



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

**For the Reporting Period
July through September 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)**

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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 requires 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: Updates to the prior quarterly report, are italicized for ease of review. It is important to note that this report only covers activities between *July and September 2014*. Any developments in managed care in rural counties that have already occurred, but took place after *September 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, 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 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. 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. Dual-eligibles and SPDs continue to be voluntary populations; however, SPDs will become a mandatory population on December 1, 2014, with the exception of San Benito County. 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 Medi-Cal managed care benefit on December 1, 2014.

C. MEDI-CAL MANAGED CARE PERFORMANCE DASHBOARD

On *August 18, 2014*, DHCS released the *third iteration* of the Medi-Cal Managed Care Performance Dashboard. The Dashboard was developed with funding from the California HealthCare Foundation. The *August 2014* Dashboard is available at *the following link*:

http://www.dhcs.ca.gov/services/Documents/MMCD/MMCD_Dashboard_August2014.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, *formerly Low Income Health Program 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 *July* through *September* 2014 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. 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 *July* through *September* 2014, there were a total of 682 state fair hearings. This reflects a decrease from the *April* through *June* 2014 reporting period, where there were a total of 720 state fair hearings:

- *July 2014: 269*
- *August 2014: 238*
- *September 2014: 175*

Of the 682 hearings, 410 (60.1%) were the responsibility of the MCP, 270 (39.6%) were the responsibility of DHCS and 2 (0.3%) were the responsibility of both DHCS and the MCP. DHCS grouped the hearings in the following categories:

- Health plan quality of care: 572
 - SPD denial/delay of medical exemption request (MER)/emergency disenrollment exemption request (EDER): 185
 - Delay/denial of medication/prescription: 98
 - Delay/denial of surgery/treatment: 76
 - Delay/denial of MER/EDER: 72
 - Delay/denial of consultation/specialist: 28
 - Delay/denial of diagnostic testing: 27
 - Delay/denial of referral: 24
 - Delay/denial of durable medical equipment: 14
 - Inpatient hospital stay: 12
 - Denial of medical supplies: 10
 - Delay/denial of physical therapy: 10
 - Delay/denial of speech therapy: 6
 - Delay/denial of long term care: 4
 - Denial of home care: 3
 - Delay/denial of CBAS services: 2
 - *Delay/denial of rehabilitation therapy: 1*
- Plan subcontractor/provider issues: 33
 - *Billing issues: 33*
- Health care plan issues: 65
 - Dispute of services: 59

- Transportation issue: 6
- Miscellaneous issues: 8
 - Dental issues: 8
- Eligibility: 5
 - *Medi-Cal*: 4
 - *Share of Cost*: 1

DHCS categorized the hearing resolutions as follows:

- Withdrawal: 317 (46.5%)
- Non-appearance: 106 (15.5%)
- Denied: 92 (13.5%)
- Closed by compliance: 86 (12.6%)
- Redirect: 64 (9.4%)
- Dismissed: 9 (1.3%)
- Granted: 8 (1.2%)

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.

There were fluctuations in the *July* through *September* 2014 data compared to the *April* through *June* 2014 reporting period; however, the data gathering systems are not capable of capturing the reasons for data fluctuations.

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 (TPM) and Geographic Managed Care (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.

Capitation rates for the rural expansion counties are not risk adjusted at this time. There is nothing new to report for the *July through September 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 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. 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 California Health and Wellness and Anthem Blue Cross to define two regions (groups of rural counties) that will provide a sufficient number of beneficiaries in order to provide meaningful reporting and quality improvement. Reporting on these two regions will begin in 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 *and DHCS will report on the data at a later time*. DHCS will continue to monitor the continuity of care process. *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*. 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. 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 (SBIRT) services for alcohol misuse by adults, *though MCPs are not responsible for administering the treatment*.

