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

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DATE: December 27, 2022

ALL PLAN LETTER 22-032
SUPERSEDES ALL PLAN LETTER 18-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: CONTINUITY OF CARE FOR MEDI-CAL BENEFICIARIES WHO NEWLY ENROLL IN MEDI-CAL MANAGED CARE FROM MEDI-CAL FEE-FOR-SERVICE, AND FOR MEDI-CAL MEMBERS WHO TRANSITION INTO A NEW MEDI-CAL MANAGED CARE HEALTH PLAN ON OR AFTER JANUARY 1, 2023

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with guidance on Continuity of Care for beneficiaries who are mandatorily transitioning from Medi-Cal Fee-For-Service (FFS) to enroll as Members in Medi-Cal managed care. In addition, this APL provides guidance on Continuity of Care for Members transitioning from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023, due to a contract termination or expiration with the Department of Health Care Services (DHCS). This APL applies to both Medi-Cal only beneficiaries and those dually eligible for Medicare and Medi-Cal, for their Medi-Cal Providers. This APL also describes other types of transitions into Medi-Cal managed care for specific Medi-Cal Member populations for which MCPs must allow Continuity of Care. This APL supersedes APL 18-008.[1]

BACKGROUND:
Beneficiaries who mandatorily transition from Medi-Cal FFS to enroll as Members in an MCP or transition from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023 have the right to request Continuity of Care with Providers in accordance with federal and state law and the MCP contract, with some

[1] APLs can be found at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

exceptions.[2,3,4,5,6] Consistent with federal law, Members must (a) have access to services consistent with the access they previously had and (b) be permitted to have continued access to services during a transition from FFS to an MCP, or a transition from MCP to MCP, and (c) be permitted to retain their current Provider for a period of time if that Provider is not in the MCP's Network when the Member, in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization.[7]

Members may request up to 12 months of Continuity of Care with a Provider if a verifiable pre-existing relationship exists with that Provider.[8] Continuity of Care with a Provider will be referred to as Continuity of Care in this APL. Additionally, if a Member has one of the conditions listed in Health and Safety Code (HSC) section 1373.96, the MCP must provide Continuity of Care for the completion of a course of treatment for that specific condition by a terminated Provider or by a nonparticipating Provider at the Member's request. Members also have the right to Continuity of Care for Covered Services and active prior treatment authorizations for Covered Services.

In addition to the requirements in this APL, MCPs must comply with the requirements in APL 21-003 and APL 22-018, or any subsequent APLs on these topics.

POLICY:

I. Continuity of Care Requirements

The Continuity of Care requirements listed in this section are in addition to those set forth in HSC section 1373.96, which provides for the Member's completion of Covered Services with a terminated Provider or by a nonparticipating Provider, if a pre-existing relationship exists with that Provider, and if the Member has one of the conditions listed

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[2] HSC sections 1367(d) and 1373.96. State law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml.
[3] Title 28 of the California Code of Regulations (CCR) section 1300.67.1. The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index.
[4] MCP boilerplate contracts can be found at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[5] Title 42 Code of Federal Regulations (CFR) section 438.62. The CFR is searchable at https://www.ecfr.gov/.
[6] Further implementation guidance applicable for 2024 transitions is forthcoming.
[7] 42 CFR section 438.62.
[8] A pre-existing relationship means the Member has seen an OON Primary Care Provider; Specialist; or select ancillary Provider including physical therapy, occupational therapy, respiratory therapy, Behavioral Health Treatment (BHT), and speech therapy Provider for a non-emergency visit, at least once during the 12 months prior to the date of their initial enrollment in the MCP, unless otherwise specified in this APL.

in HSC section 1373.96. The requirements for Continuity of Care in this section do not limit the protections defined in HSC section 1373.96. For additional information, see Section II of this APL.

If a Member is mandatorily transitioning from Medi-Cal FFS to enroll as a Member in an MCP or transitioning from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023, the Member may request Continuity of Care for up to 12 months after the enrollment date with the MCP if a pre-existing relationship exists with that Provider, regardless of the Member having a condition listed in HSC section 1373.96. Continuity of Care protections extend to Primary Care Providers, Specialists, and select ancillary Providers, including physical therapy; occupational therapy; respiratory therapy; BHT; and speech therapy Providers. These protections are subject to the Continuity of Care requirements outlined below in this section.[9]

Continuity of Care protections do not extend to all other ancillary Providers such as radiology; laboratory; dialysis centers; Non-Emergency Medical Transportation (NEMT); Non-Medical Transportation (NMT); other ancillary services; and non-enrolled Medi-Cal Providers.

