



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

**For the Reporting Period
October through December 2015**

**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 care into rural counties. *This is the final AB 1467-required report.*

The report shall include, but not be limited to, updates on the following:

- 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 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 with a comprehensive account of Medi-Cal managed care expansion into California's rural counties. *With the AB 1467 requirements commencing January 1, 2016, future quarterly reports will contain only the AB 131 requirements.*

Note: Updates to the prior quarterly report are italicized for ease of review. It is important to note that this report only covers activities between the months of *October and December 2015*. Any developments in managed care in rural counties that have already occurred, but took place after *December 2015* will be included in future quarterly reports. Past reports can be found at the following link: <http://www.dhcs.ca.gov/formsandpubs/Pages/Reports2theLegislature.aspx>.

B. BACKGROUND

AB 1467, the health omnibus budget trailer bill, authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 rural California counties.

The 28 Medi-Cal managed care rural expansion counties are Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba.

Previously, the Budget Act of 2005 authorized expansion of Medi-Cal managed care into 13 new counties. The counties of El Dorado, Imperial, Lake, Placer, and San Benito were part of this 13 county expansion effort. As a result, these counties became part of the 28 rural county expansion.

In March 2012, DHCS issued a Request for Information to solicit health plan interest in providing health care services to Medi-Cal beneficiaries in the rural fee-for-service (FFS) counties. In November 2012, DHCS issued a Request for Application (RFA) inviting interested health plans to submit formal applications to DHCS.

On February 27, 2013, DHCS released an administrative bulletin excluding the following seven counties from the RFA: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Pursuant to Welfare and Institutions Code Section 14087.98(b) and authorized under AB 1467, DHCS chose to enter into an exclusive health plan contract with an existing County Organized Health System (COHS), Partnership HealthPlan of California, for these seven counties. DHCS also chose to enter into an exclusive health plan contract with the same COHS to include Lake County, which was not part of the original RFA.

Also on February 27, 2013, DHCS announced Anthem Blue Cross and California Health and Wellness Plan as the selected plans in the following 18 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. Final health plan contracts were contingent upon all the plans' completion of State and federal plan-readiness activities. Additionally, DHCS contracted with Kaiser Foundation Health Plan in three of these counties (Amador, El Dorado and Placer) to assure continuity of care for beneficiaries given Kaiser's staff model for delivery of care was already in place.

DHCS, in collaboration with the Imperial County Public Health Department, participated in a community meeting for stakeholders in Imperial County on December 6, 2012. Local providers and Medi-Cal managed care health plans (MCPs) attended and participated in the meeting. The purpose of this meeting was to discuss the managed care model options with stakeholders and to answer questions and obtain information about the geography of Imperial County's desert landscape and how it affects access to services. Based upon CMS and DHCS collaboration, DHCS contracted with two plans in Imperial County: California Health and Wellness Plan and Molina Healthcare.

San Benito County, which originally planned to join an existing COHS plan (Central California Alliance for Health), instead operates as a single plan model (Anthem Blue Cross).

Of the approximate 400,000 Medi-Cal FFS beneficiaries in these rural counties, approximately 110,000 beneficiaries in the eight COHS counties of Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity transitioned to Medi-Cal managed care on September 1, 2013. The following populations were mandatorily enrolled into Partnership HealthPlan of California, the COHS plan operating in these counties, on September 1, 2013: children and family aid codes, seniors and persons with disabilities (SPDs), dual-eligibles (individuals eligible for Medicare and Medi-Cal) and the Healthy Families Program (HFP) population. Beneficiaries receiving Community-Based Adult Services (CBAS) benefits in the two rural COHS counties (Humboldt and Shasta), which have CBAS centers continued to receive CBAS benefits through Medi-Cal FFS until the benefit converted to a Medi-Cal managed care benefit on December 1, 2014.

