



**SEMI-ANNUAL REPORT
TO THE LEGISLATURE**

**MANDATORY ENROLLMENT OF SENIORS AND
PERSONS WITH DISABILITIES INTO
MEDI-CAL MANAGED CARE**

**July 1, 2011
Covering January through June 2011**

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

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MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES INTO MEDI-CAL MANAGED CARE

I. INTRODUCTION

Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010) permits the Department of Health Care Services (DHCS) to mandatorily enroll Medi-Cal eligible seniors and persons with disabilities (SPDs) into Medi-Cal managed care plans (MCPs) in counties operating under this model of care. The mandatory enrollment of SPDs does not apply to SPDs with Medicare coverage (Duals), SPDs with other health coverage, or SPDs in the fee-for-service (FFS) Medi-Cal system with a share-of-cost.

By delivering health care services to this high-risk population through a MCP model, DHCS will be able to provide SPD beneficiaries with a high-quality system of care that improves access and care coordination.

Welfare and Institutions (W&I) Code Section 14182(s)(1) requires DHCS to provide semi-annual reports to the Legislature that provide details of the activities undertaken for the identification, notification, education, and enrollment of SPDs into a Medi-Cal MCP. The semiannual updates shall include the key milestones for mandatory SPD enrollment into MCPs, discuss DHCS' progress toward the objectives of SPD enrollment, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, health outcomes of enrollees, assess issues related to the care management and care coordination of SPDs and relevant or necessary changes to the program. This report is the second semi-annual report to the Legislature covering the period of January 2011 through June 2011.

II. BACKGROUND

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 4.27 million Medi-Cal beneficiaries in 27 counties. DHCS provides three types of managed care models:

1. Two-Plan, which operates in 14 counties.
2. County Organized Health System, which operates in 11 counties.
3. Geographic Managed Care (GMC), which operates in two counties.

DHCS also contracts with one prepaid health plan in one additional county and with two specialty health plans.

Although SPDs were not currently required to enroll into the Two-Plan Model (TPM) or the GMC models prior to June 1, 2011, SPDs had the option to enroll on a

voluntary basis. Of the total Medi-Cal MCP enrollees served as of May 31, 2011 (Attachment A), 6.29 percent were SPD members.

III. KEY MILESTONES FOR MANDATORY SPD ENROLLMENT

Key Milestone	Completion Dates
Plan Readiness	January 2011
Sensitivity Training	January 2011
Access/Facility Site Review	January 2011
Outreach and Education	February 2011
Risk Assessment and Stratification	April 2011
Federal Approval of Waiver, Rates, and Contract Language	May 2011
SPD Mandatory Enrollment	June 2011 – May 2012

A. First Month Enrollment—June 2011

The first month of implementation of mandatory enrollment of the Medi-Cal-only SPD population into the MCPs did not present any unresolvable medical care situations. There have been some minor data glitches, and an increase of mostly informational calls at the MCP level and to the Medi-Cal Managed Care Division (MMCD) Office of the Ombudsman (OMB). At an administrative level, there has been an increase in requests for exemption from managed care enrollment and fair hearing requests. Most of the SPD-related medical exemption requests and fair hearings have been because of a lack of familiarity with the continuity of care provisions in the federal 1115 Bridge to Reform Waiver (Waiver). Both beneficiaries and providers received information regarding the provisions of the Waiver.

MCPs are reporting twice per week regarding the status of SPD enrollments. MMCD is closely monitoring Ombudsman calls, medical exemption requests, and fair hearing requests. Any health care issues that arise are being resolved as expeditiously as possible at the MCP level and in collaboration with MMCD staff when necessary.

IV. PROGRESS TOWARD OBJECTIVES OF SPD ENROLLMENT

A. Plan Readiness

DHCS completed a plan readiness review for each MCP. The purpose of the review was to ensure that each MCP would be able to serve beneficiaries identified as SPDs. The plan readiness review included three sections:

1. *Good Standing:*

The purpose of the good standing review was to certify that each MCP had no deficiencies that would prevent the MCP from providing health care services to new SPD beneficiaries. The internal review consisted of an analysis of

health plan compliance with contractual and regulatory requirements, plan financial submissions, and that corrective action resulting from DHCS' monitoring activities was completed and satisfied DHCS standards. DHCS finished the good standing reviews on January 11, 2011. All MCPs operating in the SPD mandatory enrollment counties are in good standing with no deficiencies.

