QUARTERLY UPDATE
MEDI-CAL MANAGED HEALTH CARE EXPANSION INTO RURAL COUNTIES AND THE MEDI-CAL MANAGED CARE PROGRAM

For the Reporting Period
January through March 2015

Submitted by the Department of Health Care Services pursuant to Assembly Bill 131 (Committee on Budget, Chapter 80, Statutes of 2005) and Assembly Bill 1467 (Committee on Budget, Chapter 23, Statutes of 2012)

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A. PURPOSE OF THE REPORT

Pursuant to Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), the Department of Health Care Services (DHCS) is required to provide quarterly updates commencing January 1, 2014, and ending January 1, 2016, to the policy and fiscal committees of the Legislature on DHCS's expansion of Medi-Cal managed health care into rural counties. The report shall include, but not be limited to, the following updates:

- Continuity of care requests;
- Grievance and appeal rates; and
- Utilization reports for the new counties.

AB 131 (Committee on Budget, Chapter 80, Statutes of 2005, Section 34) was the omnibus health trailer bill for the Budget Act of 2005 and required that DHCS provide quarterly updates to the policy and fiscal committees of the Legislature commencing on January 1, 2006, on DHCS's core activities to improve the Medi-Cal managed care program as they relate to the 13 expansion counties of El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, Placer, San Benito, San Luis Obispo, Sonoma and Ventura. These quarterly updates include, when applicable:

- Progress or key milestones and objectives to implement changes to the existing program,
- Submittal of State Plan Amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS),
- Submittal of any federal waiver documents to CMS, and
- Applicable key functions related to the effort to expand the Medi-Cal managed care program.

This quarterly report combines the AB 1467 and AB 131 requirements to provide the Legislature with a comprehensive account of Medi-Cal managed health care expansion into California's rural counties.

Note: Updates to the prior quarterly report are italicized for ease of review. It is important to note that this report only covers activities between *January and March 2015.* Any developments in managed care in rural counties that have already occurred, but took place after *March 2015* will be included in future quarterly reports. Past reports can be found at the following link:
http://www.dhcs.ca.gov/formsandpubs/Pages/Reports2theLegislature.aspx.

B. BACKGROUND

AB 1467, the health omnibus budget trailer bill, authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 rural California counties.

The 28 Medi-Cal managed care rural expansion counties are Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba.

Previously, the Budget Act of 2005 authorized expansion of Medi-Cal managed care into 13 new counties. The counties of El Dorado, Imperial, Lake, Placer, and San Benito were part of this 13 county expansion effort. As a result, these counties became part of the 28 rural county expansion effort.

In March 2012, DHCS issued a Request for Information to solicit health plan interest in providing health care services to Medi-Cal beneficiaries in the rural fee-for-service (FFS) counties. In November 2012, DHCS issued a Request for Application (RFA) inviting interested health plans to submit formal applications to DHCS.

On February 27, 2013, DHCS released an administrative bulletin excluding the following seven counties from the RFA: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Pursuant to Welfare and Institutions Code Section 14087.98(b) and authorized under AB 1467, DHCS chose to enter into an exclusive health plan contract with an existing County Organized Health System (COHS), Partnership HealthPlan of California, for these seven counties. DHCS also chose to enter into an exclusive health plan contract with the same COHS to include Lake County, which was not part of the original RFA.

Also on February 27, 2013, DHCS announced Anthem Blue Cross and California Health and Wellness Plan as the selected plans in the following 18 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. Final health plan contracts were contingent upon all the plans' completion of State and federal plan-readiness activities. Additionally, DHCS contracted with Kaiser Foundation Health Plan in three of these counties (Amador, El Dorado and Placer) to assure continuity of care for beneficiaries given Kaiser's staff model for delivery of care was already in place.

DHCS, in collaboration with the Imperial County Public Health Department, participated in a community meeting for stakeholders in Imperial County on December 6, 2012. Local providers and Medi-Cal managed care health plans (MCPs) attended and participated in the meeting. The purpose of this meeting was to discuss the managed care model options with stakeholders and to answer questions and obtain information about the geography of Imperial County's desert landscape and how it affects access to services. Based upon CMS and DHCS collaboration, DHCS contracted with two plans in Imperial County: California Health and Wellness Plan and Molina Healthcare.

San Benito County, which originally planned to join an existing COHS plan (Central California Alliance for Health), instead operates as a single plan model (Anthem Blue Cross).