On November 1, 2013, the remaining 20 rural counties of Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, San Benito, Sutter, Tehama, Tuolumne and Yuba transitioned from Medi-Cal FFS to Medi-Cal managed care. More than 180,000 beneficiaries in these counties transitioned from Medi-Cal FFS to managed care. The HFP and the children and family aid code populations are mandatory populations in these counties, except for in San Benito County where all populations are voluntary. SPDs became a mandatory population on December 1, 2014. Dual-eligibles continue to be voluntary populations. Beneficiaries in these counties which have CBAS centers (Butte and Imperial) continued to receive CBAS benefits through Medi-Cal FFS until the benefit converted to a Medi-Cal managed care benefit on December 1, 2014.

C. MEDI-CAL MANAGED CARE PERFORMANCE DASHBOARD

On *December 15, 2015*, DHCS released the latest iteration of the Medi-Cal Managed Care Performance Dashboard (Dashboard). The Dashboard was developed with funding from the California HealthCare Foundation. The *December 2015* Dashboard is available here:

<http://www.dhcs.ca.gov/services/Documents/MMCD/December152015Release.pdf>

The Dashboard helps DHCS, MCPs and stakeholders identify trends and better observe and understand the performance of Medi-Cal managed care. The Dashboard includes metrics that quantify and track enrollment, beneficiary demographics, beneficiary satisfaction, and health care utilization, access and quality. The Dashboard also stratifies reported data by beneficiary population including Medi-Cal-only SPDs, dual-eligible beneficiaries, the optional expansion population, and families and children.

DHCS releases the Dashboard to the public during the *third* month of each quarter through a public webinar. Previous Dashboards are available at:

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

D. UTILIZATION DATA REPORTING

The following utilization data is reported in a manner consistent with the Dashboard. Due to a lag time in receiving data from MCPs, the most recent complete utilization rates available for the 28 rural expansion counties are for the *fourth* quarter of 2014. The results are listed below:

Rural Expansion Utilization Rate Per 1,000 Member Months

Quarter 4 2014	All ¹	SPDs	Dual-Eligibles ²	OTLICP ³
Emergency Room (ER) Visits	68	124	147	25
ER Visits with Inpatient Admissions	4	14	8	1
Inpatient Admissions	28	59	203	2
Outpatient Visits	931	2,194	1,684	500
Pharmacy Claims	731	2,913	276	201

The SPD, dual-eligible, and HFP populations were differentiated from the total Medi-Cal population in order to demonstrate the variations in utilization by population type.

E. STATE FAIR HEARINGS

For the reporting period of *October through December 2015*, there were a total of 1,195 state fair hearings (SFHs) for all 58 California counties. This *looks to be an increase* from the *July through September 2015* reporting period, where there were a total of 549 SFHs. *SFHs were originally reported only if there was an outcome and the hearing was completed. DHCS is now reporting all hearings regardless of whether or not there was an outcome, thus the reason for the increase. The results are as follows:*

- *October 2015: 428*
- *November 2015: 380*
- *December 2015: 387*

Of the 1,195 SFHs, 718 (60.1 percent) were the responsibility of the MCP, 473 (39.6 percent) were the responsibility of DHCS, and 4 (.3 percent) were the responsibility of both the MCP and DHCS. DHCS grouped SFHs in the following categories:

- Health plan quality of care: 1,015
 - Delay/denial of Medical Exemption Request (MER)/Emergency Disenrollment Exemption Request (EDER): 267

¹ “All” represents an aggregate utilization rate of all Medi-Cal managed care populations, including SPDs, dual-eligibles, Optional Targeted Low Income Children’s Program (OTLICP), and other populations.

² Dual eligible means eligible for Medicare and Medicaid. In the dual eligible population, Medicare and Medi-Cal pay for the services provided, however, the numbers do not necessarily indicate that this population used this number of services. Instead, the number indicates the number of services that was paid for by Medi-Cal.

³ OTLICP is the former HFP.

