Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

SECTION A

2015 -2020
Version: February 27, 2015

DRAFT

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Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet
Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The State **of California requests a~~n amendment~~ waiver under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.**

The name of the waiver program **is Medi-Cal Specialty Mental Health Services (SMHS) Consolidation. (Please list each program name if the waiver authorizes more than one program).**

Type of request. **This is an:**
___ initial request for new waiver. All sections are filled.
_~~X~~_ amendment request for existing waiver, which modifies Section/Part
__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
~~X~~_ Document is replaced in full
_X__ renewal request
__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
_X_ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
Section A is X replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Program Description from the previous waiver period.
___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is X__ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Monitoring Plan from the previous waiver period.
___ assures there are no changes in the Monitoring Plan

from the previous waiver period.

___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: **This waiver/renewal/~~amendment~~ is requested for a period of ~~1~~ 5years ~~and 6 months~~; effective ~~January 1, 2014~~ July 1, 2015 and ending June 30, ~~2015~~ 2020. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)**

State Contact: **The State contact person for this waiver is Dina Kokkos-Gonzales, Department of Health Care Services (DHCS), who can be reached by telephone at (916) 552-9055 or fax at (916) 440 7620, or e-mail at dina.kokkos@dhcs.ca.gov. (Please list for each program).**

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Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The state is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009 (ARRA). ~~The~~ DHCS must solicit the advice of designees prior to submission to the Centers for Medicare and Medicaid Services (CMS) of any waiver renewal. On [insert date ~~September 11, 2013~~a memorandum was provided to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see attachment 1a). The State requested that comments be provided within 30 days of the date of the memo. As of the date of this submission, DHCS has not received ~~no~~written comments ~~have been received by DHCS~~from federally recognized tribes or other tribal organizations in California.

Program History:

~~**Overview of Request for Waiver Amendment**~~

~~**Effective January 1, 2014, California is requesting an amendment of the Medi-Cal SMHS Consolidation waiver. The specifics of the amendment request can be found on page 14 Section A: Program Description, Part I: Program Overview, Section A. Statutory Authority.**~~

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Overview of Request for Waiver Renewal

California is requesting renewal of the Medi-Cal SMHS Consolidation waiver. The specifics of the renewal request begin in Section A: Program Description, Part I: Program Overview, Section A. Statutory Authority.

Section 1915 (b) waivers relevant to specialty mental health services have been in effect in California since 1995. The current request refers to the ~~eighth~~ ninth renewal of the SMHS waiver and~~, if granted~~ will be effective from July 1, 201~~3~~5 to

June 30, ~~2015~~ 2020. ~~On June 30, 2013, this renewal request was granted for a two year period effective July 1, 2013-June 30, 2015.~~

Program Design for Medi-Cal Specialty Mental Health Managed Care

The design of managed care for California's Medi-Cal mental health program was phased in over several years. Medi-Cal Psychiatric Inpatient Hospital Services Consolidation was the first phase, based on the authority granted by the freedom of choice waiver approved by the Centers for Medicare and Medicaid Services (CMS) effective March 17, 1995. The second phase was Medi-Cal SMHS Consolidation, based on the renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver, which was approved by CMS on September 5, 1997~~.~~ and ~~This phase~~ has since been continuously in place~~continuously since September 5, 1997~~.

The State's enabling legislation for this waiver is set forth at Welfare and Institutions (W&I) Code, Sections 14680-14685.1 and 14700-14726 .

History/Key Events and Timeline Relevant to Mental Health services in California:

1957: California passed legislation creating the Short-Doyle Program, a delivery system for community mental health services managed by counties through directly operated and contract providers.

July 1965: Congress passed Title XVIII Medicare legislation and Title XIX Medicaid legislation as amendments to the Social Security Act (the Act) expanding the scope of health benefits to persons eligible for federal grants: for persons 65 years of age and over, (Medicare) and providing federal matching funds to states that implemented a comprehensive health care system for the poor under the administration of a single state agency (Medicaid).

1966: The California Medical Assistance Program (Medi-Cal) was established to provide for medical services to eligible federal cash grant welfare recipients. The specialty mental health services reimbursed by this program included psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists.

