the MCP's provider network, DHCS strongly encourages the MCP to secure a letter of agreement, memorandum of understanding, or contract with the provider to assure continuity of care under this APL and to enable the provider to join the MCP's network.

For coordination of care and care transition efforts required under H&S Code §1373.96, DHCS strongly encourages MCPs to allow non-contracted providers to continue a beneficiary's treatment plan for other, non-contracted services, such as laboratory testing and durable medical equipment and maintenance.

MCPs must immediately refer SPDs for a health risk assessment, as is required under Policy Letter 12-004[4], and an individual care plan must be developed within ten days of enrollment in the MCP, including authorization for 30 days of continuity of prescription drugs, as required by Welfare and Institutions Code (W&I Code) §14182(b)(22). MCPs must permit a beneficiary to continue the use of a single-source drug that was prescribed immediately prior to his or her date of enrollment, whether or not that drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the contracting physician, as required by W&I Code §14185(b) or until a new care plan is established by the MCP that does not include the drug. There is no limit to the number of drugs that may be subject to this requirement, as long as the drug(s) is part of a prescribed therapy in effect for the beneficiary prior to the date of enrollment.

Exemption Transition Data Report:
DHCS has created a data file to notify MCPs of beneficiaries who have submitted a MER and are transitioning into a MCP. The exemption transition data file will be accessible on the Secure Data Exchange Services (SDES) website for California Health Care Options: http://healthcareoptions.maximus.com/sdes/.

[4] Policy Letter 12-004 is available at: http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx.

The exemption transition data file will be posted to the SDES on a weekly basis using the same schedule and location of the Weekly Plan File (WPF). The *2014* file posting schedule is available for download from the SDES website by clicking on the *2014* File Posting Schedule link. Authorized MCP representatives who have access to the WPF will also have access to the exemption file.

MCPs will receive exemption transition data if the beneficiary has been enrolled in a MCP within one year of the date on which the exemption was denied. Once the beneficiary is enrolled in the MCP, the exemption transition data will remain in the report for four consecutive weekly reports. When a beneficiary is enrolled in a MCP, a record of the exemption denial will also be present in the WPF. If there is no exemption denial activity for beneficiaries enrolling in a particular MCP, an empty exemption file will not be posted to the SDES.

The record layout for the exemption transition data file is provided as Attachment A to this letter. Sample exemption data files have been posted on the SDES in the individual plan folders. MCPs should download and review the files and submit any technical questions to MAXIMUS at: cahcohelpdesk@maximus.com. Please use "MER/EDER Data File" in the subject line of the email.

REQUIREMENTS
MCPs must submit a quarterly Exemption Denial and Continuity of Care report to DHCS using the reporting template and instructions that are provided with this APL in Attachments *B (Revised)* and C. The quarterly reports must be submitted in the required format and emailed to: pmmp.monitoring@dhcs.ca.gov no later than 45 calendar days after the end of the quarter.

If you have any questions regarding this APL, please contact your contract manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Assistant Deputy Director
Health Care Delivery Systems

Attachments

Attachment A

Exemption Transition Data File Format

Field #	Field Name	Field Description	Attributes (length)
1.	BeneficiaryID	Beneficiary ID (MAXIMUS assigned)	Int (09)
2.	ExemptionID	Exemption record ID (MAXIMUS assigned)	Int (09)
3.	CIN	Beneficiary CIN	Char (09)
4.	FirstName	Beneficiary First Name	Char (15)
5.	MiddleInitial	Beneficiary Middle Initial	Char (01)
6.	LastName	Beneficiary Last Name	Char (20)
7.	DOB	Date Of Birth (format = MM/DD/YYYY)	Char (10)
8.	ReasonCode	Denial Reason Code	Char (01)
9.	ReasonDescription	Denial Reason Description	Char (400)
10.	Denial Date	Denial Date (format = MM/DD/YYYY)	Char (10)
11.	ProviderID	Provider ID	Vchar (10)
12.	ICD9-1	International Classification of Diseases (Ninth	Vchar (06)
13.	ICD9-2	International Classification of Diseases (Ninth	Vchar (06)
14.	PlanOfLastTrans	Plan Number in which beneficiary is enrolled	Vchar (03)

Attachment B *(REVISED)*

Health Plan Reporting Instructions

Introduction

These instructions describe the MER Denial and Continuity of Care reporting template and outline the requirements, references, and headers/categories.