- Delay/denial of medication/prescription: 216
- SPD delay/denial of MER/EDER: 200
- Delay/denial of surgery/treatment: 134
- Delay/denial of diagnostic testing: 42
- Delay/denial of referral: 38
- Delay/denial of durable medical equipment (DME): 29
- Delay/denial of consultation/specialist: 17
- Denial of medical supplies: 15
- Inpatient hospital stay: 14
- *Wheelchair/power wheelchair/scooter*: 12
- *Poor medical care*: 10
- Delay/denial of physical therapy: 9
- Delay/denial of speech therapy: 5
- *Delay/denial of home health care*: 3
- Delay/denial of CBAS services: 1
- *Delay/denial of rehabilitation therapy*: 1
- Delay/denial of skilled nursing facility: 1
- *Hepatitis C*: 1
- Plan subcontractor/provider issues: 82
 - Billing/reimbursement issues: 78
 - Health plan not covering bill/paying provider: 4
- Health care plan issues: 89
 - Dispute of services: 75
 - Transportation issue: 9
 - *Customer service/staff Issue*: 2
 - *Dispute of medical records*: 1
 - *Unhappy with plan's grievance resolution*: 1
 - *Wants the same plan as Medicare plan*: 1
- Miscellaneous issues: 9
 - *Dental*: 4
 - *Vision*: 3
 - *Mental health (MH)*: 2

DHCS categorized the 534 SFH resolutions as follows:

- Withdrawal: 284 (53.2%)
- Denied: 88 (16.5%)
- Non-appearance: 83 (15.5%)
- Redirect: 35 (6.6%)
- Dismissed: 21 (3.9%)
- Closed by compliance: 13 (2.4%)
- Granted: 10 (1.9%)

Note that a withdrawal indicates that an issue has been resolved, resulting in the member withdrawing the case and no longer needing a SFH. A redirect is when a case was incorrectly assigned to DHCS. In these instances, DHCS requests the California Department of Social Services to redirect the case to the appropriate entity.

In the 28 expansion counties, for the reporting period of *October through December 2015*, there were a total of 121 SFHs:

- *October 2015: 32*
- *November 2015: 38*
- *December 2015: 51*

Of the 121 SFHs, 60 (49.6 percent) were the responsibility of the MCP. Sixty (49.6 percent) were the responsibility of DHCS, and 1 (0.8 percent) was the responsibility of both the MCP and DHCS. DHCS grouped SFHs in the following categories:

- Health plan quality of care: 113
 - Delay/denial of MER/EDER: 38
 - Delay/denial of medication/prescription: 26
 - SPD delay/denial of MER/EDER: 22
 - *Delay/denial of DME: 7*
 - Delay/denial of surgery/treatment: 7
 - Delay/denial of diagnostic testing: 6
 - *Delay/denial in referral: 3*
 - Inpatient hospital stay: 1
 - *Wheelchair/power wheelchair/scooter: 1*
 - *Delay/denial of skilled nursing facility: 1*
 - *Delay/denial of physical therapy: 1*
- Plan subcontractor/provider issues: 4
 - Billing/reimbursement issues: 3
 - Plan not covering bill/paying provider: 1
- Health care plan issues: 4
 - Dispute of services: 3
 - Transportation issue: 1

DHCS categorized *the 48 SFH resolutions* as follows:

- Withdrawal: 31 (64.6%)
- Denied: 8 (16.6%)
- Non-appearance: 4 (8.3%)
- Redirect: 2 (4.2%)
- *Closed by compliance: 1 (2.1%)*
- Dismissed: 1 (2.1%)
- Granted: 1 (2.1%)

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

SFH data fluctuates due to a variety of reasons including hearings being closed and later reopened and issues with the timing and transfer of data.

DHCS tracks SFH data by entering the information into a database and organizing the data by category and hearing type (DHCS only, MCP only, or both). DHCS resolves MCP-only issues by contacting MCPs to provide position statements. When it is a DHCS issue, DHCS provides a position statement. When warranted, DHCS will contact a claimant or provider to request additional information. When the beneficiary's health condition warrants it, DHCS will approve the beneficiary's request and disenroll him/her from an MCP.

F. RISK-ADJUSTED CAPITATION RATES

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented risk-adjusted capitation rates for Two-Plan and Geographic Managed Care plans. Capitation rates were risk-adjusted to match each MCP's projected costs to their capitated payments more effectively. To calculate the final capitation rates, the final risk-adjusted scores were applied to the developed county average capitation rates. For the first and second years, risk adjustments were phased in using a rate comprised of 20 percent risk-adjusted county average rates and 80 percent plan-specific rates. For the third year, risk adjustments were phased in using a rate comprised of 25 percent risk-adjusted county average rates and 75 percent plan-specific rates. For the fourth year, risk adjustments were phased in using a rate comprised of 35 percent risk-adjusted county average rates and 65 percent plan-specific rates.