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

To assist MCPs in the implementation of MH and SUD services, DHCS released four All Plan Letters (APLs) which provide guidance and applicable requirements related to the expanded MH and SUD benefits:

- APL 13-018, November 27, 2013: 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 mental health services. The APL is available at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>.
- APL 13-021, December 13, 2013: describes the MCPs' responsibilities for providing outpatient mental health services to adults and children. The APL is available at:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf>.
- APL 14-004, February 10, 2014: explains the obligations of Medi-Cal MCPs to provide SBIRT services for MCP *beneficiaries* ages 18 and older who misuse alcohol. The APL is available at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-004.pdf>; and
- APL 14-005, March 11, 2014: notifies the MCPs that voluntary inpatient detox (VID) is a new FFS Medi-Cal benefit that is available to all Medi-Cal beneficiaries who meet medically necessary criteria. Beneficiaries may receive VID services in a general acute hospital. The APL is available at the following link:
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-005.pdf>.

MCPs continue to report to DHCS that beneficiaries are interested in the Medi-Cal mental health benefits and providers, MCPs, and MHPs are working together and effectively communicating, referring beneficiaries, as appropriate, and processing the claims. If 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, 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. This workgroup will transition its focus to other MH issue areas. DHCS will begin the next workgroup series in the beginning of 2015, with the next series of meetings focusing on excluded diagnoses.*

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 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, *as stated above*, APL 13-018 provides information regarding the MHP MOU and MCP MOU requirements. The MOUs were due to DHCS by June 30, 2014. *Out of 98 total MOUs, DHCS received*

and executed 81 MOUs. DHCS received but has not executed 14 MOUs, due to the MOUs being under county review and/or awaiting final signature. The remaining 17 MCPs have not submitted their MOUs. DHCS is requiring these MCPs to submit monthly status updates and is in continued communication with these MCPs to ensure the MOUs are completed promptly.

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 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 is currently identifying key agencies, departments, and organizations to include as part of the process and is organizing expert stakeholder groups that will meet to discuss specific issue areas. DHCS will continue to work closely with CMS and stakeholder groups through 2014 and 2015 as part of the 2015 Waiver renewal process.

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

On August 9, 2014, DHCS submitted an amendment to the 1115 Waiver to mandatorily enroll SPDs in rural managed care counties, effective December 1, 2014. DHCS expects to receive a response from CMS in the coming months.

There are no State Plan Amendment updates for the July through September 2014 reporting period.

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.

The eight CCI counties participating in Cal MediConnect are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

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 fee-for-service or an MA plan.

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 Medi-Cal LTSS benefits 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.

In July 2014 the following activities occurred:

- *Passive enrollment of dual-eligibles in Medi-Cal managed care and in Medi-Cal FFS into Cal MediConnect plans began in Los Angeles County.*
- *Dual-eligibles who reside in Los Angeles County and who opt out of Cal MediConnect and are enrolled in Medi-Cal FFS began to receive Medi-Cal LTSS.*
- *Dual-eligibles who reside in Santa Clara County and who are already in Medi-Cal managed care began to receive Medi-Cal LTSS benefits.*
- *A Superior Court judge ruled that the State may appoint a conservator to take over the finances of Alameda Alliance for Health, which is also the Cal MediConnect plan for Alameda County. The conservatorship will operate for a year and is retroactive to May 5, 2014, which is the day that the Department of Managed Health Care took over the finances of Alameda Alliance.*

In August 2014, dual-eligibles in Medi-Cal FFS, but excluded from Cal MediConnect, began to receive Medi-Cal LTSS benefits in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara Counties

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/ci-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	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

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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 <i>Molina Healthcare of California Partner Plan, Inc.</i>
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
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
EAS	External Accountability Set
EDER	Emergency Disenrollment Exemption Request
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.
<i>LTSS</i>	<i>Long Term Services and Supports</i>
<i>MA</i>	<i>Medicare Advantage</i>
MCP	Medi-Cal Managed Care Health Plan
MER	Medical Exemption Request
MHP	Mental Health Plan
MOU	Memoranda of Understanding
MPL	Minimum Performance Level
PCP	Primary Care Provider
RFA	Request for Application
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SPA	State Plan Amendment
SPD	Seniors and Persons with Disabilities
STC	Special Terms and Conditions
TLIC	Targeted Low-Income Children
TPM	Two-Plan Model
VID	Voluntary Inpatient Detoxification