2. *Network Assessment:*

DHCS completed a network assessment to ensure that each MCP's network was prepared and able to serve SPD beneficiaries. In anticipation that SPDs would need greater access to specialty provider services than other Medi-Cal populations, DHCS evaluated the ability of the MCPs to provide adequate access to specialty care. The network evaluation included a combination of past and projected utilization data; MCP-specific projected SPD enrollment; MCP input regarding the current utilization of specialty care; and use of non-contracted providers in meeting specialty care needs (including MCP preparations to meet the increased demands on their network).

DHCS completed network evaluations for all MCPs in January 2011. On March 1, 2011, DHCS submitted network certifications for all MCPs to the Centers for Medicare and Medicaid Services (CMS). The county network certifications ensure that each MCP has a sufficient provider network to provide health care services to the newly enrolled SPD beneficiaries.

DHCS will continue to work with the Department of Managed Health Care (DMHC) to monitor MCP networks and ensure that access exists for all Medi-Cal beneficiaries.

3. *New and revised Contract Deliverables:*

DHCS required each MCP to submit new or revised deliverables consistent with new SPD-specific contract language by May 2, 2011. The deliverables included:

- Updated policies and procedures for conducting facility site reviews.
- Enhanced coordination of care requirements and communication.
- Health Risk Assessments.
- Person-centered planning.
- Accessibility information for beneficiaries.
- Access to non-network specialty providers.

B. Sensitivity Training

DHCS contracted with the Western University of Health Sciences (WUHS) to create a statewide training curriculum to provide health plan trainers with web-based training modules and the necessary tools to conduct SPD sensitivity training. All appropriate MCP staff and all contracted providers received the

training.

Using stakeholder input, the curriculum was developed to include an educational strategy that provides awareness of the disability culture and the competence and sensitivity required when serving individuals living with disabilities. Contracted Medi-Cal MCP trainers were provided with two “train the trainer” workshops held in Oakland on January 19-20, 2011, and in Los Angeles on January 26-27, 2011. Applicable state staff also received the SPD sensitivity training in March 2011.

MCPs are required to utilize the web-based training tools and resources provided by DHCS; they are also encouraged to develop plan-specific training materials customized to meet audience needs. DHCS outlined the SPD sensitivity training requirements in its MMCD All Plan Letter 11-010.

C. Access/Facility Site Review

DHCS contracted with WUHS to develop a Facility Site Review (FSR) tool to be used by MCPs to determine the level of physical accessibility of MCP provider sites, including specialists and ancillary service providers that serve a high volume of SPDs. The physical accessibility assessment tool was developed using MCP and stakeholder input. MCPs are required to make the results of these assessments available to members through their websites and provider directories. The information provided must display, at a minimum, the level of access met per provider site as either “basic access” or “limited access.” Additionally, the MCPs must display whether the site has medical equipment access as defined in Attachment C of the FSR. DHCS outlined the above requirements in its MMCD Policy Letter 11-013.

D. Outreach and Education

The phase-in process to enroll SPDs will occur monthly for 12 months. DHCS developed an extensive outreach and education strategy that includes three separate mailings and two telephone calls to the affected SPD beneficiaries as follows:

- The first mailing is a 90-day notice intended to inform SPD beneficiaries of the upcoming change to their health care delivery system.
- A telephone call follows the written notice to verbally educate beneficiaries on the upcoming change and assist with questions.
- The second notice is a 60-day enrollment packet that includes a county-specific insert notifying SPD beneficiaries of their MCP choices and additional educational information.
- The final outreach attempt is a second telephone call focused on informing SPD beneficiaries of their ability to choose a MCP, provide assistance in the enrollment process, and address questions.

- The 30-day intent-to-default notice is the final mailing. This mailing is only for those SPD beneficiaries that have not made a MCP selection. The notice informs the SPD beneficiaries that if they do not choose a MCP, DHCS will make the assignment. SPD beneficiaries that enrolled on June 1, 2011, received the first 90-day notice by March 1, 2011.