Of the approximate 400,000 Medi-Cal FFS beneficiaries in these rural counties, approximately 110,000 beneficiaries in the eight COHS counties of Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity transitioned to Medi-Cal managed care on September 1, 2013. The following populations were mandatorily enrolled into Partnership HealthPlan of California, the COHS plan operating in these counties, on September 1, 2013: children and family aid codes, seniors and persons with disabilities (SPDs), dual-eligibles (individuals eligible for Medicare and Medi-Cal) and the Healthy Families Program (HFP) population. Beneficiaries receiving Community-Based Adult Services (CBAS) benefits in the two rural COHS counties (Humboldt and Shasta), which have CBAS centers will continue to receive CBAS benefits through Medi-Cal FFS. The CBAS benefit converted to a Medi-Cal managed care benefit on December 1, 2014.

On November 1, 2013, the remaining 20 rural counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, San Benito, Sutter, Tehama, Tuolumne and Yuba transitioned from Medi-Cal FFS to Medi-Cal managed care. More than 180,000 beneficiaries in these counties transitioned from Medi-Cal FFS to managed care. The HFP and the children and family aid code populations are mandatory populations in these counties, except for in San Benito County where all populations are voluntary. SPDs became a mandatory population on December 1, 2014. Dual-eligibles continue to be voluntary populations. Beneficiaries in these counties which have CBAS centers (Butte and Imperial) continued to receive CBAS benefits through Medi-Cal FFS until the benefit converted to a Medi-Cal managed care benefit on December 1, 2014.

C. MEDI-CAL MANAGED CARE PERFORMANCE DASHBOARD

On *March 5, 2015*, DHCS released the *fifth* iteration of the Medi-Cal Managed Care Performance Dashboard (Dashboard). The Dashboard was developed with funding from the California HealthCare Foundation. The *March 2015* Dashboard is available here:
http://www.dhcs.ca.gov/services/Documents/MMCD/20150305MMCPDashboard.pdf.

The Dashboard helps DHCS, MCPs and stakeholders identify trends and better observe and understand the performance of Medi-Cal managed care. The Dashboard includes metrics that quantify and track enrollment, beneficiary demographics, beneficiary satisfaction, and health care utilization, access and quality. The Dashboard also stratifies reported data by beneficiary population including Medi-Cal-only SPDs, dual-eligible beneficiaries, the optional expansion population, and families and children.

DHCS releases the Dashboard to the public during the *second* month of each quarter through a public webinar. Previous Dashboards are available at:
http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx.

D. UTILIZATION DATA REPORTING

Utilization data for Medi-Cal managed care rural expansion for the period of *January* through *March 2015* will be reported in a future report. Due to a lag time in receiving the data from the MCPs, utilization rates reported at this time are incomplete. However, DHCS expects to begin reporting on utilization data in the *April through June 2015* quarterly report.

E. STATE FAIR HEARINGS

For the reporting period of *January through March 2015,* there were a total of *671* state fair hearings for all 58 California counties. This reflects *an increase* from the *October through December* 2014 reporting period, where there were a total of *627* state fair hearings:

- *January 2015: 304*
- *February 2015: 230*
- *March 2015: 137*

Of the *671* hearings*, 477 (71.1%)* were the responsibility of the MCP, *192 (28.6%)* were the responsibility of DHCS *and 2 (.3%) were the responsibility of both the MCP and DHCS*. DHCS grouped the hearings in the following categories*:*

- Health plan quality of care*: 546*
    - Delay/denial of medication/prescription: *149*
    - SPD denial/delay of medical exemption request (MER)/emergency disenrollment exemption request (EDER): *111*
    - Delay/denial of MER/EDER: *81*
    - Delay/denial of surgery/treatment: *56*
    - Delay/denial of diagnostic testing: *39*
    - Delay/denial of durable medical equipment: *28*
    - Delay/denial of referral: *26*
    - Delay/denial of consultation/specialist: *15*
    - Denial of medical supplies: *15*
    - Inpatient hospital stay: *12*
    - Delay/denial of physical therapy: *6*
    - Delay/denial of speech therapy: *4*
    - Denial of home care: *2*
    - Delay/denial of CBAS services: *2*
- Plan subcontractor/provider issue: *63*
    - *Billing/reimbursement issues: 62*
    - *Health plan not covering bill/paying provider: 1*
- Health care plan issues: *53*
    - Dispute of services: *50*
    - Transportation issue: *3*
    - No response to filed grievance/