- Data must be submitted in Excel. Do not PDF the data.
- The three months of data must be aggregated into one figure to represent the quarter.

Calendar

The report is due 45 days after the end of each calendar year quarter. For reference, the calendar quarters are listed below:

- Q1 - January, February, and March
- Q2 - April, May, and June
- Q3 - July, August, and September
- Q4 - October, November, December

If the report is not submitted 45 days after the end of the quarter, a reminder email will be sent to the health plan contact. Reports should be emailed to pmmp.monitoring@dhcs.ca.gov and include the health plan's name and which quarter report is attached.

SPD Aid Codes

For *non-COHS plans*, all reports specific to SPDs should include Medi-Cal only SPDs in the below aid codes.

Managed Care Model	Aid Code
Non-COHS	10, 14, 16, 20, 24, 26, 36, 60, 64, 66, 1E, 1H, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V

MER Denial and Continuity of Care Worksheet

(Continuity of Care Template.xlsx)

This worksheet covers the following requirement:

- Number of SPD members who received a MER denial; number of non-SPD members who received a MER denial; number of health plan approvals; and number of denials with reasons categories for SPD and non-SPD beneficiaries.

Important Note: If there are any other reasons for denials, you must identify exactly what the denial reason is.

Instructions for filling out each column:

- Plan Code (Column A): Fill in the plan code for each county the plan is in. This plan code must match the county listed in the county column.
- Plan Name (Column B): Fill in the Plan name.
- County (Column C): Fill in the county for each county the plan is in. The county must match the plan code listed in the plan code column.
- # of Non-SPD MER Denials (Column D): The total number of MER denials that were included in the MER Denial data file for the quarter that are not for SPD beneficiaries.
- # of SPD MER Denials (Column E): The total number of MER denials that were included in the MER Denial data file for the quarter that are for SPD beneficiaries.
- Overall # of MER Denials (Column F): The total number of MER denials that were included in the MER Denial data file for the quarter. This number must equal the sum of Column D plus Column E.
- # of approvals (Column G): The total number of continuity of care approvals.
- # of in process (Column H): The total number of Continuity of Care requests that are in the middle of being processed and have not yet been approved or denied.
- # of denials (Column I): The total number of all denied Continuity of Care requests. This number must equal the sum of Column H plus Column I plus Column J plus Column K plus Column L.
- # of denials based on no link between SPD & provider (Column J): The number of denied Continuity of Care requests based on there not being a link between the SPD and the provider in the FFS utilization data provided by DHCS.
- # of denials based on of quality of care issues (Column K): The number of denied Continuity of Care requests based on there being quality of care issues with the provider.
- # of denials because provider did not accept rate (Column L): The number of denied Continuity of Care requests based on the provider not accepting the rate.
- # of denials because provider refused to work with managed care (Column M): The number of denied Continuity of Care requests based on the provider refusing to work with managed care.
- # of denials based on other reasons (add note in column O) (Column N): The number of denials based on any other reason. An explanation of the reason must be added in Column L.
- Explanation of other reasons (Column O): For any denials based on other reasons, an explanation must be entered in this column.

Attachment C: MER Denial and Continuity of Care (COC) Report

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
					F=G+J+K					K=M+N+O+P+Q								
Plan Code	Plan Name	County	# of Non SPD MER Denials	# of SPD MER Denials	Overall # of MER Denials on DHCS Report	# of COC approvals	For COC approvals, average # of days to approve	Average length (in days) of COC approvals	# of COC in process	# of COC denials	For COC denials, average # of days to deny	# of denials based on no link between SPD & provider	# of denials based on of quality of care issues	# of denials because provider did not accept rate	# of denials because provider refused to work with managed care	# of denials based on other reasons (add note in column R)	Explanation of other reasons	For COC Approvals, # of beneficiary care plans that have changed
		Total:																