In collaboration with DHCS, the University of California, Berkeley (UCB) conducted one community presentation in each Two-Plan and GMC County regarding SPD enrollment. The development of the community presentation included stakeholder input and review. UCB completed the community presentations in April 2011.

Stakeholders voiced concerns that one presentation per county was insufficient. Therefore, DHCS coordinated with the California Health Care Foundation, Center for Health Care Strategies, to conduct five statewide webinars during the month of May. A recorded copy of the webinar and a frequently asked questions (FAQs) document (that is cumulative for all five webinars) will be available on the DHCS website in late July or early August.

E. Risk Assessment and Stratification

During the period January through April 2011, DHCS completed implementation of an ongoing data exchange process established to provide MCPs with FFS utilization data and current information on Treatment Authorization Requests (TARs) for new mandatory SPD members. This data allows MCPs to perform the mandated health risk assessment and stratification of their newly enrolled SPD members. In February and April of 2011, DHCS provided MCPs with sample files to test the data exchange process and to allow MCPs to become familiar with the FFS data. The data sets developed for this process are fully compliant with the State and federal privacy requirements. During the testing process, DHCS staff responded to MCP questions using an e-mailbox set up for this purpose. DHCS also posted data-related FAQs on the website, and resolved issues related to MCPs' access to the secure file transfer protocol site. As of June 2011, the monthly process was "live," and MCPs were able to access monthly member data files for their new mandatory SPD members.

W&I Code Section 14182(c) (12) (A) requires MCPs to conduct a risk stratification and risk assessment of new SPD members. The risk stratification determines a member's health status as high risk or low risk followed by a 45 or 105-day requirement to conduct the risk assessment of the new SPD member. The risk assessment allows the MCP to determine health care management needs. W&I Code Section 14182 requires the use of a MCP-developed and DHCS-approved risk stratification and risk assessment tool. MCPs are required to solicit and consider stakeholder and consumer input into the development of the tools.

Beginning in August 2010, DHCS solicited input from MCP medical directors regarding the processes MCPs will use to conduct the risk stratification and risk assessment of new SPD members and in the development of a MMCD Policy Letter.

DHCS provided the MMCD Advisory Group with a draft of the Policy Letter for comment and input. DHCS made revisions to incorporate input received. In January 2011, DHCS released Policy Letter 11-001 to plans providing the criteria and minimum requirements necessary for DHCS approval and the required submission by MCPs to DHCS in March 2011.

In addition, DHCS developed a Member Evaluation Tool (MET) that allows beneficiaries to complete a self-assessment of their health status. The MET is included in the 60-day enrollment packet. Completion of the MET by the beneficiary is voluntary and those METs completed and returned to DHCS are to the member's selected or assigned MCP. The purpose of the MET is to obtain additional, or in some cases the only, member information for MCP use in the risk stratification/risk assessment process.

F. Federal Approval of Waiver, Rates, and Contract Language

On November 2, 2010, DHCS received approval from CMS for California's five-year Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform. CMS approved the Waiver for the period November 1, 2010, through October 31, 2015.

DHCS worked with MCPs and CMS to ensure compliance with SB 208 (Steinberg, Chapter 714, Statutes of 2010) and the 1115 Waiver Special Terms and Conditions. DHCS submitted the final contract amendments to CMS for approval on April 1, 2011.

Mercer Health and Benefits LLC (Mercer), DHCS' actuarial services contractor, developed preliminary capitation rates for the SPD population. DHCS provided MCPs with the preliminary rates in November 2010. In December 2010, DHCS held a meeting to discuss and obtain feedback on the preliminary rates. Based on input received, DHCS and Mercer decided to re-examine the assumptions. In January 2011, DHCS recalculated rates and held another meeting with MCPs to discuss updates in the rate development process and obtain feedback prior to finalizing rates. DHCS finalized rates in February 2011 for inclusion in new contracts and submitted rate certifications to CMS in March 2011. Please refer to section VIII, sub-section G of this report for additional information on the rate development process. DHCS submitted rate certifications and contract language for MCPs to CMS in April 2011. CMS approved the contracts on May 31, 2011.