Not allowed to file/unhappy with results*: 0*

- Miscellaneous issues: 7
  - Dental issues: *6*
  - Vision issues*: 1*
- Eligibility: *2*
  - *Managed care: 1*
  - *Share of cost: 1*

DHCS categorized the hearing resolutions as follows:

- Withdrawal: *283 (42.2%)*
- Non-appearance: *102* (*15.2*%)
- Denied: *90* (*13.4*%)
- Redirect: *87* (13%)
- Closed by compliance: *65* (*9.7*%)
- Granted: *17* (*2.5*%)
- Dismissed: *27* (*4*%)

In the 28 expansion counties, for the reporting period of *January through March 2015,* there were a total of *51* state fair hearings:

- *January 2015: 15*
- *February 2015: 14*
- *March 2015: 22*

Of the *51* hearings*, 46 (90.2%)* were the responsibility of the MCP *and 5 (9.8%)* were the responsibility of DHCS. DHCS grouped the hearings in the following categories*:*

- Health plan quality of care*: 37*
  - Delay/denial of medication/prescription: *10*
  - Delay/denial of surgery/treatment: *10*
  - Delay/denial of diagnostic testing: *6*
  - SPD denial/delay of MER/EDER: *3*
  - Delay/denial of durable medical equipment: *3*
  - Delay/denial of MER/EDER: *2*
  - Delay/denial of consultation/specialist: *1*
  - Inpatient hospital stay: *1*
  - Denial of medical supplies: *1*
- Plan subcontractor/provider issue; billing/reimbursement issues: 7
- Health care plan issues: *7*
  - Dispute of services: *6*
  - Transportation issue: *1*

DHCS categorized the hearing resolutions as follows:

- Withdrawal: *23 (62.2%)*
- Redirect: *5* (13.5%)

- Denied: *5* (*13.5*%)
- Closed by compliance: *2* (*5.4*%)
- Non-appearance: *2* (*5.4*%)

The total number of hearing resolutions differs from the total number of hearings for the quarter due to not all of the hearings having been resolved at the time of the reporting.

State fair hearing data fluctuates due to a variety of reasons including hearings being closed and later reopened and issues with the timing and transfer of data.

DHCS tracks state fair hearing data by entering the information into a database and organizing the data by category and hearing type (DHCS only, MCP only, or both). DHCS resolves MCP-only issues by contacting the MCP to provide a position statement. When it is a DHCS issue, DHCS provides a position statement. When warranted, DHCS will contact a claimant or provider to request additional information. When the beneficiary's health condition warrants it, DHCS will approve the beneficiary's request and disenroll him/her from an MCP.

F. RISK-ADJUSTED CAPITATION RATES

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented risk-adjusted capitation rates for Two-Plan Model and Geographic Managed Care MCPs. Capitation rates were risk-adjusted to match each MCP's projected costs to their capitated payments more effectively. To calculate the final capitation rates, the final risk-adjusted scores were applied to the developed county average capitation rates. For the first and second years, risk-adjustments were phased in using a rate comprised of 20% risk-adjusted county average rates and 80% plan-specific rates. For the third year, risk-adjustments were phased in using a rate comprised of 25% risk-adjusted county average rates and 75% plan-specific rates. For the fourth year, risk-adjustments were phased in using a rate comprised of 35% risk-adjusted county average rates and 65% plan-specific rates.

For rate years in 2013-2014, the county average rate increases to 40% and the plan-specific rate decreases to 60%. For rate years in 2014-2015, the county average rate increases to 50% and the plan-specific rate decreases to 50%. Capitation rates for the rural expansion counties are not risk adjusted at this time.

G. MEASURING QUALITY OF CARE PROVIDED TO BENEFICIARIES BY MCPs

California's External Accountability Set measures assess the quality of services provided by MCPs and form the basis for quality improvement efforts. DHCS contracts require MCPs to perform at least as well as the lowest performing 25% of Medicaid plans in the United States (minimum performance level [MPL]). MCPs are held to the MPL after their first full year of operation in a county. As a result, data for rural counties will be included in upcoming reports.