MCPs are only required to provide Continuity of Care for covered benefits.

MCPs must process Continuity of Care requests by following the requirements outlined below:

A. Processing Continuity of Care Requests

1. Acceptance of Requests

MCPs must accept Continuity of Care requests from the Member, authorized representative, or Provider over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or online form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requester over the telephone.

2. Retroactive Requests

[9] Continuity of Care requirements include: 1) The Provider is willing to accept the MCP's contract rates or Medi-Cal FFS rates; 2) The Provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues; and 3) The Provider is a California State Plan approved Provider.

MCPs must retroactively approve a Continuity of Care request and reimburse Providers for services that were already provided if the request meets all Continuity of Care requirements outlined below in subsection A.3, including the Provider being willing to accept the MCP's contract rates or Medi-Cal FFS rates, and the services that are the subject of the retroactive request meet the following requirements:

- Occurred after the Member's enrollment into the MCP.
- Have dates of service that are within 30 calendar days of the first service for which the Provider requests retroactive reimbursement (i.e., the first date of service is not more than 30 calendar days from the date of the reimbursement request.

3. Completion of Requests

The Continuity of Care process begins when the MCP receives the Continuity of Care request. The MCP must first determine if the Member has a pre-existing relationship with the Provider. MCPs must request from an Out-of-Network (OON) Provider all relevant treatment information, for the purposes of determining Medical Necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulation. MCPs must provide Continuity of Care when the following requirements are met:

- The MCP is able to determine that the Member has a pre-existing relationship with the Provider;
- The Provider is willing to accept the MCP's contract rates or Medi-Cal FFS rates;
- The Provider meets the MCP's applicable professional standards and has no disqualifying quality of care issues;[10] and
- The Provider is a California State Plan approved Provider.[11]

4. Validating Pre-Existing Relationship

The MCP must determine if a relationship exists through use of data provided by DHCS or by an MCP with its contract expiring or terminating, such as Medi-Cal FFS utilization data or claims data from an MCP. A Member, authorized representative, or Provider may also provide information to the

[10] For the purposes of this APL, a quality of care issue means the MCP 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 MCP Members.

[11] The Provider must be enrolled and participating in the Medi-Cal program. A list of suspended or ineligible Providers is available here: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/sandi.

MCP that demonstrates a pre-existing relationship with the Provider. A Member's self-attestation of a pre-existing relationship is not sufficient proof (instead, actual documentation must be provided), unless the MCP makes this option available to the Member.

Following identification of a pre-existing relationship, the MCP must determine if the Provider is a Network Provider. If the Provider is a Network Provider, then the MCP must allow the Member to continue seeing the Provider. If the Provider is not a Network Provider, the MCP must contact the Provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish Continuity of Care for the Member.

5. **Timeline**
   The MCP must begin to process non-urgent requests within five working days following the receipt of the Continuity of Care request. Additionally, each Continuity of Care request must be completed within the following timelines from the date the MCP received the request:
   - 30 calendar days for non-urgent requests;
   - 15 calendar days if the Member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   - As soon as possible, but no longer than three calendar days for urgent requests (i.e., there is identified risk of harm to the Member).[12]

6. **Member Notifications**
   MCPs must provide acknowledgment of the Continuity of Care request within the timeframes specified below, advising the Member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. MCPs must notify the Member by using the Member's known preference of communication or by notifying the Member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:
   - For non-urgent requests, within seven calendar days of the decision.
   - For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.

[12] For the purposes of this APL, "risk of harm" is defined as an imminent and serious threat to the health of the Member.

A Continuity of Care request is considered complete when an MCP notifies the Member of the MCP's decision. An MCP must attempt to notify the Member of the Continuity of Care decision via the Member's preferred method of communication or by telephone.

MCPs must also send a notice by mail to the Member within seven calendar days of the Continuity of Care decision.

a. Member Notification of Denial
For Continuity of Care requests that are denied, the MCP must include the following information in the notice:

- A statement of the MCP's decision.
- A clear and concise explanation of the reason for denial.
- The Member's right to file a grievance or appeal. For additional information on grievances and appeals, refer to APL 21-011 or subsequent iterations of this APL.

