



## **QUARTERLY UPDATE**

# **MEDI-CAL MANAGED CARE PROGRAM**

**For the Reporting Period  
October through December 2012**

**Department of Health Care Services  
Medi-Cal Managed Care Division**

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## A. PURPOSE OF THE REPORT

Senate Bill (SB) 77 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2005), authorized the Department of Health Care Services (DHCS) to expand the Medi-Cal managed care program into 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura.

Since January 1, 2006, DHCS has been required to provide quarterly updates to the policy and fiscal committees of the Legislature on DHCS's core activities to improve the Medi-Cal managed care program as they relate to the 13 expansion counties.

Pursuant to SB 77, the quarterly updates shall include, when applicable:

- Progress or key milestones and objectives to implement changes to the existing program;
- Submittal of State Plan Amendments to the Centers for Medicare and Medicaid Services;
- Submittal of any federal waiver documents; and,
- Applicable key functions related to the effort to expand the Medi-Cal Managed Care Program.

This report is not intended to update the ongoing development, implementation, and expansion efforts pursuant to DHCS's Section 1115 Demonstration Waiver (Demonstration Waiver). Updates regarding the Demonstration Waiver, and expansions therein, are provided in DHCS's semi-annual report to the Legislature titled "Mandatory Enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care," as well as subsequent legislative reports mandated by law. The purpose of this report is to provide quarterly updates to the policy and fiscal committees of the Legislature on DHCS's core activities to improve the Medi-Cal managed care program relative to the 13 expansion counties listed above.

The expansion effort into the remaining counties of El Dorado, Imperial, Placer, Lake and San Benito, will continue pursuant to Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), otherwise known as the Rural County Medi-Cal Managed Care Expansion. An update regarding the Rural County Medi-Cal Managed Care Expansion is provided below.

Updates to this report are *italicized* for ease of review.

## **B. Medi-Cal Managed Care Rural County Expansion**

*Pursuant to AB 1467 (Chapter 23, Statutes 2012), the 2012-13 State budget authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 rural California counties. Currently beneficiaries in these counties are receiving their Medi-Cal on a Fee-For-Service (FFS) basis. On June 1, 2013, approximately 410,000 Medi-Cal beneficiaries will make the transition from FFS to Medi-Cal managed care in these rural 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, Nevada, Mono, 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 San Benito and Lake were part of this 13 county expansion effort; however, these counties to date still remain FFS counties. As a result, these counties are part of the 28 rural county expansion effort; however, as previously decided during the 13 county expansion the County Organized Health System (COHS) Central California Alliance for Health will expand into San Benito County, and Partnership HealthPlan of California will expand into Lake County.*

*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 remaining rural FFS counties. In November 2012, a Request for Application was issued inviting interested health plans to submit formal applications to DHCS.*

*Health plans that submit applications are required, among other things, to have previous experience serving Medicaid beneficiaries, including diverse populations, experience partnering with public and traditional safety net health care providers, and experience working with local stakeholders, including consumers, providers, advocates, and county officials on health plan oversight and in the delivery of care. Health plans are required to show recent successful experience with the expansion of managed care into a rural area. The application submission deadline is scheduled for January 21, 2013, and the acceptance and denial of applications is scheduled for February 25, 2013.*

## **C. MEDI-CAL MANAGED CARE DASHBOARD**

*DHCS is in the process of creating a Medi-Cal managed care dashboard. The first internal iteration of the dashboard will be finalized in the Spring of 2013. The dashboard will be used to monitor Medi-Cal managed care health plans (MCPs) to gain a better understanding of what is occurring at individual MCPs, as well as assess the MCP model on a statewide aggregate level. It will report on measures including enrollment, appeals and grievances, network adequacy, financial standing, and quality. In addition, the data will include breakouts of subsets of the Medi-Cal population, for example, Seniors and Persons with Disabilities and Healthy Families Program (HFP) populations.*

*Though the initial version will be finalized in the Spring of 2013, DHCS intends to continue to expand and evolve the dashboard following completion of this initial version based on stakeholder feedback and an assessment of the initial measures.*

#### **D. REDUCING HOSPITAL READMISSIONS COLLABORATIVE**

In July of 2011, DHCS began meeting with MCPs and DHCS's *External Quality Review Organization (EQRO)*, Health Services Advisory Group, to begin a new statewide collaborative Quality Improvement Project (QIP) titled, "Reducing All Cause Hospital Readmissions (ACR) Collaborative." *In this context, a hospital readmission is defined as a preventable or avoidable hospital admission that occurs within 30 days after discharge from the first or index hospital admission.*

Over the next three years, the goals for the ACR Collaborative are to: 1) understand the reasons why Medi-Cal members 21 years of age and older are readmitted to the hospital, and 2) identify and implement effective strategies to reduce hospital readmission rates.

*In 2012, MCPs in collaboration with the Medi-Cal Managed Care Division (MMCD) and its EQRO developed guiding principles for the collaborative process and a customized Healthcare Effectiveness Data Information Set (HEDIS)-like measure specific to the Medi-Cal population. Additionally, this workgroup began developing an evaluation plan for this collaborative.*

*MCPs submitted their ACR Collaborative QIP proposals to MMCD, including barrier analysis, planned interventions, and 2011 historical data. All MCP QIP proposals were reviewed by MMCD and then validated by the EQRO. MCPs will be ready to begin implementation of planned interventions in January 2013.*

*In June 2013, the EQRO will publish an interim report that details the activities of the ACR Collaborative through the study design phase of the QIPs.*

#### **E. ASSEMBLY BILL 1422 GROSS PREMIUMS TAX SUNSET EXTENSION**

AB 1422 (Bass, Chapter 157, Statutes of 2009) added MCPs to the list of entities subject to California's gross premiums tax, or Managed Care Organization (MCO) tax, a 2.35 percent tax on total operating revenue. The proceeds from this tax are appropriated to DHCS for the Medi-Cal managed care program and to the Managed Risk Medical Insurance Board (MRMIB) for the HFP.

The bill took effect retroactively to January 1, 2009, and was scheduled to sunset on January 1, 2011. SB 208 (Steinberg, Chapter 714, Statutes of 2010) extended the sunset date of AB 1422 to June 30, 2011. State Budget Health Trailer Bill ABX1 21 (Blumenfield, Chapter 11, Statutes of 2011) extended the sunset date again from June 30, 2011 to June 30, 2012. In 2012, DHCS proposed trailer bill language to extend the MCO tax; however, this proposal was denied.

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

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented maternity supplemental payments and risk-adjusted capitation rates for Two-Plan Model (TPM) and Geographic Managed Care (GMC) MCPs. The maternity supplemental payments to MCPs were in addition to monthly capitation payments and were based on MCP reports of delivery events.

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 are being 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 will be phased in using a rate comprised of 35 percent risk-adjusted county average rates and 65 percent plan-specific rates.

*Currently, rates are being developed to reflect the effects of SB 208 (Steinberg, Chapter 714, Statutes of 2010), AB 97 (Committee on Budget, Chapter 3, Statutes of 2011), SB 335 (Hernandez, Chapter 286, Statutes of 2011), the Patient Protection and Affordable Care Act, and adjustments for the Genetically Handicapped Persons Program, Community Based Adult Services (CBAS), and HFP.*

## **G. COMMUNITY BASED ADULT SERVICES**

AB 97 eliminated Adult Day Health Care (ADHC) services as an optional Medi-Cal benefit. DHCS became the defendant in a lawsuit (*Darling v. Douglas*) to halt the elimination of ADHC. DHCS entered into a settlement agreement with the plaintiffs to establish a new program called CBAS that offers some of the same services as ADHC and allows beneficiaries to remain in their communities; however, CBAS has stricter eligibility requirements to achieve cost savings.

ADHC ended on February 29, 2012, and fee-for-service CBAS began on March 1, 2012. The MCPs operating in COHS counties began covering CBAS on July 1, 2012, with the exception of Gold Coast Health Plan (GCHP) in Ventura County. *The TPM, GMC and GCHP MCPs began covering CBAS on October 1, 2012.*

MCPs contracted with former ADHC centers that are certified CBAS providers. MCPs assume two responsibilities in relation to CBAS: 1) the assessment process to determine eligibility for CBAS, and 2) the reassessment process to ensure that CBAS members continue to receive the level of CBAS services needed. DHCS executed contract amendments outlining MCP responsibilities in managing CBAS that included rates to cover the daily provision of CBAS.