G. SPD Mandatory Enrollment

The 1115 Waiver and W&I section 14182 requires a phased-in enrollment process to transition existing FFS SPDs into Medi-Cal MCPs. The 12-month phased-in process began June 1, 2011, and will continue until May 1, 2012. SPDs who become eligible for Medi-Cal benefits and meet the criteria for mandatory enrollment into a MCP on or after June 1, 2011, are not eligible for the phased-in enrollment process and are required to enroll into a MCP within 30 days.

DHCS developed an SPD Linkage Default Protocol to use when the SPD beneficiary does not make an affirmative MCP choice during the enrollment period. With input from the Stakeholder Advisory Committee (SAC), DHCS developed a default protocol that attempts to link each SPD beneficiary with a MCP that contracts with the FFS provider most utilized by the beneficiary.

If a SPD beneficiary cannot be linked to a MCP, DHCS follows the current default algorithm, which considers quality of care along with available provider choices. The default protocol applies to existing SPD beneficiaries, during their birth month, if they fail to make a MCP choice during the enrollment period. The default protocol also applies to new Medi-Cal SPD beneficiaries who are required to enroll in a MCP within 30 days following establishment of their Medi-Cal eligibility.

DHCS modified the existing enrollment broker system to identify the affected FFS SPD beneficiaries and new SPD eligibles on and after June 2011.

V. **SUBMITAL OF FEDERAL SPAs and WAIVERS**

The 1115 Waiver incorporated DHCS' Medi-Cal managed care population. Inclusion of the entire managed care program under the Waiver eliminates the need to submit State Plan Amendments to CMS during the term of the Waiver.

VI. **HEALTH OUTCOMES OF ENROLLEES**

In accordance with federal quality assurance requirements, DHCS currently requires contracted MCPs to report performance measurement scores annually. The scores include a number of Healthcare Effectiveness Data Information Set (HEDIS) measures related to quality of care, access to care, and timeliness of care provided to Medi-Cal MCP members. HEDIS measures are established by the National Committee for Quality Assurance; they are considered to be the "gold standard" of performance measures used nationally to assess the quality of care provided by commercial, Medicaid, and Medicare plans.

The HEDIS measures for which DHCS currently requires MCPs to report focuses on access to care provided to:

- Women, children, and adolescents.
- Ambulatory care services provided to members of all ages.
- Screening for diseases such as breast and cervical cancer.
- Care provided to members with chronic diseases such as diabetes and asthma.
- Other serious conditions such as upper respiratory infections in children and acute bronchitis in adults.

Beginning March 2011, DHCS began work to make changes to the required performance measures for 2012. These changes will include the addition of further measures relevant to SPDs and planning ahead for stratified reporting. The objective is that MCPs will eventually report scores for some measures for both their entire population and specifically for SPDs. DHCS also began development work related to the CMS-required utilization data reporting for the new mandatory SPDs in the following areas: avoidable hospitalizations, hospital readmissions, emergency room utilization, and outcome measures related to person-centered care planning and delivery.

In June 2011, DHCS began soliciting input from MCPs and other stakeholders regarding performance measure additions and changes relevant to SPDs. In August 2011, DHCS will announce the required performance measures for 2012. However, stratified reporting for SPDs will not begin until 2013 as the new mandatory SPD members will not be enrolled in MCPs long enough in 2011 (the “measurement year” for 2012 performance measure rates) to be reflected in MCP scores. The new SPD members will need to participate in their MCPs long enough for MCPs to collect data to generate statistically significant performance scores. It will take several years before the performance measurement scores fully reflect member health outcomes.

VII. CARE MANAGEMENT AND COORDINATION

Providers must manage the care of patients with chronic health conditions; serious and complex medical needs; multiple co-morbidities; and care of the elderly and disabled. The coordination of medically necessary care can be a challenge for patients and their primary care providers (PCPs). Current contract language requires MCPs to support PCPs in their case management and care coordination activities. The PCPs must also maintain procedures for monitoring. MCPs are responsible for these coordination activities for members who receive health care services within the MCP provider networks and when members receive services outside of the networks. Case management, care coordination, and care management are terms often used interchangeably.