1971: California added Short-Doyle community mental health services into the scope of benefits of the Medi-Cal program. This change enabled counties to obtain federal matching funds for their costs of providing Short-Doyle community mental health services to persons eligible for Medi-Cal. This program came to be known as Short-Doyle/Medi-Cal (SD/MC). SD/MC services included many of the services provided by the Short-Doyle program, but not all. Socialization, vocational rehabilitation, residential services and services for homeless persons, for instance, were not benefits under the SD/MC program.

At this point in time, mental health services were provided by two co-existing programs: the SD/MC program and the Fee-for-Service/Medi-Cal (FFS/MC) program which provided psychiatric inpatient hospital services, professional services provided by psychiatrists and psychologists and nursing facility services. However, the SD/MC program provided a much broader range of mental health services, using a wider group of service delivery personnel, than were offered under FFS/MC.

October 1989: A Medicaid State Plan Amendment (SPA) added targeted case management for individuals with mental illness to the scope of benefits offered under the SD/MC system.

July 1993: A SPA added mental health services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered.

March 17, 1995: Based on approval of a Section 1915(b) Freedom of Choice waiver, the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver, California consolidated psychiatric inpatient hospital services provided through the SD/MC and the FFS/MC programs. Through this consolidation, county mental health departments became responsible for both SD/MC and FFS/MC psychiatric inpatient hospital systems for the first time. The Health Care Financing Administration (HCFA) (now CMS) approved SPA 95-016, which described the reimbursement methodology used for psychiatric inpatient hospital services under the consolidated program. The initial Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver period was March 17, 1995 until the waiver was renewed on September 5, 1997.

February 1995: A separate Section 1915(b) waiver was also approved for the Medi-Cal Mental Health Care Field Test (San Mateo County) to field test various aspects of a fully integrated and consolidated Mental Health Plan (MHP) for Medi-Cal beneficiaries. The field test included the provision of both psychiatric inpatient hospital services and other specialty mental health services.

August 1997: A first waiver renewal request for the San Mateo Field test was submitted. It was approved by CMS on June 1998.

- **San Mateo County continued the systems put in place during the initial waiver period and began field testing federal reimbursement based on a six-level case rate, with three levels of payment for children and three levels for adults.**
- **San Mateo County MHP assumed the authorization and management of pharmacy and related laboratory services when prescribed by a psychiatrist for a mental health condition. FFP is claimed for these services based on fee-for-service payments to the Pharmacy Benefits Management contractor and the MHP administrative costs for the services.**

The first waiver renewal/modified waiver was in effect from September 5, 1997

through November 19, 2000.

- **September 1997: California requested and was granted a renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver program to include both inpatient hospital and outpatient, professional, case management and other specialty mental health services under the responsibility of a single MHP in each county. The renewed waiver (approved by CMS September 5, 1997) was called Medi-Cal SMHS Consolidation. The services provided through the SMHS waiver program mirrored the services provided under the SD/MC program and it also included mental health services originally provided through the FFS/MC program such as psychiatric inpatient hospital services, psychiatrist services and psychologist services. Nursing facility services (which were provided through the FFS/MC) were not consolidated into the SMHS waiver program; thus, psychiatric nursing facility services is not considered to be a service provided through the SMHS waiver.**

  Although the SMHS waiver consolidated services provided through the SD/MC and the FFS/MC programs, the term "SD/MC services" remained in general usage to describe the services provided under the SMHS waiver which are now called "specialty mental health services." ~~The State is in the process of eliminating the usage of the term "Short-Doyle services" and "SD/MC services" when referring to specialty mental health services.~~

- **November 1, 1997 through July 1, 1998: Implementation of the renewed waiver, referred to as "Phase II" implementation, was phased in, depending on the readiness of a single entity (the MHP) in each county.**
  - **MHPs became responsible for authorization and payment of professional specialty mental health services that were previously reimbursed through the FFS/MC claiming system.**
  - **Both inpatient hospital and professional Medi-Cal specialty mental health services previously reimbursed through FFS/MC and SD/MC claiming systems became the responsibility of the MHPs.**

November 20, 2000, through November 19, 2002: This was the second waiver period for the SMHS waiver program.

July 30, 2001 through July 25, 2003: This was the second waiver period for the San Mateo field test to continue to field test the elements described above.

April 28, 2003 through April 27, 2005: This was the third waiver period for the SMHS waiver program.