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

G. MEASURING QUALITY OF CARE PROVIDED TO BENEFICIARIES BY MCPs

DHCS's External Accountability Set measures assess the quality of services provided by MCPs and form the basis for quality improvement efforts. DHCS contracts require MCPs to perform at least as well as the lowest performing 25 percent of Medicaid plans in the United States (Minimum Performance Level [MPL]). MCPs are held to the MPL after their first full year of operation in a county.

To accommodate for the more sparsely populated rural regions, DHCS worked with the MCPs to define several regions (groups of rural counties), that would provide a sufficient number of beneficiaries in order to yield meaningful reporting and quality improvement. California Health and Wellness and Anthem Blue Cross are providing information for two regions: Region 1—Butte, Colusa, Glenn, Plumas, Sierra, Sutter, and Tehama Counties; and Region 2—Alpine, Amador, Calaveras, El Dorado, Inyo, Mariposa, Mono, Nevada, Placer, Tuolumne, and Yuba Counties. Kaiser North is providing information on one region: Amador, El Dorado, Placer, and Sacramento Counties. Partnership HealthPlan of California is providing information on four regions:

Southeast—Napa, Solano, and Yolo Counties; Southwest—Lake, Marin, Mendocino, Sonoma Counties; Northeast—Lassen, Modoc, Shasta, Siskiyou, and Trinity Counties; and Northwest—Del Norte and Humboldt Counties.

Reporting on these regions is available as part of the most recent Dashboard, which was released in *December 2015*. The Dashboard is available at:

<http://www.dhcs.ca.gov/services/Documents/MMCD/December152015Release.pdf>.

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 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. *Due to a lag time, DHCS has data for the period of July through September 2015. MCPs granted 191 out of 197 (97 percent) continuity of care requests during the third quarter. The six continuity of care requests were denied for the following reasons:*

- *Providers were in-network: 5*
- *California Children's Services-approved services under Service Authorization Request: 1*

The DHCS continuity of care webpage is available at the following link:

<http://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx>. This 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 MH AND SUBSTANCE USE DISORDER SERVICES

As a part of the enacted 2013-14 Budget, specifically through the trailer bill language in Senate Bill X1-1 (Hernandez and Steinberg, Chapter 4, Statutes of 2013), effective January 1, 2014, California expanded MH and substance use disorder (SUD) services provided through the Medi-Cal program.

DHCS expanded the Medi-Cal MH services available to its beneficiaries. As a result, MCPs are required to provide covered MH benefits, excluding those benefits provided by the county MH plans (MHPs) under the Specialty MH Services (SMHS) Waiver. Outpatient MH benefits are available to beneficiaries through the MCP's non-SMHS. MCPs and MHPs are working together to assist members in accessing care in the appropriate settings. For beneficiaries not enrolled in an MCP, these benefits are provided through Medi-Cal FFS.

Medi-Cal SMHS currently provided by the MHPs will continue to be provided by the MHPs for Medi-Cal beneficiaries that meet the medical necessity criteria for these services. Expanded SUD benefits will continue to be provided through the current delivery systems: Medi-Cal FFS or county-administered Drug Medi-Cal, depending on the benefit. In addition, MCPs are required to provide Screening and Brief Intervention and Referral to Treatment services for alcohol misuse by adults, though MCPs are not responsible for administering the treatment.

DHCS is monitoring the expansion of MH and SUD services provided through the Medi-Cal program. MCPs are required to submit MH health data reports on grievances, continuity of care, and referrals to the MHPs. DHCS continues to review this data to ensure that the expanded services are in place and that members are accessing these services.