DHCS modified the contract language to further define and strengthen MCP requirements for case management and care coordination across the continuum of

care for SPD members. New language specifies that MCPs must provide case management and care coordination through basic or complex case-management activities. Basic case management services are provided by the PCP and include health and behavioral assessments; identification of appropriate providers and facilities (including those out of the network) to meet patient care needs; coordination of care through direct communication; patient and family education; and coordination of carved out and linked services.

Complex case-management services include all of the above basic components and further require management of acute or chronic illnesses, including emotional and social support issues; intense coordination of resources to ensure members regain optimal health or improved functionality; and development of specific individual care plans that are updated at least annually.

VIII. OTHER SPD INFORMATION

A. Data Stakeholder Workgroup

In April 2011, DHCS, in accordance with Section 14182.1 of the W&I Code, convened a data stakeholder workgroup to review the existing encounter, claims, and financial data submission requirements in Medi-Cal MCP contracts. As mandated by SB 208 (Steinberg, Chapter 714, Statutes of 2010), the group's membership included representatives from Medi-Cal MCPs, MCP associations, hospitals, individual health care providers, physician groups, and consumer representatives. During April and May of 2011, the data workgroup met four times to provide input to the DHCS regarding current and future data submission requirements, data quality challenges, and incentives and penalties related to MCP compliance with the new requirements. Meeting materials and notes for the data workgroup are available on the DHCS website:

<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDSB208DataWrkgpr.aspx>.

DHCS will consider the workgroup's input in developing updated data submission standards for MCPs. These updated requirements will become effective January 1, 2012. The new requirements will include financial penalties that may be imposed for each month that a MCP fails to submit data in compliance with the new standards.

B. Stakeholder Advisory Committee (SAC), Section 1115 Waiver

The purpose of the SAC is to advise DHCS on the development and implementation of the Section 1115 Waiver. The chairperson is the Director of DHCS and the committee includes several technical workgroup groups comprised of individuals chosen for their expertise in the following areas:

- Seniors and persons with disabilities (SPDs)
- California Children’s Services (CCS) program
- Behavioral health
- Health Care Coverage Initiatives (HCCI)
- Dual eligibles

The technical workgroups identify issues, develop options, and inform DHCS of issues affecting the Waiver. The most recent SAC meeting was held on June 1, 2011, which included an update on the transition of SPDs into Medi-Cal Managed Care. The update included the following:

- Community presentations
- Internal/external trainings
- Network access reviews
- Contracts and deliverables
- Risk stratification/health assessments
- DMHC/DHCS Interagency Agreement
- Data sharing; stakeholder data workgroup
- Webinars held
- Letters of interest
- Adjustments

C. Medi-Cal Managed Care Office of the Ombudsman

The OMB uses a Microsoft Customer Relationship Management System (CRM) that tracks incoming beneficiary phone calls. In June 2010, the OMB added “SPD Access” as a sub-category for tracking in the CRM. The OMB reviews the CRM’s “Case Detail by Issue Type” report and the “Sub-Issues and Referrals by Primary Issue” report to identify trends. The OMB tracks SPD access on an ongoing basis.

D. Monitoring Activities

During the first quarter of 2011, DHCS solicited stakeholder input and comments for CMS before finalizing the report elements that are to be used to track and report on the transition of SPDs into MCPs. The monitoring elements will include enrollment patterns; outreach results; continuity of care requests; risk assessment and stratification results; member concerns and grievances; utilization data; and care coordination data. In February 2011, DHCS presented a fully developed outline for monitoring reporting via a conference call with the SAC. The DHCS is now developing the monitoring report format and data collection tools.

E. DHCS/DMHC SPD Related Interagency Agreement (IA), per SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010).

DHCS and DMHC are required to initiate and maintain an IA. The purpose of the IA is to facilitate an agreement for DMHC to conduct provider network reviews, medical audits, and financial audits relative to the SPD member population, on behalf of DHCS. Network assessment reviews will occur quarterly. Medical audits will occur at least once every 36 months. Financial audits will occur once every 36 months.