If the MCP and the OON Provider are unable to reach an agreement because they cannot agree to a rate, or the MCP has documented quality of care issues with the Provider, the MCP must offer the Member a Network Provider alternative. If the Member does not make a choice, the Member must be referred to a Network Provider. If the Member disagrees with the Continuity of Care determination, the Member maintains the right to file a grievance.

b. Member Notification of Approval
For Continuity of Care requests that are approved, the MCP must include the following information in the notice:

- A statement of the MCP's decision.
- The duration of the Continuity of Care arrangement.
- The process that will occur to transition the Member's care at the end of the Continuity of Care period.
- The Member's right to choose a different Network Provider.

If a Provider meets all of the necessary requirements, including entering into a letter of agreement or contract with the MCP, the MCP must allow the Member to have access to that Provider for the length of the Continuity of Care period unless the Provider is only willing to work with the MCP for a shorter timeframe. In this case, the MCP

must allow the Member to have access to that Provider for the shorter period of time.

When the Continuity of Care agreement has been established, the MCP must work with the Provider to establish a plan of care for the Member. At any time, Members may change their Provider to a Network Provider regardless of whether or not a Continuity of Care relationship has been established.

The MCP must notify the Member 30 calendar days before the end of the Continuity of Care period, using the Member's preferred method of communication, about the process that will occur to transition the Member's care to a Network Provider at the end of the Continuity of Care period. This process includes engaging with the Member and Provider before the end of the Continuity of Care period to ensure continuity of services through the transition to a new Provider.

7. **Provider Referral Outside of the MCP Network**
   The MCP must work with the approved OON Provider and communicate its requirements on letters of agreements, including referral and authorization processes, to ensure that the OON Provider does not refer the Member to another OON Provider without authorization from the MCP. In such cases, the MCP will make the referral, if medically necessary, if the MCP does not have an appropriate Provider within its Network.

8. **12-Month Continuity of Care Period Restart**
   If a Member changes MCPs by choice following the initial enrollment in an MCP or if a Member loses and then later regains MCP eligibility during the 12-month Continuity of Care period, the 12-month Continuity of Care period for a pre-existing Provider may start over one time. For example, if a Member enrolls in an MCP on January 1, 2023, but then later changes MCPs by choice on April 1, 2023, then the 12-month Continuity of Care may start over one time and the Member may see the Provider until April of the following year.

   If the Member changes MCPs or loses and then later regains MCP eligibility a second time (or more), the Continuity of Care period does not start over and the Member does not have the right to a new 12 months of Continuity of Care. If the Member returns to Medi-Cal FFS, if applicable, and later re-enrolls in an MCP, the Continuity of Care period does not start over.

B. Scheduled Specialist Appointments

At the Member, authorized representative, or Provider's request, MCPs must allow transitioning Members to keep authorized and scheduled Specialist appointments with OON Providers when Continuity of Care has been established and the appointments occur during the 12-month Continuity of Care period.[13]

If a Member, authorized representative, or Provider contacts the MCP to request to keep an authorized and scheduled Specialist appointment with an OON Provider that the Member has not seen in the previous 12 months and there is no established relationship with the OON Provider, the MCP may arrange for the Member to keep the appointment or schedule an appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider.

If the MCP is unable to arrange a Specialist appointment with a Network Provider on or before the Member's scheduled appointment with the OON Provider, the MCP is encouraged to make a good faith effort to allow the Member to keep their appointment with the OON Provider. However, since the appointment with the OON Provider occurs after the Member's transition to the MCP, it does not establish the requisite pre-existing Provider relationship for the Member to submit a Continuity of Care request.

II. Additional Continuity of Care Protections in HSC section 1373.96

HSC section 1373.96 offers additional protections for Members to continue seeing a terminated or nonparticipating Provider, at a Member, authorized representative, or Provider's request, to complete Covered Services for specific conditions outlined in the table below. HSC section 1373.96 specifies timeframes for each condition, some of which differ from the policy in this APL. The following table describes the protections in HSC section 1373.96, some of which overlap and some of which are in addition to protections provided by the policy in this APL.