To accommodate for the more sparsely populated rural regions, DHCS worked with *MCPs to define several regions (groups of rural counties), that will provide a sufficient number of beneficiaries in order to provide meaningful reporting and quality improvement. California Health and Wellness and Anthem Blue Cross are providing information for two regions: Region 1—Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties; and Region 2—Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties. Kaiser North is providing information on one region: Amador, El Dorado, Placer, and Sacramento Counties. Partnership HealthPlan of California is providing information on four regions: Southeast—Napa, Solano, and Yolo Counties; Southwest—Lake, Marin, Mendocino, Sonoma Counties; Northeast—Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties; and Northwest—Del Norte and Humboldt Counties.* Reporting on these regions will become available in summer 2015 for services provided in 2014.

H. CONTINUITY OF CARE

In the interest of preserving beneficiary access to FFS primary care providers (PCP) and specialists, DHCS established continuity of care protections for beneficiaries in rural counties who are being transitioned from FFS to managed care. State law requires MCPs to provide beneficiaries with the completion of certain covered services that a beneficiary was receiving from a non-participating provider or from a terminated provider, subject to certain conditions. Continuity of care services must be provided for up to 12 months, if certain requirements are met, such as 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. In addition, Health and Safety Code Section 1373.96 sets forth further requirements.

In addition to protecting beneficiaries, the continuity of care process is designed to foster a permanent relationship between the MCP and the PCP or specialist providing treatment under the continuity of care process. Continuity of care arrangements can lead to a PCP or specialist joining the MCP's network on a permanent basis. DHCS developed the continuity of care protections in collaboration with stakeholders and presented the protections at various stakeholder forums.

DHCS monitors continuity of care requests for rural expansion through health plan data reporting. For the period of *October through December 2014,* MCPs granted *91 out of 97 (94%) continuity of care requests. The six continuity of care denials were due to the following reasons:*

- *Unable to determine member had established relationship with provider;*
- *Member denied need for continuity of care request at this time;*
- *Provider in network;*
- *Unable to contact member after multiple attempts; and*
- *Member not actively enrolled.*

DHCS will report on the January through March 2015 data in a future report.

The DHCS continuity of care webpage is available at: http://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx. The webpage is designed to assist providers and beneficiaries in navigating the continuity of care process. The webpage includes key DHCS policy guidance and outlines beneficiary protections related to continuity of care.

I. OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

As a part of the enacted 2013-14 Budget, specifically through the trailer bill language in Senate Bill X1-1 (Hernandez and Steinberg, Chapter 4, Statutes of 2013), effective January 1, 2014, California expanded mental health (MH) and substance use disorder (SUD) services provided through the Medi-Cal program.

DHCS expanded the Medi-Cal MH services available to its beneficiaries and MCPs are required to provide covered mental health benefits, excluding those benefits provided by the county Mental Health Plans (MHPs) under the Specialty Mental Health Services Waiver. Outpatient MH benefits are available to beneficiaries through the MCP's non-specialty mental health services. *MCPs and MHPs are working together* to assist members in accessing care in the appropriate settings. For beneficiaries not enrolled in an MCP, these benefits are provided through Medi-Cal FFS.

Medi-Cal specialty MH services currently provided by the MHPs will continue to be provided by the MHPs for Medi-Cal beneficiaries that meet the medical necessity criteria *for these services*. Expanded SUD benefits will continue to be provided through the current delivery systems: Medi-Cal FFS or county-administered Drug Medi-Cal depending on the benefit. In addition, MCPs are required to provide Screening and Brief Intervention and Referral to Treatment services for alcohol misuse by adults, though MCPs are not responsible for administering the treatment.

DHCS is monitoring the expansion of MH and SUD services provided through the Medi-Cal program. MCPs are required to submit mental health data reports on grievances, continuity of care, and referrals to the MHPs. DHCS *continues to review* this data to ensure that the expanded services are in place and that members are accessing these services.

DHCS *is* engaged in several issues that require a more in-depth stakeholder process. For example, DHCS convened a Delivery System Dispute Resolution Workgroup comprised of the MCPs and association representatives from the County Behavioral Health Directors Association and the California Association of Health Plans. The purpose of the workgroup was to develop a dispute resolution process to ensure that beneficiaries are not juggled between the MCPs and the MHPs and that no beneficiary falls through the cracks. Based on stakeholder input, DHCS *finalized* a dispute resolution process at the state level when issues cannot be resolved at the local level between MCPs and MHPs. *Additional information can be found in All Plan Letter*

15-007, which is available at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-007.pdf.

DHCS is organizing additional workgroups *composed of MCPs and MHPs that will* focus on other MH issue areas. *DHCS is determining which topics to discuss and is planning to begin* the next workgroup series *in summer* 2015.