DHCS and DMHC collaborated to develop a framework for the IA that reflects the key issues including roles and responsibilities. DHCS and DMHC anticipate executing the IA by the end of July 2011.

F. Rate Development

DHCS and Mercer held "All Plan Rate Development" meetings in August and December 2010, and an All Plan conference call in November 2010, to discuss the rate development process for the SPD population. In November 2010, DHCS released to the MCPs, preliminary capitation rates for the SPD population to initiate discussions with the MCPs concerning the methodology. DHCS based the preliminary rates on FFS claims data adjusted for services carved out under managed care and on county average managed care rates adjusted for risk factor differences between FFS and managed care. DHCS held a final meeting with the MCPs on January 25, 2011, and issued rates to the MCPs on February 2, 2011. DHCS sent the associated rate worksheets to the MCPs on February 15, 2011.

Mercer utilized a number of assumptions within the rate development process. The first assumption is that it generally takes three months for a beneficiary to enroll in a MCP and begin using services; therefore, excluded from rate development are the FFS costs for the first three months. FFS costs during the first few months of eligibility are typically higher than during subsequent months. An additional assumption when translating FFS costs into managed care rates is that there will be shifts in utilization patterns under managed care as compared to FFS. Specifically:

- There will be a reduction in inpatient utilization, resulting in savings for inpatient costs over FFS. Inpatient unit costs will increase slightly.
- Emergency Room (ER) utilization will lower and ER unit costs will increase.
- Utilization for PCPs and specialist providers will increase and unit costs will lower for PCPs; the assumption is that efficiencies will result from the managed care contracting process.
- Pharmacy utilization and mix will change, with the expectation that the MCPs will be aggressive in the utilization of generic drugs.

The following website location gives a summary of the utilization and cost adjustment factors:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/All-PlanMtgPresentation_01-25-2011.pdf

In addition, the proposed SPD rates include an additional 0.5 percent for the MCPs to cover the new administrative requirements for care coordination of the SPD population.

DHCS received considerable feedback at the December 2010 meeting and worked with the MCPs to address concerns, which centered on primary care unit costs; inpatient utilization reductions; and the pharmacy mix between name brand and generic drugs. DHCS and Mercer specifically re-examined assumptions and made appropriate adjustments.

DHCS received Mercer's recalculated SPD rates in January 2011; a meeting with the MCPs followed at the end of January 2011 to discuss updates in the rate development process and to obtain feedback prior to the February 2011 finalization of rates.

G. Rates - Risk Analysis

The California Health Care Foundation contracted with Mercer to conduct a risk analysis of the SPD population. The objective was to determine whether the population of SPDs without Medicare coverage currently served by MCPs in Two Plan Model counties, differs from the Medi-Cal SPD population in the FFS program. Mercer's report, developed in April 2010 and released in September 2010, is available on the following DHCS website:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/SPD_Study_Final_092810.pdf.

DHCS utilized this study as a preliminary assessment of the risk of the SPD population in FFS Medi-Cal. It is important to emphasize that objective of the study was strictly to gather information on the SPD population and not intended for rate setting purposes.

The study used Medicaid Rx (version 5.0) risk adjustment software developed by the University of California, San Diego, to develop risk scores from pharmacy utilization data to assess the acuity level of each of the populations. The software classifies each beneficiary into one of 43 disease categories and 10 age/gender categories based on pharmaceutical utilization patterns. The study compared the results for beneficiaries in Medi-Cal FFS and Two Plan managed care populations. The initial study indicated that overall, the acuity levels between the two populations were very similar. In six of the 12 Two Plan model managed care counties, managed care beneficiaries had a higher acuity level

than those beneficiaries in FFS, whereas the opposite was true in the remaining six managed care counties.

In June 2010, results were updated using the most recent Medicaid Rx model (version 5.2) and more recent pharmacy utilization data. The updated results reflect that managed care members have a higher acuity level in the majority of the Two-Plan model counties (ten of 12), indicating that FFS may not be serving the higher risk members as effectively as managed care.