Condition	**Timeframe in which the MCP must provide for the completion of Covered Services**
Acute	For the duration of the condition.
Serious Chronic	For the period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider. The completion of

[13] Transitioning Members include beneficiaries who mandatorily transition from Medi-Cal FFS to enroll as Members into an MCP and Members who mandatorily transition from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023.

Condition	Timeframe in which the MCP must provide for the completion of Covered Services
	Covered Services must not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
Pregnancy and Postpartum Care	For the duration of the pregnancy and immediate postpartum period of 12 months.[14] For purposes of an individual who presents written documentation of being diagnosed with a maternal mental health condition from the individual's treating health care Provider, completion of Covered Services for the maternal mental health condition must not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
Terminal Illness	For the duration of the terminal illness. This may exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member.
Care of a Newborn Child between Birth and Age 36 Months	Must not exceed 12 months from the contract termination date or the effective date of coverage for a newly covered Member.
Performance of a surgery or other procedure that is authorized by the MCP as part of a documented course of treatment and has been recommended and documented by the Provider to occur within 180 days of the contract's termination date or within 180 days of the effective	Within 180 days of the termination date or effective date of coverage.

[14] Effective April 1, 2022, DHCS extended the postpartum care coverage period for individuals eligible for pregnancy and postpartum care services under Medi-Cal from 60 days to 365 days (12 months) as part of the American Rescue Plan Act Postpartum Care Expansion. Additional information is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/pregnancy-landing and https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/DHCSStakeholderNews/032522StakeholderUpdates.aspx.

Condition	Timeframe in which the MCP must provide for the completion of Covered Services
date of coverage for a newly covered Member.	

If an MCP is not able to come to an agreement with the terminated Provider or nonparticipating Provider, or if the Member, authorized representative, or Provider does not submit a request for the completion of Covered Services by said Provider, the MCP is not required to continue the Provider's services.[15]

III. Continuity of Medi-Cal Covered Services and Prior Treatment Authorizations

All Members have the right to continue receiving Medi-Cal services covered under the MCP's Contract when transitioning to an MCP even in circumstances in which the Member does not continue receiving services from their pre-existing Provider. The MCP must arrange for Continuity of Care for Covered Services without delay to the Member with a Network Provider, or if there is no Network Provider to provide the Covered Service, with an OON Provider.[16,17] In an instance where a Member would like their OON Provider to provide a service and they have a pre-existing relationship with the OON Provider, they may make a Continuity of Care request if they are mandatorily transitioning from Medi-Cal FFS to an MCP, transitioning from an MCP with its contracts expiring or terminating to a new MCP on or after January 1, 2023, or if the conditions in HSC section 1373.96 are met. The MCP must make a good faith effort to enter an agreement if all Continuity of Care requirements are met.[18]

Following a Member's mandatory transition from Medi-Cal FFS to an MCP or from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023, active prior treatment authorizations for services remain in effect for 90 days and must be honored without a request by the Member, authorized representative, or Provider. The MCP must arrange for services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider.[19] After 90 days, the active treatment authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the MCP, whichever is shorter. If the MCP does not complete a new assessment, the active treatment authorization remains in effect and after 90 days,

[15] HSC section 1373.96(d) and (e).
[16] MCP Contract, Exhibit A, Attachment 9, Section 16A
[17] 42 CFR section 438.62
[18] The MCP is not required to make a good faith effort to enter an agreement with ineligible ancillary, NEMT, or NMT Providers in which Continuity of Care protections do not extend.
[19] MCP Contract, Exhibit A, Attachment 9, Section 16A

the MCP may reassess the Member's prior treatment authorization at any time. A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. If an MCP is reassessing Enhanced Care Management (ECM) authorizations after 90 days, the MCP must reassess against ECM discontinuation criteria, not the ECM Population of Focus eligibility criteria.[20]

Additionally, in an instance where a service has been rendered with an OON Provider, and that Provider satisfies the Continuity of Care requirements, the Member, authorized representative, or Provider may request Continuity of Care to retroactively cover the service. See additional information and requirements for retroactive requests under section I.A.2 of this APL.