Other issues are being worked out on a county-by-county basis with DHCS oversight. For example, MCPs and MHPs have developed or amended their Memoranda of Understanding (MOUs) to better coordinate care across the plans. Per the DHCS/MCP contract, MCPs are required to execute an MOU with the local county MHPs. APL 13-018 provides information regarding the MHP and MCP MOU requirements. APL 13-018 can be accessed here:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf. The MOUs were due to DHCS by June 30, 2014. Out of 98 total MOUs, DHCS has received and executed *89* MOUs to date. DHCS received but has not executed *five* MOUs, due to the MOUs being under *MCP or* county review and/or awaiting final signature. The remaining *four* MOUs (from *two* MCPs) have not yet been submitted. DHCS is requiring these MCPs to submit weekly status updates and is in continued communication with these MCPs.

DHCS is also working with MCPs and Regional Centers (RCs) to ensure the implementation of Behavioral Health Treatment (BHT) services as part of the Early Periodic Screening, Diagnosis and Treatment requirements for Medi-Cal beneficiaries under the age of 21. MCPs were required to cover these services effective September 15, 2014. Additional information is found below in Section J of this report and the requirements are explained in APL 14-017 which is available here:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf. DHCS is preparing to transition members who are currently receiving BHT at the RCs to the MCPs. This transition *is expected to occur before the end of 2015*.

DHCS continues to be involved in several stakeholder outreach efforts and to develop materials to provide guidance to MCPs on providing the MH and SUD services. Information, meeting presentations, and an email inbox where stakeholders can provide input can be accessed here: http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD_Partners-Stakeholders.aspx.

J. STATE PLAN AMENDMENTS AND FEDERAL WAIVERS

California's existing 1115 "Bridge to Reform" Medicaid Waiver, which began in 2010, is a five-year demonstration of health care reform initiatives that are designed to prepare for the significant changes spurred by the federal Patient Protection and Affordable Care Act. California's 1115 Demonstration Waiver is due to expire October 31, 2015. To begin the renewal process, in July 2014, DHCS held a public kick-off meeting and developed an Initial Concepts document. DHCS organized an 1115 *Demonstration*

Waiver Stakeholder Advisory Committee and *six* separate stakeholder workgroups to develop concepts on specific issue areas. These groups met several times *from November through February 2015*. *DHCS delivered a presentation on renewal updates to the Stakeholder Advisory Committee in February 2015 and to stakeholder groups through a webinar in March 2015.* DHCS will continue to *update and hold meetings for the Stakeholder* Advisory Committee *and other stakeholder groups on the status of the waiver process throughout 2015*.

DHCS officially submitted the state's application package to renew the Section 1115 Demonstration Waiver to CMS on March 27, 2015. With a Waiver start date of November 2015, DHCS will be in negotiations with CMS on its new 1115 Waiver throughout 2015.

Additional information on the 2015 waiver renewal is available at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx.

On September 3, 2014, DHCS submitted a Demonstration Waiver amendment to CMS to expand full-scope Medi-Cal benefits to qualified low-income pregnant women with incomes up to and including 138% of the Federal Poverty Level. CMS approval of this Demonstration Waiver amendment is pending.

DHCS *submitted* SPA 14-026 to CMS on September 30, 2014 to add behavioral health treatment (BHT) services as a Medi-Cal benefit to treat Autism Spectrum Disorder. SPA 14-026 will add BHT services to individuals under the age of 21 who are eligible for EPSDT services who meet medical necessity criteria. *SPA 14-026 is still pending CMS approval.* DHCS also submitted SPA 14-021 to CMS *late last year* to include pregnant woman as a mandatory Medicaid eligibility group, as long as certain income requirements are met. *SPA 14-026 is pending CMS approval.*

K. THE COORDINATED CARE INITIATIVE

In January 2012, Governor Brown announced his intent to enhance health outcomes and beneficiary satisfaction for low-income SPDs by shifting service delivery away from institutional care to home and community-based settings. To implement this goal, the Legislature passed and Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012), and SB 94 (Chapter 37, Statutes of 2013) which authorized the implementation of the Coordinated Care Initiative (CCI).

The three major components of the CCI are:

1. A three-year Duals Demonstration Project (Cal MediConnect) for full-benefit dual-eligibles that combines the full continuum of acute, primary, institutional, and home and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for dual-eligibles; and

3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD dual-eligibles.