A reason for the risk shift to managed care in the updated study was due to several large contracting MCPs not submitting completed pharmacy data for the initial study, thus skewing a comparison. Submission of plan pharmacy data was much more complete for the updated study. In counties where the measured acuity of the managed care population is lower than FFS, the managed care penetration rate is also lower.

In the updated study, Mercer performed an analysis of the two GMC counties and results show that the risk scores for managed care are lower than the corresponding FFS populations. In November 2010, DHCS presented the updated study to MCPs and conducted a follow-up meeting in December 2010.

H. Other Rate Related Issues

SB 208 (Steinberg, Chapter 714, Statutes of 2010), requires DHCS to work with designated public hospitals (DPHs) and their stakeholders to develop an intergovernmental transfer (IGT) mechanism to account for certified public expenditure (CPE) funding that will be lost because of the transition of the SPD population into MCPs. Additionally, the legislation allows DHCS and LA Care (the local initiative in Los Angeles County), to develop a risk sharing mechanism for a three-year period. The intent is to mitigate the risk for Los Angeles County, which had the largest differential between the normalized FFS Risk Score and the normalized Managed Care Risk Score. This occurred when Mercer conducted the initial study of the risk differentials between managed care and FFS.

Discussions occurred with the various stakeholders regarding the IGTs, but action did not proceed until the base rates for the SPDs became final in February 2011. Following release of the SPD rates, discussions continued with the DPHs to determine the appropriate amounts for the CPE replacements. DHCS is in the process of gathering and analyzing data to validate the concerns of the DPHs.

DHCS requested a proposal from Los Angeles County to address the risk mitigation legislation, but as of the date of this report, Los Angeles County has not sent a response.

Attachment A

Total SPD Enrollment of All Plans as of May 31, 2011 (Based on Invoice Data)

Plan	4/30/11 SPDs	5/31/11 SPDs
GMC SD	9,080	12,059
GMC Sac	12,971	15,578
Alameda	10,805	12,930
Contra Costa	5,229	6,243
Fresno	9,273	10,771
Kern	7,043	8,152
LA	48,610	65,011
Riverside	9,876	12,052
San Bernardino	11,820	14,179
San Francisco	2,904	4,714
San Joaquin	6,443	7,719
Santa Clara	7,136	8,947
Stanislaus	3,623	4,335
Tulare	3,806	1,448
Kings	323	580
Madera	307	543
Orange	34,495	34,582
SLO	5,292	3,165
Santa Barbara	3,147	5,324
Merced	6,685	3,551
Monterey	5,279	5,300
Santa Cruz	3,535	6,642
San Mateo	7,503	7,476
Solano	8,077	8,106
Sonoma	6,168	6,255
Napa	1,686	1,690
Yolo	3,247	3,265
Total SPDs All Plans	234,363	270,617
Total Managed Care Enrollment	4,274,929	4,301,877
	0.054822665	0.062906727
SPD Percentage	5.482266489	6.290672653

Attachment B

Abbreviations and Acronyms

AG	Advisory Group
CMS	Centers for Medicare and Medicaid Services
COHS	County-Operated Health System (Model of Medi-Cal managed care)
CPE	Certified Public Expenditures
CRM	Microsoft Customer Relationship Management System
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
DPH	Designated Public Hospitals
FAQs	Frequently Asked Questions
FFS	Fee-For-Service
FTP	File Transfer Protocol
GMC	Geographic Managed Care (Model of Medi-Cal managed care)
HCCI	Health Care Coverage Initiatives
HEDIS	Healthcare Effectiveness Data Information Set
IGT	Intergovernmental Transfer
MCP	Medi-Cal Managed Care Plan
Mercer	Mercer Health and Benefits LLC
MET	Member Evaluation Tool
MMCD	Medi-Cal Managed Care Division
OMB	Office of the Ombudsman
PCP	Primary Care Provider
SB	Senate Bill
SAC	Stakeholder Advisory Committee
SPDs	Seniors and Persons with Disabilities
TARs	Treatment Authorization Requests
TPM	Two-Plan Model (Model of Medi-Cal managed care)
UCB	University of California, Berkeley
Waiver	Federal Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform