



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

**For the Reporting Period
January through March 2014**

**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)**

TABLE OF CONTENTS

A. Purpose of the Report.....	1
B. Background.....	2
C. Medi-Cal Managed Care Dashboard.....	3
D. Utilization Data Reporting.....	4
E. State Fair Hearings.....	4
F. Risk-Adjusted Capitation Rates.....	5
G. Measuring Quality of Care Provided to Beneficiaries by MCPs.....	6
H. Continuity of Care.....	6
I. Healthy Families Program (HFP) Transition.....	7
J. Outpatient Mental Health and Substance Use Disorder Services.....	9
K. State Plan Amendments and Federal Waivers.....	11
Attachment A: Medi-Cal Managed Care Division Update of Rural Expansion Dates, Managed Care Models and Plans.....	12
Attachment B: Abbreviations and Acronyms.....	14

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.*

Even though this is the first AB 1467 quarterly report that DHCS is submitting to the Legislature, DHCS has been reporting on rural expansion efforts for several years pursuant to AB 131 (Committee on Budget, Chapter 80, Statutes of 2005, Section 34). AB 131 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 a comprehensive account of Medi-Cal managed health care expansion into California's rural counties.

Note: New updates to this report, including the AB 1467 additions and AB 131 updates are in *italics* for ease of review. *It is important to note that this report only covers activities between January 2014 and March 2014. Any developments in managed care in rural counties that have already occurred, but took place after March 2014 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 (Committee on Budget, Chapter 23, Statutes of 2012), 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 are 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 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 Health Plan 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 Partnership Plan 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 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 Partnership Plan).

Of the approximate 400,000 Medi-Cal FFS beneficiaries in these rural counties, 110,000 in the eight COHS counties of Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity transitioned to managed care on September 1, 2013. The following populations were mandatorily enrolled into Medi-Cal managed care 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 transitioning Healthy Families Program (HFP) population. Beneficiaries receiving Community-Based Adult Services (CBAS) benefits in the two rural COHS counties which have CBAS centers (Humboldt and Shasta) will continue to receive CBAS benefits through Medi-Cal FFS. The CBAS benefit will convert 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. Over 180,000 beneficiaries in these counties transitioned from Medi-Cal FFS to managed care. The HFP and the children and family aid codes populations were mandatorily enrolled into Medi-Cal managed care, except for San Benito County where all populations were treated as voluntary. Dual-eligibles and SPDs were voluntary populations but will become mandatory populations *no sooner than* April 2014. Beneficiaries in these counties which have CBAS centers (Butte and Imperial) continue to receive CBAS benefits through Medi-Cal FFS until the benefit converts to a managed care benefit on December 1, 2014.

Additional information on Medi-Cal managed care expansion activities can be found on the DHCS Medi-Cal Managed Care Expansion Page at the following link:
<http://www.dhcs.ca.gov/provgovpart/Pages/Medi-CalManagedCareExpansion.aspx>

C. MEDI-CAL MANAGED CARE DASHBOARD

On February 6, 2014, DHCS released the Quarter 3, 2013, edition of the Medi-Cal Managed Care Division (MMCD) Performance Dashboard for the Medi-Cal Managed Care program. The MMCD Dashboard was developed with funding from the California HealthCare Foundation. The dashboard is available at:
http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_2013.pdf.

The dashboard will help DHCS and its stakeholders *to identify trends and better observe and* understand MCP activities on all levels: statewide, by managed care model (i.e., COHS, Two-Plan Model [TPM], Geographic Managed Care [GMC], *and Regional Model*), and within an individual MCP. *The dashboard includes* metrics submitted by

MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, MCP finances, care coordination, and continuity of care. The dashboard also *stratifies* reported data by beneficiary population including Medi-Cal-only SPDs, *dual-eligible beneficiaries, and children transitioned from HFP into Medi-Cal managed care.*

DHCS plans to post the Quarter 4 - 2013 edition of the MMCD Performance Dashboard in May 2014 and will conduct a webinar with stakeholders to discuss the results.

D. UTILIZATION DATA REPORTING

Utilization data for Medi-Cal managed care rural expansion for the period of January through March 2014 will be reported in a future report. Due to a lag time in the data, utilization rates reported at this time are incomplete. Once the rural expansion utilization data is complete, DHCS will report these rates, as appropriate, consistent with other managed care expansion populations.

