



QUARTERLY UPDATE

MEDI-CAL MANAGED CARE PROGRAM

**For the Reporting Period
January through March 2013**

**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.

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 counties of Kings, Madera, Marin, Merced, Mendocino, San Luis Obispo, Sonoma, and Ventura is now complete.* 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 Medi-Cal Managed Care Rural County Expansion. An update regarding this 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 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 *September 1, 2013*, approximately *400,000* Medi-Cal beneficiaries will begin to 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 *El Dorado, Imperial, Placer, Lake and San Benito* 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. *As previously decided during the 13 county expansion effort, Lake County will become a County Organized Health System (COHS) 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 (RFA) was issued inviting interested health plans to submit formal applications to DHCS.

Health plans that *submitted applications were* 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 *were* required to show recent successful experience with the expansion of managed care into a rural area.

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, §14087.98(b) and authorized under AB 1467, DHCS chose to enter into an exclusive health plan contract with an existing COHS for these seven counties.

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 are contingent upon all the plans' completion of state and federal plan-readiness activities. Additionally, DHCS will contract with Kaiser Foundation Health Plan in three (3) of these counties (Amador, El Dorado, and Placer) to assure continuity of care given Kaiser's closed network.

DHCS, in collaboration with the Imperial County Public Health Department participated in a community meeting that was publically noticed for stakeholders in Imperial County on December 6, 2012. Local providers and Medi-Cal managed care plans 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 and its effect on access to services. Imperial County selected a plan model and DHCS approved their operation as a single plan model, using Geographic Managed Care (GMC) enrollment rules.

San Benito County, originally planned as a COHS, will instead operate as a single plan model, similar to Imperial.

C. MEDI-CAL MANAGED CARE DASHBOARD

DHCS is in the process of creating a Medi-Cal managed care dashboard. *Through funding from the California Healthcare Foundation (CHCF), DHCS and CHCF have engaged a vendor, Navigant, to help facilitate the dashboard process.* 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 MCPs on a statewide aggregate level. The dashboard 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 (SPDs) and Healthy Families Program (HFP) populations. Though the initial version will be finalized in June 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.

A Medi-Cal Managed Care Dashboard Technical Advisory Group (TAG) has been created to ensure that the dashboard reflects stakeholder input. This group is comprised of DHCS and CHCF staff, legislative staff, health plan representatives, and a group of key stakeholders representing the broad range of beneficiaries who access care through Medi-Cal managed care. The TAG has met once via conference call and it will meet again in person in early May 2013. The TAG is currently identifying goals for the DHCS dashboard, which will influence which measures are included or excluded from the initial version of the dashboard.

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 submitted their ACR Collaborative QIP proposals to *the Medi-Cal Managed Care Division (MMCD)*, including 2011 historical data. MCP QIP proposals were reviewed by MMCD and then validated by the EQRO. *In January and February 2013, all MCPs participated in individualized technical assistance calls with DHCS and the EQRO to discuss their barrier analyses and planned interventions, with feedback provided to optimize the chance of success. Six MCPs are required to submit revisions in May 2013. All MCPs will submit their first re-measurement report based on 2012 data in September 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. 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 and 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 *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 *are being* 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 will increase to 40 percent and the plan-specific rate will decrease to 55 percent. A quality factor will be introduced to account for the remaining five percent, to the extent possible, otherwise the remaining 5% will be plan specific.*

Rates have been 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, and HFP. The rates were retroactive back to July of 2011.

F. 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: [Quality improvement requirements issued in Plan Policy letters](#)

DHCS is in the process of implementing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for 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. *In February 2013, 73,260 CAHPS surveys were mailed to adult beneficiaries and parents or caretakers of child beneficiaries. Survey results include member responses in four areas:*

- *rating of health plan*
- *rating of all health care*
- *rating of personal doctor*
- *rating of specialist seen most often*

Additionally, the results of five composite measures reflect member experiences with:

- *getting needed care*
- *getting care quickly*
- *how well doctors communicate*
- *customer service*
- *shared decision making*

The survey includes, for the first time, identification of respondents who are SPDs. This will allow comparative analysis of beneficiary satisfaction between SPDs and the Medi-Cal managed care population as a whole. The survey will close in May 2013, and the final report will be published in January of 2014.

G. HEALTHY FAMILIES PROGRAM TRANSITION

AB 1494 (Committee on Budget, Chapter 28, Statutes of 2012), as amended by AB 1468 (Committee on Budget, Chapter 438, Statutes of 2012), provides for the transition of HFP subscribers to Medi-Cal commencing January 1, 2013. The HFP, administered by the Managed Risk Medical Insurance Board, 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 *began* servicing newly eligible children under the TLIC Program.

A schedule of the four phases:

Phase 1, Part A: *Effective* January 1, 2013, children *transitioned* 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 *included* approximately 178,643 children.

Phase 1, Part B: *Effective* March 1, 2013, children *transitioned* 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 *included* approximately 92,352 children.

Phase 1, Part C: Will begin no sooner than April 1, 2013 - children *transitioning into Medi-Cal MCPs in San Joaquin and Stanislaus counties, and children in Health Net in Kern, Tulare, and Sacramento Counties. Children in Health Net in Los Angeles and San Diego Counties will transition into Medi-Cal MCPs no sooner than May 1, 2013.* This phase includes approximately 98,577 children, *with approximately 62,557 of those children transitioning on May 1, 2013.*

Phase 2: Will begin no sooner than April 1, 2013 - children enrolled in a HFP health plan that is also a 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 228,194 children.

Phase 3: Will begin 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. *This phase includes approximately 116,835 children.*

Phase 4: Will begin 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. *This phase includes approximately 37,383 children.*

H. State Plan Amendments and Federal Waivers

Nothing to report for the January through March 2013 quarter.

Attachment A

Table of Abbreviations and Acronyms

AB	Assembly Bill
ACR	All Cause Hospital Readmissions
CAHPS	Consumer Assistance of Healthcare Providers and Systems
CHCF	California Healthcare Foundation
COHS	County Organized Health System
DHCS	Department of Health Care Services
EQRO	External Quality Review Organization
FFS	Fee-For-Service
GMC	Geographic Managed Care
HFP	Healthy Families Program
MCP	Medi-Cal Managed Care Health Plan
MMCD	Medi-Cal Managed Care Division
QIP	Quality Improvement Project
RFA	Request for Application
SB	Senate Bill
SPD	Seniors and Persons with Disabilities
TAG	Technical Advisory Group
TLIC	Targeted Low-Income Children