A. Durable Medical Equipment Rentals and Medical Supplies

MCPs must allow transitioning Members to keep their existing Durable Medical Equipment (DME) rentals and medical supplies from their existing Provider, under the previous Prior Authorization for a minimum of 90 days following MCP enrollment and until the new MCP is able to reassess, the new equipment or supplies are in possession of the Member, and ready for use.[21] Continuity of DME and medical supplies must be honored without a request by the Member, authorized representative, or Provider. Additionally, if DME or medical supplies have been arranged for a transitioning Member but the equipment or supplies have not been delivered, the MCP must allow the delivery and for the Member to keep the equipment or supplies for a minimum of 90 days following MCP enrollment and until the new MCP is able to reassess. If the MCP does not complete a new assessment, the authorization remains in effect for the duration of the treatment authorization. After 90 days, the MCP may reassess the Member's authorization at any time and require the Member to switch to a Network DME Provider.

B. Non-Emergency Medical Transportation and Non-Medical Transportation

For NEMT and NMT, MCPs must allow Members to keep the modality of transportation under the previous Prior Authorization with a Network Provider

[20] The ECM Policy Guide is available at: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx
[21] This is subject to the existing DME Provider meeting the Continuity of Care requirements outlined in section I of the APL above.

until the new MCP is able to reassess the Member's continued transportation needs.

MCPs must use Treatment Authorization Request (TAR) data or Prior Authorization data to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. MCPs must pay claims for Prior Authorizations or existing authorizations when data is incomplete.

IV. Member and Provider Outreach and Education

MCPs must inform Members of their Continuity of Care protections and include information about these protections in Member information packets, handbooks, and on the MCP's website.[22] This information must include how a Member, authorized representative, and Provider may initiate a Continuity of Care request with the MCP. In accordance with APL 21-004 or subsequent iterations of the APL, the MCP must translate these documents into threshold languages and make them available in alternative formats, upon request. MCPs must provide training to call center and other staff who come into regular contact with Members about Continuity of Care protections.

V. Reporting

MCPs must continue to report on existing metrics related to any Continuity of Care provisions outlined in state law and regulations, or other state guidance documents. DHCS may request additional reporting on Continuity of Care at any time and in a manner determined by DHCS.

VI. Specific Contexts

There are other transitions for specific Member populations that MCPs must allow Continuity of Care for, which have distinct processing requirements and timelines.[23]

A. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition – Continuity Of Care For Approved Provider Types:
MCPs are required to cover Non-Specialty Mental Health Services (NSMHS), as outlined in APL 22-005 and APL 22-006, or any subsequent iterations of these APLs. County Mental Health Plans (MHPs) are required to provide Specialty

[22] HSC sections 1363(a)(15) and 1373.96.
[23] This section does not cover all Continuity of Care protections for all situations or populations. There are other specific populations that offer additional protections and are contained in APLs or information notices specific to those populations. For long term care, see APL 22-018 and any subsequent APLs on this topic. For specialty mental health, see Behavioral Health Information Notice (BHIN) 22-011 and Mental Health and Substance Use Disorder Services (MHSUDS) 18-059. BHINS and MHSUDS can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx.

Mental Health Services (SMHS) for Members who meet the criteria for SMHS. DHCS recognizes that the Medical Necessity criteria for impairment and intervention for SMHS differ between children and adults. Under the Early and Periodic Screening, Diagnostic, and Treatment benefit, the impairment component of the SMHS Medical Necessity criteria for Members under 21 years of age is less stringent than it is for adults. Therefore, children with a lower level of impairment may meet Medical Necessity criteria for SMHS.[24]

MCPs must provide Continuity of Care with an OON SMHS Provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies to receive SMHS from the MHP and instead becomes eligible to receive NSMHS from the MCP. In this situation, the Continuity of Care requirement only applies to psychiatrists and/or mental health Provider types that are permitted, through California's Medicaid State Plan, to provide NSMHS (referred to in the State Plan as "Psychology").[25]

The MCP must allow, at the request of the Member, authorized representative, or Provider, up to 12 months Continuity of Care with the OON MHP Provider in accordance with the requirements in this APL. After the Continuity of Care period ends, the Member must choose a mental health Provider in the MCP's Network for NSMHS. If the Member later requires additional SMHS from the MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to the MCP for NSMHS, the 12-month Continuity of Care period may start over one time. If the Member requires SMHS from the MHP subsequent to the Continuity of Care period, the Continuity of Care period does not start over when the Member returns to the MCP or changes MCPs (i.e., the Member does not have the right to a new 12 months of Continuity of Care).

B. Covered California To Medi-Cal Transition

This section specifies requirements for populations that undergo a mandatory transition from Covered California to Medi-Cal managed care coverage due to the Covered California yearly coverage renewal determination or changes in a Member's eligibility circumstances that may occur at any time throughout the year. These requirements are limited to these transitioning Members.

To ensure that care coordination requirements are met, the MCP must ask these Members if there are upcoming health care appointments or treatments

[24] SMHS Medical Necessity criteria are outlined in Title 9 CCR sections 1830.205 and 1830.210.
[25] State Plan Amendment 19-0007, Limitations on Attachment 3.1-A Page 11a is available at: https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA19-0007ApvPkg.pdf

scheduled and assist them. If the Member requests Continuity of Care, the MCP must help initiate the process at that time according to the requirements in this APL. The MCP must contact the new Member by telephone, letter, or other preferred method of communication, no later than 15 calendar days after enrollment.[26] The requirements noted above in this paragraph must be included in this initial Member contact process. The MCP must make a good faith effort to learn from and obtain information from the Member so that it is able to honor active prior treatment authorizations with a Network Provider and/or establish Continuity of Care.

The MCP must honor any active prior treatment authorizations for 90 days for services that are covered under its MCP Contract. The MCP must arrange for services authorized under the active prior treatment authorization with a Network Provider, or if there is no Network Provider to provide the service, with an OON Provider.[27] After 90 days, the active authorization remains in effect for the duration of the treatment authorization or until completion of a new assessment by the MCP, whichever is shorter. A new assessment is considered complete by the MCP if the Member has been seen in-person and/or via synchronous Telehealth by a Network Provider and this Provider has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization. Prior treatment authorizations must be honored without a request by the Member, authorized representative, or Provider.

The MCP must, at the Member, authorized representative, or Provider's request, offer up to 12 months of Continuity of Care, in accordance with the requirements in this APL.

C. Pregnant and Post-Partum Members and Newborns

HSC section 1373.96 requires MCPs to, at the request of a Member, authorized representative, or Provider, provide for the completion of Covered Services relating to pregnancy, during pregnancy, and immediately after the delivery (the post-partum period, which is 12 months), and care of a newborn child between birth and age 36 months, by a terminated or nonparticipating health plan Provider. These requirements apply for pregnant and post-partum Members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements. Please refer to HSC section 1373.96 for additional information about applicable circumstances and requirements.

[26] This does not limit the requirements set forth in HSC section 1373.96.
[27] MCP Contract, Exhibit A, Attachment 9, Section 16A

Pregnant and post-partum Members who are assigned a mandatory aid code, who are transitioning from Medi-Cal FFS to an MCP or from MCPs with contracts expiring or terminating to a new MCP on or after January 1, 2023, have the right to request Continuity of Care in accordance with the MCP Contract and the requirements listed in this APL. This requirement is applicable to any existing Medi-Cal Provider relationship that is allowed under the general requirements of this APL.

D. Terminally Ill Members

HSC section 1373.96 requires MCPs to, at the request of a Member, authorized representative, or Provider, provide for the completion of Covered Services of a Member with a terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services must be provided for the duration of a terminal illness, even if it exceeds 12 months from the contract termination date or 12 months from the effective date of coverage for a new Member.

E. Medical Exemption Requests

A Medical Exemption Request (MER) is a request for temporary exemption from enrollment into an MCP only until the Member's medical condition has stabilized to a level that would enable the Member to transfer to a Network Provider of the same specialty without deleterious medical effects. A MER is a temporary exemption from MCP enrollment that only applies to Members transitioning from Medi-Cal FFS to an MCP. A MER should only be used to preserve Continuity of Care with a Medi-Cal FFS Provider under the circumstances described in this paragraph.

MCPs are required to consider MERs that have been denied as automatic Continuity of Care requests to allow Members to complete courses of treatment with OON Providers in accordance with APL 17-007 or subsequent iterations of this APL. The MCP must process the Continuity of Care request in accordance to section I.A of this APL, including the validation of a pre-existing relationship with the Provider, and make a good faith effort to come to an agreement with the OON Provider for the duration of the treatment. If the MCP reaches an agreement with the Provider, the MCP must allow the Member Continuity of Care for up to 12 months after the enrollment date with the MCP.

The requirements contained in this APL will necessitate a change in MCPs' contractually required policies and procedures (P&Ps). MCPs must submit their updated P&Ps to their Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[28] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

[28] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic and your MCP contract.