Cal MediConnect is a voluntary program; however, those dual-eligibles who opt-out of Cal MediConnect must still enroll in an MCP for their Medi-Cal benefits (including dual-eligibles who are enrolled in a Medicare Advantage [MA] plan). Full-benefit dual-eligibles enrolled in an MCP for their Medi-Cal benefits, and who opt-out of Cal MediConnect, or are not eligible for Cal MediConnect, will continue to receive their Medicare services either through Medicare FFS or an MA plan.

The seven CCI counties participating in Cal MediConnect are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Note that Alameda County is no longer listed as a CCI county. In order for Alameda Alliance for Health to improve and focus on its financial and operational condition and transition back to local control, DMHC, DHCS, Alameda Alliance for Health, and local providers agreed as of November 2014 that Alameda County should no longer participate in CCI.

In April 2014, the State began passive enrollment into the Cal MediConnect plan in San Mateo County and dual-eligibles already in Medi-Cal managed care began to receive Managed Long Term Services and Supports (MLTSS) in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo Counties. In May 2014, the State began passive enrollment into Cal MediConnect plans and also began mandatory enrollment of dual-eligibles in Medi-Cal FFS into managed care for their Medi-Cal benefits in Riverside, San Bernardino, and San Diego Counties.

As of July 2014, all counties were implementing CCI, with the exception of *Santa Clara and* Orange *Counties. Santa Clara County began passive enrollment into Cal MediConnect in January 2015. Orange County is* scheduled to begin opt-in enrollment in July 2015 and passive enrollment in August 2015 *by birth month*. *Orange County will passively enroll skilled nursing facility dual-eligibles into the Cal MediConnect plan in August 2015 as well, but will enroll them by facility, rather than by birth month.*

Also in January 2015, dual-eligibles in Medi-Cal FFS residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara Counties began to receive MLTSS.

The timeline for CCI implementation in each of the counties is available at the following link, under the heading "Enrollment Chart": http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/.

Legislative reports on the CCI are available at: http://www.dhcs.ca.gov/pages/lga.aspx.

Attachment A Medi-Cal Managed Care Update of Rural Expansion Dates Managed Care Models and Plans			
County	**Implementation Date**	**Managed Care Model**	**Plan Name(s)**
Del Norte	9/1/2013	COHS	Partnership HealthPlan of California
Humboldt	9/1/2013	COHS	Partnership HealthPlan of California
Lake	9/1/2013	COHS	Partnership HealthPlan of California
Lassen	9/1/2013	COHS	Partnership HealthPlan of California
Modoc	9/1/2013	COHS	Partnership HealthPlan of California
Shasta	9/1/2013	COHS	Partnership HealthPlan of California
Siskiyou	9/1/2013	COHS	Partnership HealthPlan of California
Trinity	9/1/2013	COHS	Partnership HealthPlan of California
Alpine	11/1/2013	Regional Model (RM)	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Amador	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Butte	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Calaveras	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Colusa	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
El Dorado	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Glenn	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Inyo	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Mariposa	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Mono	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Nevada	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Placer	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Plumas	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Sierra	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan

Attachment A Medi-Cal Managed Care Update of Rural Expansion Dates Managed Care Models and Plans			
County	**Implementation Date**	**Managed Care Model**	**Plan Name(s)**
Sutter	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Tehama	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Tuolumne	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Yuba	11/1/2013	RM	Anthem Blue Cross Partnership Plan California Health and Wellness Plan
Imperial	11/1/2013	Imperial Model	California Health and Wellness Plan Molina Healthcare of California Partner Plan, Inc.
San Benito	11/1/2013	San Benito Model	Anthem Blue Cross Partnership Plan

Attachment B

Abbreviations and Acronyms

AB	Assembly Bill
BHT	Behavioral Health Treatment
CBAS	Community-Based Adult Services
CCI	Coordinated Care Initiative
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health System
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
EDER	Emergency Disenrollment Exemption Request
FFS	Fee-For-Service
HFP	Healthy Families Program
LTSS	Long Term Services and Supports
MA	Medicare Advantage
MLTSS	Managed Long Term Services and Supports
MCP	Medi-Cal Managed Care Health Plan
MER	Medical Exemption Request
MH	Mental Health
MHP	Mental Health Plan
MOU	Memoranda of Understanding
MPL	Minimum Performance Level
PCP	Primary Care Provider
RC	Regional Centers
RFA	Request for Application
SB	Senate Bill
SPA	State Plan Amendment
SPD	Seniors and Persons with Disabilities
SUD	Substance Use Disorder