



**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 2016**

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

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## A. PURPOSE OF THE REPORT

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.

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 care into rural counties. *The October through December 2015 report was the final AB 1467-required report. As a result, future quarterly reports do not contain updates on continuity of care requests and utilization reports.*

*With the AB 1467 requirements ending January 1, 2016, this quarterly report includes only the AB 131 requirements.*

**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 the months of *January and March 2016*. Any developments in managed care in rural counties that have already occurred, but took place after *March 2016* 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.

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 continued to receive CBAS benefits through Medi-Cal FFS until the 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 16, 2016*, DHCS released the latest iteration of the Medi-Cal Managed Care Performance Dashboard (Dashboard). The Dashboard was developed with funding from the California HealthCare Foundation. The *March 2016* Dashboard is available here:

<http://www.dhcs.ca.gov/services/Documents/MMCD/March162016Release.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 third month of each quarter through a public webinar. Previous Dashboards are available at:

<http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx>.

### **D. STATE FAIR HEARINGS**

For the reporting period of *January* through *March 2016*, there were a total of *1,075* state fair hearings (SFHs) for all 58 California counties. This *is a decrease* from the *October* through *December 2016* reporting period, where there were a total of *1,195* SFHs. SFHs were originally reported only if there was an outcome and the hearing was

completed. DHCS is now reporting all hearing *requests* regardless of whether or not there was an outcome *or decision in a particular quarter*. The results are as follows:

- *January 2016: 379*
- *February 2016: 366*
- *March 2016: 330*

Of the 1,075 SFHs, 633 (58.9 percent) were the responsibility of the MCP, 439 (40.8 percent) were the responsibility of DHCS, and 3 (0.3 percent) were the responsibility of both the MCP and DHCS. DHCS grouped SFHs in the following categories:

- Health plan quality of care: 936
  - Delay/denial of Medical Exemption Request (MER)/Emergency Disenrollment Exemption Request (EDER): 219
  - SPD delay/denial of MER/EDER: 215
  - Delay/denial of surgery/treatment: 158
  - Delay/denial of medication/prescription: 145
  - Delay/denial of diagnostic testing: 38
  - Delay/denial of referral: 34
  - Delay/denial of consultation/specialist: 24
  - Delay/denial of durable medical equipment (DME): 22
  - Denial of medical supplies: 22
  - Wheelchair/power wheelchair/scooter: 21
  - Delay/denial of physical therapy: 14
  - Inpatient hospital stay: 11
  - Delay/denial of speech therapy: 5
  - *Delay/denial of long term care: 2*
  - Delay/denial of home health care: 1
  - Delay/denial of rehabilitation therapy: 1
  - Delay/denial of skilled nursing facility: 1
- Plan subcontractor/provider issues: 50
  - Billing/reimbursement issues: 49
  - Health plan not covering bill/paying provider: 1
- Health care plan issues: 80
  - Dispute of services: 74
  - Transportation issues: 6
- Miscellaneous issues: 9
  - Dental: 6
  - Mental health (MH): 2
  - Vision: 1

*Of the 1,075 SFHs that were filed during this reporting period, 342 SFHs rendered resolutions during the same reporting period. DHCS categorized the 342 SFH resolutions as follows:*

- *Withdrawal: 180 (52.6%)*

- Non-appearance: 56 (16.4%)
- Denied: 41 (12%)
- Redirect: 34 (10%)
- *Duplicate case* 10 (2.9%)
- Granted: 9 (2.6%)
- Dismissed: 8 (2.3%)
- *Alternated*: 2 (.6%)
- *Granted in part*: 1 (.3%)
- *Rehearing (denied)*: 1 (.3%)

Note that a withdrawal indicates that an issue has been resolved, resulting in the member withdrawing the case and no longer needing a SFH. A redirect is when a case was incorrectly assigned to DHCS. In these instances, DHCS requests the California Department of Social Services to redirect the case to the appropriate entity. *A rehearing is when a claimant is unsatisfied with the final decision of the initial hearing and requests a rehearing. The rehearing request is either granted or denied. If the rehearing request is granted, then it is submitted as a new hearing.*

In the 28 expansion counties, for the reporting period of *January through March 2016*, there were a total of 90 SFHs. *As stated above, DHCS is reporting all hearing requests regardless of whether or not there was an outcome or decision in a particular quarter.*