DHCS is engaged in several issues that require a more in-depth stakeholder process. For example, DHCS convened a Delivery System Dispute Resolution Workgroup comprised of the MCPs and association representatives from the County Behavioral Health Directors Association and the California Association of Health Plans. The purpose of the workgroup was to develop a dispute resolution process to ensure that beneficiaries are not juggled between the MCPs and the MHPs and that no beneficiary falls through the cracks. Based on stakeholder input, DHCS finalized a dispute resolution process at the state level when issues cannot be resolved at the local level between MCPs and MHPs. Additional information can be found in All Plan Letter (APL) 15-007, which is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-007.pdf>.

DHCS also organized a collaborative workgroup between MCPs and MHPs. The first *two meetings occurred in the third and fourth quarters of 2015, and the third meeting will occur in February 2016.* Agenda items for these meetings include access to services,

care coordination, management of the moderate diagnosis groups, and management of complex diagnoses, such as eating disorders.

Other issues are being worked out on a county-by-county basis with DHCS oversight. For example, MCPs and MHPs have developed or amended their Memoranda of Understanding (MOU) to better coordinate care across the plans. Per the DHCS/MCP contract, MCPs are required to execute an MOU with the local county MHPs. APL 13-018 provides information regarding the MHP and MCP MOU requirements. APL 13-018 can be accessed at the following link:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf>. The MOUs were due to DHCS by June 30, 2014. DHCS has received and executed all 98 of the MOUs.

DHCS is also working with MCPs and Regional Centers (RCs) to ensure the implementation of Behavioral Health Treatment (BHT) services as part of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for Medi-Cal beneficiaries under the age of 21. MCPs were required to cover these services effective September 15, 2014. Additional information is available below in Section J of this report and the requirements are explained in APL 14-017 which is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>. *Beginning on February 1, 2016, DHCS will begin transitioning beneficiaries receiving BHT in the RCs to the MCPs. DHCS has begun to assist with the transition by providing MCPs with relevant beneficiary and claims data to aid them in determining necessary services and arranging continuity of care when applicable.*

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. SPAs AND FEDERAL WAIVERS

California's existing 1115 "Bridge to Reform" Medicaid Waiver, which began in 2010, is a five-year demonstration of health care reform initiatives that are designed to prepare for the significant changes spurred by the federal Patient Protection and Affordable Care Act. California's 1115 Demonstration Waiver *expired on October 31, 2015*. To begin the renewal process, in July 2014, DHCS held a public kick-off meeting and developed an Initial Concepts document. DHCS organized an 1115 Demonstration Waiver Stakeholder Advisory Committee and six separate stakeholder workgroups to develop concepts on specific issue areas. These groups met several times from November through February 2015. DHCS delivered a presentation on renewal updates to the Stakeholder Advisory Committee in February 2015 and to stakeholder groups through a webinar in March 2015.

DHCS officially submitted the state's application package to renew the Section 1115 Demonstration Waiver to CMS on March 27, 2015. *With an expiration date of October*

31, 2015 looming, CMS granted a three-month extension to the existing 1115 Waiver through the end of the year. On December 30, 2015, CMS approved the renewal, extending California's demonstration waiver titled, "California Medi-Cal 2020 Demonstration." The renewal extends the waiver for another five years.

Additional information on the 2015 waiver renewal and Medi-Cal 2020 is available at: <http://www.dhcs.ca.gov/provgovpart/Pages/waiverrenewal.aspx>.

On September 29, 2014, DHCS submitted a waiver amendment to CMS to allow for the addition of BHT to the list of covered benefits available to children ages 0 to 21 years who have a diagnosis of Autism Spectrum Disorder (ASD). This waiver amendment will add BHT services for individuals under the age of 21 who are eligible for EPSDT services who meet medical necessity criteria. CMS approved this waiver amendment on October 16, 2014.

DHCS submitted SPA 14-026 to CMS on September 30, 2014 to add BHT services as a Medi-Cal benefit to treat ASD. Similar to the waiver amendment, SPA 14-026 will add BHT services for individuals under the age of 21 who are eligible for EPSDT services who meet medical necessity criteria. SPA 14-026 is still pending CMS approval.

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 as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD dual-eligibles.