E. STATE FAIR HEARINGS

For the reporting period of January through March 2014, there were a total of 774 state fair hearings:

- *January: 240*
- *February: 251*
- *March: 283*

Of the 774 hearings, 545 (70.4%) were the responsibility of the MCP, 225 (29.1%) were the responsibility of DHCS, and 4 (0.5%) were the responsibility of both DHCS and the MCP. DHCS grouped the hearings in the following categories:

- *Health plan quality of care: 681*
 - *Delay/denial of medication/prescription: 169*
 - *SPD denial/delay of medical exemption request (MER)/emergency disenrollment exemption request (EDER): 133*
 - *Delay/denial of surgery/treatment: 96*
 - *Delay/denial of MER/EDER: 90*
 - *Delay/denial of durable medical equipment: 51*
 - *Delay/denial of consultation/specialist: 41*
 - *Delay/denial of diagnostic testing: 29*
 - *Denial of medical supplies: 22*
 - *Delay/denial of referral: 18*
 - *Inpatient hospital stay: 11*
 - *Delay/denial of CBAS services: 8*
 - *Delay/denial of speech therapy: 7*
 - *Delay/denial of physical therapy: 5*
 - *Denial of home care: 2*
 - *Delay/denial of rehabilitation therapy: 1*

- Health care plan issues: 59
 - Dispute of services: 58
 - Transportation issue: 1
- Plan subcontractor/provider issues: 32 (100% - billing issues);
- Eligibility (share of cost): 1

DHCS categorized the hearing resolutions as follows:

- Withdrawal: 260 (33.6%)
- Denied: 172 (22.2%)
- Non-appearance: 114 (14.7%)
- Closed by compliance: 81 (10.5%)
- Redirect: 56 (7.2%)
- Granted: 50 (6.5%)
- Dismissed: 38 (4.9%)
- Granted in part: 3 (0.4%)

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 TPM and GMC 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 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.

There is nothing to report for the January through March 2014 reporting period.

G. MEASURING QUALITY OF CARE PROVIDED TO BENEFICIARIES BY MCPs

California's *External Accountability Set (EAS)* measures assess the quality of services provided by MCPs, and form the basis for quality improvement efforts. DHCS's 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]).

During the *first quarter of 2014*, DHCS *continued its* targeted approach to MCPs with substandard performance. The one MCP with persistent, pervasive substandard performance *submitted a* Corrective Action Plan, *and DHCS met with this MCP on a monthly basis to assess its progress. DHCS provided intensified monitoring to additional MCPs that did not meet the MPL, including reviewing the MCP's quarterly evaluations of their rapid cycle improvement efforts.* DHCS also worked with *the external quality review organization to proactively utilize the MCPs' Quality Improvement Plans to ensure performance exceeds the minimum requirements. DHCS has begun to require all MCPs with poor performance to develop quarterly targets for interim outcomes that can be assessed during the year. For the MCP that submitted the Corrective Action Plan, these process measures have shown some successes. The final annual outcomes for measurement year 2014 will be reported in summer 2015.*

During the *first quarter of 2014*, DHCS *obtained input from within DHCS and from MCPs to adopt the National Quality Forum's criteria for evaluating performance measures. These criteria are being used to review the current EAS indicators in light of CMS's Core Child and Adult set of measures. This will result in DHCS implementing these revisions to the EAS in measurement year 2015, and reporting on them no sooner than June 2016.*

H. CONTINUITY OF CARE

In the interest of preserving a beneficiary's access to a FFS primary care provider (PCP) and specialists, DHCS established continuity of care protections for beneficiaries in rural counties who are being transitioned from FFS and into MCPs. State law requires MCPs to provide beneficiaries with the completion of certain covered services that the beneficiary was receiving from a non-participating provider or from a terminated provider, subject to certain conditions. Continuity of care services must be provided for up to 12 months for the following: an acute condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn child, and the performance of certain previously planned surgeries as stipulated in Health and Safety Code Section 1373.96. DHCS developed the continuity of care protections in collaboration with stakeholders and presented the protections at various stakeholder forums.

DHCS is developing a continuity of care webpage that will assist providers and beneficiaries in navigating the continuity of care process and will outline beneficiary protections. The webpage will include key DHCS policy guidance and will be launched in April 2014.

DHCS monitors continuity of care requests for rural expansion through health plan data reporting. For the period of January through March 2014, 625 of 687 (91%) of continuity of care requests were granted. Based on the content of the data submissions, DHCS contacts each MCP operating in a rural county to discuss continuity of care denials. In the limited circumstances when continuity of care was denied, the provider was either a current MCP provider or was unwilling to contract with the MCP, or the MCP was unable to contact the beneficiary. In those instances, the MCP is contractually required to work with the beneficiary to obtain treatment through an in-network PCP or specialist. DHCS will continue to monitor the continuity of care process.

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 an MCP network on a permanent basis.

I. HEALTHY FAMILIES PROGRAM (HFP) TRANSITION

AB 1494 (Committee on Budget, Chapter 28, Statutes of 2012), as amended by AB 1468 (Committee on Budget, Chapter 438, Statutes of 2012), provided for the transition of HFP subscribers to Medi-Cal commencing January 1, 2013. The HFP, administered by the Managed Risk Medical Insurance Board, provided children with health, dental, and vision coverage. Throughout 2013, DHCS transitioned children enrolled in the HFP into the Medi-Cal program under a newly created Optional Targeted Low-Income Children's (OTLIC) Program, from which these children will continue to receive their health, dental, and vision benefits, as well as mental health (MH) and substance use disorder (SUD) services.

The transition of HFP children occurred in four primary phases (see schedule of the four phases below). In the first two phases, HFP children were linked to a MCP that was also the child's HFP health plan, by either direct assignment or assignment to *the Medi-Cal MCP* that subcontracted with the *HFP health plan*. In Phase 3, children who had no linkage to the MCPs in their county of residence were given a choice of MCPs available in their county of residence, with the exception of COHS counties where the child was assigned to the only available MCP, the COHS plan. In Phase 4, children transitioned into those MCPs that were implemented pursuant to the Medi-Cal Managed Care Rural County Expansion authorized by AB 1467.

Additionally, effective January 1, 2013, MCPs began servicing newly eligible children under the OTLIC Program.

A schedule of the four phases follows:

Phase 1, Part A: Effective January 1, 2013, children transitioned into Medi-Cal MCPs in the following counties: Alameda, Orange, Riverside, Santa Clara, San Bernardino, San

Diego, San Francisco, and San Mateo (with the exception of HFP children in Health Net in San Diego). This phase included approximately 178,643 children.

Phase 1, Part B: Effective March 1, 2013, children transitioned into Medi-Cal MCPs in the following counties: Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Monterey, Napa, Sacramento, Santa Barbara, Santa Cruz, San Luis Obispo, Solano, Sonoma, Tulare, and Yolo (with the exception of HFP children in Health Net in Kern, Los Angeles, Sacramento, and Tulare). This phase included approximately 92,352 children.

Phase 1, Part C: Effective April 1, 2013, children transitioned into Medi-Cal MCPs in San Joaquin and Stanislaus counties, *as well as into* Health Net in Kern, Tulare, and Sacramento counties. Children in Health Net in Los Angeles and San Diego counties transitioned into Medi-Cal MCPs on May 1, 2013. This phase included approximately 98,577 children, of which approximately 62,557 transitioned on May 1, 2013.

Phase 2: Effective April 1, 2013, children enrolled in an HFP health plan that was also a subcontractor of a Medi-Cal MCP in the child's county of residence, to the extent possible, were enrolled into a MCP that included the child's HFP plan. This phase included approximately 228,194 children.

Phase 3: Effective August 1, 2013, children enrolled in a HFP health plan that was not a Medi-Cal MCP, and didn't contract or subcontract with a Medi-Cal MCP in the child's county of residence, were enrolled in a Medi-Cal MCP in that county. *Families were provided with the opportunity to choose their children's MCP ahead of the transition date. Default* enrollment included consideration of the child's primary care providers pursuant to the requirements of State statute. This phase included approximately 95,801 children.

Phase 4, *Part A*: Effective September 1, 2013, children residing in a county that was not a Medi-Cal managed care county were transitioned into Medi-Cal MCPs upon the successful completion of efforts to expand Medi-Cal managed care. DHCS completed this expansion in the eight northern California counties of Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity on September 1, 2013. *This phase included approximately 6,840 children.*

Phase 4, Part B: Effective November, 1, 2013, children residing in a county that was not a Medi-Cal managed care county were transitioned into Medi-Cal MCPs upon the successful completion of efforts to expand Medi-Cal managed care. DHCS completed this expansion into 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. This phase included approximately 25,087 children.

Access for Infants and Mothers (AIM)-linked children, who are children born to women enrolled in the AIM program, transitioned on a different timeline. Those children born to

women enrolled in AIM received automatic eligibility in HFP for up to the child's first year. Beginning on August 1, 2013, *with the Phase 3 transition*, AIM-linked children began transitioning into Medi-Cal. *The transition of AIM-linked children continued on November 1, 2013, with the Phase 4, Part B transition. The final group of AIM-linked children transitioned to Medi-Cal effective February 1, 2014.* The HFP ceased operations on January 31, 2014.

DHCS has worked cooperatively with consumers, stakeholders and legislative staff to facilitate a smooth transition of HFP to Medi-Cal. The following link provides information on stakeholder meetings that have been held with postings of recorded webinars, slideshow presentations and other reference documents:

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

J. 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 (SB) X1-1 (Hernandez and Steinberg, Chapter 4, Statutes of 2013), effective January 1, 2014, California *has expanded* MH and SUD services provided through the Medi-Cal program.

DHCS *expanded* the Medi-Cal MH services available to its beneficiaries and MCPs will be required to provide covered MH benefits, excluding those benefits provided by the county Mental Health Plans (MHPs) under the Specialty Mental Health Services Waiver. Outpatient MH benefits will be available through MCPs for beneficiaries with mild to moderate impairment of mental, emotional or behavioral functioning resulting from any MH condition defined by the current Diagnostic and Statistical Manual. For beneficiaries not enrolled in an MCP, these benefits will be provided through Medi-Cal FFS.

Medi-Cal specialty mental health services currently provided by the MHPs will continue to be provided by the MHPs for Medi-Cal beneficiaries that meet the medical necessity criteria. 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 will be required to provide Screening and Brief Intervention and Referral to Treatment services for alcohol misuse by adults.

DHCS was required to submit and seek approval from CMS to implement the MH and SUD benefit expansion. DHCS prepared the following documents:

- SPA 13-008 to expand psychology services to all beneficiaries and remove the two-visit limit on psychology services effective January 1, 2014. CMS approved the SPA on December 19, 2013. The letter and approved SPA are available at this link:

<http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Approved%20State%20Plan%2013-008%20ADA.pdf>;

- DHCS revised the Standard Terms and Conditions (STCs) for the 1115(a) Demonstration Waiver through amendment 11-W-00193/9 to carve in the additional behavioral health benefits into managed care. CMS approved the STCs on December 24, 2013; and
- CMS approved amendments to the Specialty Mental Health Services 1915(b) waiver on December 26, 2013. DHCS sought a five year waiver renewal term, but CMS approved a two year term, from July 1, 2013, through June 30, 2015.

DHCS released two All Plan Letters (APLs) which provide guidance and applicable requirements related to the expanded MH benefits. DHCS published APL 13-018 which describes the responsibilities of Medi-Cal MCPs for amending or replacing the Memoranda of Understanding (MOU) with county MHPs for the coordination of Medi-Cal MH services. APL 13-018 is available at this link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>.

DHCS published APL 13-021 which describes the MCPs' responsibilities for providing outpatient MH services to adults and children. APL 13-021 can be accessed here:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf>.

MCPs have reported to DHCS that beneficiaries are interested in the new MH benefits and providers, MCPs, and MHPs are working together and effectively communicating, referring beneficiaries, as appropriate, and processing the claims. If the beneficiaries are confused about the services, the MCPs report that they are handling those issues at the local level and directing beneficiaries to the appropriate location to receive care.

DHCS remains engaged in several issues that have required a more in-depth stakeholder process. For example, there is a Service System Dispute Resolution Workgroup within DHCS that is working to develop a process to ensure that beneficiaries are not juggled between the MCPs and the MHPs and that no beneficiary falls through the cracks.

Other issues are being worked out on a county-by-county basis and with DHCS oversight. For example, MCPs and MHPs are in the process of developing or amending their memorandums 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. In addition, APL 13-018 provides information regarding the MHP MOU and MCP MOU requirements. APL 13-018 can be found at the following link: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>. The MOUs are due to DHCS by June 30, 2014.

DHCS continues to be involved in several stakeholder outreach efforts and to develop materials to provide guidance to MCPs on providing the mental health and substance use disorder 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

K. STATE PLAN AMENDMENTS AND FEDERAL WAIVERS

On December 24, 2013, DHCS received approval from CMS for the “California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment Medi-Cal Expansion to Newly Eligible Individuals/Integration of Medi-Cal Outpatient Mental Health Services” waiver amendment.

This waiver amendment allows the State to extend Medicaid services to childless adults as described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Many of these individuals were already enrolled through the existing Demonstration Waiver’s Low Income Health Programs (LIHPs). This waiver amendment also allows for a seamless transition of LIHP-Medi-Cal Expansion program beneficiaries into the Medi-Cal managed care delivery system. Further, this waiver amendment provides DHCS with the federal authority to enroll a newly eligible population, that can now qualify for Medi-Cal, based on expanded income eligibility criteria, as described in AB X1-1 (Perez, Chapter 3, Statutes of 2013). Specifically, AB X1-1 expands Medi-Cal eligibility to childless adults with annual incomes up to 133 percent of the federal poverty level, effective January 1, 2014. Finally, this waiver amendment authorizes DHCS to expand the Medi-Cal managed care package of benefits to include outpatient mental health services and allows DHCS to require MCPs to cover outpatient mental health services provided by licensed health care professionals acting within the scope of their license. Those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver are excluded. Additional information is included above in the “Outpatient Mental Health and Substance Use Disorder Services” section.

On March 19, 2014, CMS approved further amendments to California's section 1115(a) demonstration (11-W-00193/9), entitled "California Bridge to Reform Demonstration." The amendment relevant to rural counties provides clarification to the Special Terms and Conditions needed to allow the Program for All-Inclusive Care for the Elderly (PACE) to operate in Humboldt County, alongside the Humboldt County Operated Health System. COHS plans must enroll all Medicaid beneficiaries residing in the county in which it operates. In Humboldt County, beneficiaries may be subsequently disenrolled from COHS and enrolled in PACE, if eligible. Medicaid beneficiaries residing in COHS counties may not be enrolled in any other alternative delivery system without prior approval from CMS and an amendment to this demonstration.

**Attachment A
Medi-Cal Managed Care Division
Update of Rural Expansion Dates
Managed Care Models and Plans**

County	Implementation Date	Managed Care Model	Plan Name(s)
Del Norte	9/1/2013	County Organized Health System (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 Division
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
San Benito	11/1/2013	San Benito Model	Anthem Blue Cross Partnership Plan

Attachment B

Abbreviations and Acronyms

AB	Assembly Bill
ACR	All-Cause (Hospital) Readmissions
AIM	Access for Infants and Mothers
APL	All Plan Letter
CBAS	Community-Based Adult Services
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health System
DHCS	Department of Health Care Services
<i>EAS</i>	<i>External Accountability Set</i>
<i>EDER</i>	<i>Emergency Disenrollment Exemption Request</i>
EDIP	Encounter Data Improvement Project
EDQMRP	Encounter Data Quality Monitoring and Reporting Plan
EDQU	Encounter Data Quality Unit
EQRO	External Quality Review Organization
FFS	Fee-For-Service
GMC	Geographic Managed Care
HFP	Healthy Families Program
HSAG	Health Services Advisory Group, Inc.
LIHP	Low Income Health Program
MCP	Medi-Cal Managed Care Health Plan
<i>MER</i>	<i>Medical Exemption Request</i>
MH	Mental Health
MHP	Mental Health Plan
MMCD	Medi-Cal Managed Care Division
<i>MOU</i>	<i>Memoranda of Understanding</i>
MPL	Minimum Performance Level
<i>OTLIC</i>	<i>Optional Targeted Low-Income Children's (OTLIC) Program</i>
<i>PACE</i>	<i>Program for All-Inclusive Care for the Elderly</i>
<i>PCP</i>	<i>Primary Care Provider</i>
RFA	Request for Application
SB	Senate Bill
SPA	State Plan Amendment
SPD	Seniors and Persons with Disabilities
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TLIC	Targeted Low-Income Children
TPM	Two-Plan Model