- *January 2016*: 36
- *February 2016*: 28
- *March 2016*: 26

Of the 90 SFHs, 51 (56.7 percent) were the responsibility of the MCP. *Thirty-eight (42.2 percent) were the responsibility of DHCS, and 1 (1.1 percent) was the responsibility of both the MCP and DHCS. DHCS grouped SFHs in the following categories:*

- Health plan quality of care: 79
  - SPD delay/denial of MER/EDER: 22
  - Delay/denial of medication/prescription: 17
  - Delay/denial of MER/EDER: 14
  - Delay/denial of surgery/treatment: 7
  - Delay/denial of diagnostic testing: 7
  - Wheelchair/power wheelchair/scooter: 4
  - Delay/denial of DME: 3
  - Delay/denial in referral: 2
  - Inpatient hospital stay: 2
  - Delay/denial of physical therapy: 1
- Plan subcontractor/provider issues: 4
  - Billing/reimbursement issues: 4
- Health care plan issues: 5
  - Dispute of services: 5

Of the 90 SFHs that were filed during this reporting period, 35 SFHs rendered resolutions during the same reporting period. DHCS categorized the 35 SFH resolutions as follows:

- Withdrawal: 20 (57.2%)
- Denied: 6 (17.1%)
- Non-appearance: 5 (14.3%)
- Redirect: 2 (5.7%)
- Duplicate case: 2 (5.7%)

The total number of SFH resolutions may differ from the total number of hearings for the quarter, because not all hearings are resolved during the reporting period.

SFH 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 SFH 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 MCPs to provide position statements. 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.

## **E. RISK-ADJUSTED CAPITATION RATES**

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented risk-adjusted capitation rates for Two-Plan and Geographic Managed Care plans. 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 percent risk-adjusted county average rates and 80 percent plan-specific rates. For the third year, risk adjustments were phased in using a rate comprised of 25 percent risk-adjusted county average rates and 75 percent plan-specific rates. For the fourth year, risk adjustments were phased in using a rate comprised of 35 percent risk-adjusted county average rates and 65 percent plan-specific rates.

For rate years in 2013-2014, the county-average rate increases to 40 percent and the plan-specific rate decreases to 60 percent. For rate years in 2014-2015, the county-average rate increases to 50 percent and the plan-specific rate decreases to 50 percent. For the 2015-2016 rate year the county-average rate increases to 60 percent and the plan-specific rate decreases to 40 percent. Capitation rates for the rural expansion counties are not risk adjusted at this time.

## **F. MEASURING QUALITY OF CARE PROVIDED TO BENEFICIARIES BY MCPs**

DHCS'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 percent 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. *Reporting year 2016, based on data from measurement year 2015, will be the first year that MCPs are held to the MPL on performance measures in the rural expansion counties.*

To accommodate for the more sparsely populated rural regions, DHCS worked with the MCPs to define several regions (groups of rural counties), that would provide a sufficient number of beneficiaries in order to yield 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 is available as part of the most recent Dashboard, released in *March 2016*. The Dashboard is available at:

<http://www.dhcs.ca.gov/services/Documents/MMCD/March162016Release.pdf>.

## **G. OUTPATIENT MH 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 MH and substance use disorder (SUD) services provided through the Medi-Cal program.

DHCS expanded the Medi-Cal MH services available to its beneficiaries. As a result, MCPs are required to provide covered MH benefits, excluding those benefits provided by the county MH plans (MHPs) under the Specialty MH Services (SMHS) Waiver. Outpatient MH benefits are available to beneficiaries through the MCP's non-SMHS. 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 SMHS 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 MH 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 (APL) 15-007, which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-007.pdf>.

DHCS also organized a collaborative workgroup between MCPs and MHPs. The first two meetings occurred in the third and fourth quarters of 2015, and the third meeting will occur in February 2016. *The next meeting is scheduled for summer 2016.* Agenda items for these meetings include access to services, care coordination, management of the moderate diagnosis groups, and management of complex diagnoses, such as eating disorders.

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 (MOU) 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 at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>. DHCS has received and executed all 98 of the MOUs.

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 (EPSDT) requirements for Medi-Cal beneficiaries under the age of 21. MCPs were required to cover these services effective September 15, 2014. Additional information is available below in Section J of this report and the requirements are explained in APL 14-017 which is available at:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>. Beginning in February 1, 2016, DHCS began transitioning beneficiaries receiving BHT in the RCs to the MCPs. DHCS has assisted with the transition by providing MCPs with relevant beneficiary and claims data to aid them in determining necessary services and arranging continuity of care when applicable. As of March 2016, approximately 6,800 beneficiaries are receiving BHT services through MCPs. This includes transitioned and new beneficiaries who have accessed care after implementation of the benefit in Medi-Cal in September 2014. For those beneficiaries who have transitioned, 90 percent have secured continuity of care with their existing providers, and the remaining have been safely transitioned to in-network providers following receipt of treatment information.

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](http://www.dhcs.ca.gov/provgovpart/Pages/MH-SUD_Partners-Stakeholders.aspx).

## **H. SPAs 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 expired on 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 officially submitted the state's application package to renew the Section 1115 Demonstration Waiver to CMS on March 27, 2015. With an expiration date of October 31, 2015 looming, CMS granted a three-month extension to the existing 1115 Waiver through the end of the year. On December 30, 2015, CMS approved the renewal, extending California's demonstration waiver titled, "California Medi-Cal 2020 Demonstration." The renewal extends the waiver for another five years.

*DHCS held a public webinar on January 26, 2016 to give stakeholders a walkthrough of the Med-Cal 2020 Waiver's programs and requirements. DHCS will continue to keep stakeholders engaged as Medi-Cal 2020 is further developed and implemented.* Additional information on the 2015 waiver renewal and Medi-Cal 2020 is available at: <http://www.dhcs.ca.gov/provgovpart/Pages/waiverrenewal.aspx>.

DHCS submitted SPA 14-026 to CMS on September 30, 2014 to add BHT services as a Medi-Cal benefit to treat ASD. Similar to the waiver amendment, SPA 14-026 will add

BHT services for individuals under the age of 21 who are eligible for EPSDT services who meet medical necessity criteria. *CMS approved SPA 14-026 on January 26, 2016.*

*DHCS submitted SPA 16-007 to CMS on March 28, 2016. The SPA would implement a Health Homes Program (HHP) in 11 counties for beneficiaries with chronic conditions. MCPs would be responsible for the administration of the HHP.*

## **I. 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 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, the Department of Managed Health Care, DHCS, Alameda Alliance for Health, and local providers agreed that as of November 2014 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, DHCS 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. Santa Clara County began passive enrollment into Cal MediConnect in January 2015. Orange County began opt-in enrollment in July 2015 and passive enrollment began in August 2015 by birth month. Orange County began to 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<br>California Health and Wellness Plan |
| Amador    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Butte     | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Calaveras | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Colusa    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| El Dorado | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Glenn     | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Inyo      | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Mariposa  | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Mono      | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Nevada    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Placer    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Plumas    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |
| Sierra    | 11/1/2013           | RM                  | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan |

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Medi-Cal Managed Care  
Update of Rural Expansion Dates  
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| County     | Implementation Date | Managed Care Model | Plan Name(s)  |
|------------|---------------------|--------------------|---|
| Sutter     | 11/1/2013           | RM                 | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan                 |
| Tehama     | 11/1/2013           | RM                 | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan                 |
| Tuolumne   | 11/1/2013           | RM                 | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan                 |
| Yuba       | 11/1/2013           | RM                 | Anthem Blue Cross Partnership Plan<br>California Health and Wellness Plan                 |
| Imperial   | 11/1/2013           | Imperial Model     | California Health and Wellness Plan<br>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                                     |
| ASD                | Autism Spectrum Disorder                          |
| BHT                | Behavioral Health Treatment                       |
| Cal<br>MediConnect | Duals Demonstration Project                       |
| 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                |
| Dashboard          | Medi-Cal Managed Care Performance Dashboard       |
| DME                | Durable Medical Equipment                         |
| EDER               | Emergency Disenrollment Exemption Request         |
| EPSDT              | Early Periodic Screening, Diagnosis and Treatment |
| FFS                | Fee-For-Service                                   |
| HFP                | Healthy Families Program                          |
| 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                         |
| RC                 | Regional Centers                                  |
| RFA                | Request for Application                           |
| SB                 | Senate Bill                                       |
| SFH                | State Fair Hearing                                |
| SMHS               | Specialty Mental Health Services                  |
| SPA                | State Plan Amendment                              |
| SPD                | Seniors and Persons with Disabilities             |
| SUD                | Substance Use Disorder                            |