## **H. HEALTHCARE EFFECTIVENESS DATA INFORMATION SET**

*DHCS is in the process of finalizing the annual update to the quality and performance improvement program requirements for 2013, and anticipates its release and posting to the MMCD website in April 2013:*

<http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>

*DHCS is in the process of finalizing questions that will be used in the Consumer Assistance of Healthcare Providers and Systems Survey which will be conducted in 2013. DHCS administers this survey every three years, and the information gathered is used to evaluate Medi-Cal beneficiaries' experiences and satisfaction levels with the health care received.*

## **I. HEALTHY FAMILIES PROGRAM TRANSITION**

*AB 1494 (Committee on Budget, Chapter 28, Statutes of 2012) provides for the transition of HFP subscribers to Medi-Cal commencing January 1, 2013. HFP, administered by MRMIB, provides children with health, dental, and vision coverage. By the conclusion of 2013, DHCS intends to transition children enrolled in the HFP to the Medi-Cal program under a newly created Targeted Low-Income Children's (TLIC) Program, where they will continue to receive their health, dental, and vision benefits, as well as mental health and substance use disorder services.*

*The transition of the HFP children will occur throughout 2013 in four primary phases. In the first two phases HFP children will be linked with a MCP that is also the child's current HFP health plan, either through direct assignment or assignment to a plan that subcontracts with a MCP. In phase three, children will be given a choice of MCPs available in their county of residence, with the exception of COHS counties where the child will be assigned to the only available MCP, the COHS plan. Phase four children will be transitioned into MCPs that are implemented pursuant to the Medi-Cal Managed Care Rural County Expansion authorized by AB 1467.*

*Additionally, effective January 1, 2013, MCPs will begin servicing any new eligible children under the TLIC Program.*

*A schedule of the four phases:*

*Phase 1, Part A: Will be no sooner than January 1, 2013, with children transitioning into Medi-Cal MCPs in the following counties: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego (with the exception of Health Net). This phase includes approximately 197,000 children.*

*Phase 1, Part B: Will be no sooner than March 1, 2013, with children transitioning into Medi-Cal MCPs in the following counties (with the exception of Health Net): Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Tulare, Sacramento, Napa, Solano,*

*Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo. This phase includes approximately 95,000 children.*

*Phase 1, Part C: Will be no sooner than April 1, 2013, with children in Health Net transitioning into Medi-Cal MCPs in the following counties: Kern, Los Angeles, Tulare, Sacramento, San Diego, San Joaquin, and Stanislaus. This phase includes approximately 110,000 children.*

*Phase 2: Will be no sooner than April 1, 2013, children enrolled in a HFP health plan that is also the subcontractor of a Medi-Cal MCP in the child's county of residence, to the extent possible, will be enrolled into a MCP that includes the child's current plan. This phase includes approximately 268,000 children.*

*Phase 3: Will be no sooner than August 1, 2013, children enrolled in a HFP health plan that is not a Medi-Cal MCP, and does not contract or subcontract with a Medi-Cal MCP in the child's county of residence, will be enrolled in a Medi-Cal MCP in that county. Enrollment shall include consideration of the child's primary care providers pursuant to the requirements of state statute.*

*Phase 4: Will be no sooner than September 1, 2013, children residing in a county that is not currently a Medi-Cal managed care county will be transitioned into Medi-Cal MCPs, upon the successful completion efforts to expand Medi-Cal managed care statewide. Pursuant to AB 1467, DHCS is in the process of expanding Medi-Cal managed care into the 28 rural counties that do not currently have managed care. DHCS intends to complete this expansion prior to September 1, 2013.*

## Attachment A

### Abbreviations and Acronyms

AB	Assembly Bill
ACR	All Cause Hospital Readmissions
ADHC	Adult Day Health Care
CBAS	Community Based Adult Services
COHS	County Organized Health System
Demonstration Waiver	DHCS's Section 1115 Demonstration Waiver titled, "California's Bridge to Reform."
DHCS	Department of Health Care Services
EQRO	External Quality Review Organization
FFS	Fee-For-Service
GCHP	Gold Coast Health Plan
GMC	Geographic Managed Care
HEDIS®	Healthcare Effectiveness Data and Information Set
HFP	Healthy Families Program
MCO	Managed Care Organization
MCP	Medi-Cal Managed Care Health Plan
MMCD	Medi-Cal Managed Care Division
MRMIB	The Managed Risk Medical Insurance Board
QIP	Quality Improvement Project
SB	Senate Bill
TLIC	Targeted Low-Income Children
TPM	Two-Plan Model