Cal MediConnect is a voluntary program; however, those dual-eligibles who opt-out of Cal MediConnect must still enroll in an MCP for their Medi-Cal benefits (including dual-eligibles who are enrolled in a Medicare Advantage [MA] plan). Full-benefit

dual-eligibles enrolled in an MCP for their Medi-Cal benefits, and who opt-out of Cal MediConnect, or are not eligible for Cal MediConnect, will continue to receive their Medicare services either through Medicare FFS or an MA plan.

The seven CCI counties participating in Cal MediConnect are Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Note that Alameda County is no longer listed as a CCI county. In order for Alameda Alliance for Health to improve and focus on its financial and operational condition and transition back to local control, the Department of Managed Health Care, DHCS, Alameda Alliance for Health, and local providers agreed that as of November 2014 Alameda County should no longer participate in CCI.

In April 2014, the State began passive enrollment into the Cal MediConnect plan in San Mateo County and dual-eligibles already in Medi-Cal managed care began to receive Managed Long Term Services and Supports (MLTSS) in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo Counties. In May 2014, DHCS began passive enrollment into Cal MediConnect plans and also began mandatory enrollment of dual-eligibles in Medi-Cal FFS into managed care for their Medi-Cal benefits in Riverside, San Bernardino, and San Diego Counties. Santa Clara County began passive enrollment into Cal MediConnect in January 2015. Orange County began opt-in enrollment in July 2015 and passive enrollment began in August 2015 by birth month. Orange County began to passively enroll skilled nursing facility dual-eligibles into the Cal MediConnect plan in August 2015 as well, but will enroll them by facility, rather than by birth month.

Also in January 2015, dual-eligibles in Medi-Cal FFS residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara Counties began to receive MLTSS. The timeline for CCI implementation in each of the counties is available at the following link, under the heading "Enrollment Chart": <http://www.calduals.org/implementation/cqi-documents/enrollment-charts-timelines/>.

Legislative reports on the CCI are available at: <http://www.dhcs.ca.gov/pages/lga.aspx>.

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

County	Implementation Date	Managed Care Model	Plan Name(s)
Del Norte	9/1/2013	COHS	Partnership HealthPlan of California
Humboldt	9/1/2013	COHS	Partnership HealthPlan of California
Lake	9/1/2013	COHS	Partnership HealthPlan of California
Lassen	9/1/2013	COHS	Partnership HealthPlan of California
Modoc	9/1/2013	COHS	Partnership HealthPlan of California
Shasta	9/1/2013	COHS	Partnership HealthPlan of California
Siskiyou	9/1/2013	COHS	Partnership HealthPlan of California
Trinity	9/1/2013	COHS	Partnership HealthPlan of California
Alpine	11/1/2013	Regional Model (RM)	Anthem Blue Cross Partnership Plan 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
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 Molina Healthcare of California Partner Plan, Inc.
San Benito	11/1/2013	San Benito Model	Anthem Blue Cross Partnership Plan

Attachment B

Abbreviations and Acronyms

AB	Assembly Bill
ASD	Autism Spectrum Disorder
BHT	Behavioral Health Treatment
Cal MediConnect	Duals Demonstration Project
CBAS	Community-Based Adult Services
CCI	Coordinated Care Initiative
CMS	Centers for Medicare & Medicaid Services
COHS	County Organized Health System
DHCS	Department of Health Care Services
Dashboard	Medi-Cal Managed Care Performance Dashboard
<i>DME</i>	<i>Durable Medical Equipment</i>
EDER	Emergency Disenrollment Exemption Request
EPSDT	Early Periodic Screening, Diagnosis and Treatment
ER	Emergency Room
FFS	Fee-For-Service
HFP	Healthy Families Program
OTLICP	Optional Targeted Low Income Children's Program
MA	Medicare Advantage
MLTSS	Managed Long Term Services and Supports
MCP	Medi-Cal Managed Care Health Plan
MER	Medical Exemption Request
MH	Mental Health
MHP	Mental Health Plan
MOU	Memoranda of Understanding
MPL	Minimum Performance Level
PCP	Primary Care Provider
RC	Regional Centers
RFA	Request for Application
SB	Senate Bill
SFH	State Fair Hearing
SMHS	Specialty Mental Health Services
SPA	State Plan Amendment
SPD	Seniors and Persons with Disabilities
SUD	Substance Use Disorder