July 24, 2003: To permit California to continue to operate the Field Test for San Mateo County from July 26, 2003, through July 25, 2005, CMS approved California's request for a two-year continuation of the Medi-Cal Mental Health Care Field Test (San Mateo County), under Section 1915(b) (4) of the Act, to

continue to field test the elements described above. This approval included a waiver of the following sections of the Act: 1902(a) (1) Statewideness, 1902(a) (10) (B) Comparability of Services, and 1902(a) (23) Freedom of Choice. This was the last renewal request for the San Mateo Field Test.

The fourth waiver period for the SMHS waiver was in effect April 1, 2005 through March 31, 2007.

July 1, 2005: San Mateo County was fully incorporated into California's SMHS waiver program.

- **As a component of the Medi-Cal SMHS waiver program, the State continued the laboratory and pharmacy aspect of the San Mateo field test since this had proven effective for the San Mateo MHP and its beneficiaries.**
- **The State did not propose that other MHPs cover these services.**

July 1, 2005: The State added Solano County MHP to the Medi-Cal SMHS waiver program and contracted with the Solano County Mental Health Department to serve as the MHP for the provision of some specialty mental health services. The Solano MHP maintained its status as a subcontractor to Solano's managed care plan (Partnership HealthPlan of California). Partnership HealthPlan was responsible for the specialty mental health services covered through its managed care contract with DHCS. In turn, Partnership HealthPlan contracted with the Solano MHP and Kaiser Permanente to provide some specialty mental health services for Partnership HealthPlan enrollees.

The fifth waiver period for the SMHS waiver was in effect April 1, 2007 through June 30, 2009.

- **DMH Contracts with MHPs**
  Effective Fiscal Year (FY) 06/07, the contract between DMH and MHPs was in effect for three years rather than being renewed annually as had previously been the case.

- **Conlan Law Suit**
  During the fifth waiver period, the State implemented the California Court of Appeal's August 15, 2005 decision in the case of *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354. In this case, the court determined that under 42 U.S.C. Section 1396a(a)(10)(B) (the "comparability provision") DHCS was required to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage (the "retroactivity period"). DMH implemented procedures to process specialty mental health services beneficiary reimbursement claims.

- **The Mental Health Services Act (MHSA)**

In November 2004, the voters of California approved Proposition 63- a ballot initiative, which enacted the Mental Health Services Act (MHSA). The MHSA imposes a 1 percent income tax on personal income in excess of $1 million to fund county mental health programs. The Act establishes a prevention, and early intervention program and funds innovative programs and infrastructure, technology and training to support the mental health system.

- Katie A. Lawsuit
  Katie A. v. Diana Bonta is a class action lawsuit that was filed in 2002 against the California Department of Social Services (CDSS) and the California DHCS wherein the plaintiffs alleged that foster children and children "at imminent risk of foster care placement" are not receiving adequate mental health services. Citing the time and effort needed to resolve the complex issues in this case, in March 2009, the court appointed a Special Master.

- Therapeutic Behavioral Services (TBS)
  As the result of the court order in *Emily Q. v. Bonta*, an EPSDT supplemental specialty mental health service (as defined in Title 9, CCR, Section 1810.215) called TBS has, since 1999, been provided under the SMHS waiver to Medi-Cal eligible children under 21 years of age who meet the class definition and demonstrate medical necessity under the waiver for the service. In November 2008, the federal court adopted a Nine-Point Plan to increase access and to improve delivery of TBS. Additionally, it created a comprehensive set of requirements for settling the *Emily Q v. Bonta* lawsuit and ending the Court's jurisdiction in December 2010.

The sixth waiver period for the SMHS waiver was in effect October 1, 2009 through June 30, 2011:

- The MHPs continued to function under a contract with DMH. DMH and MHP representatives met to identify needed changes to the contract.

- Emily Q vs. Bonta lawsuit
  On December 16, 2010 with concurrence from the ~~s~~Special ~~m~~Master, the Court found that DMH had implemented Points One through Eight of the Nine Point Plan. On December 21, 2010, the court issued an additional order stating that the ~~s~~Special ~~m~~Master's appointment shall end on April 29, 2011 and the court's jurisdiction will end on May 6, 2011.

- Katie A. Lawsuit
  The sSpecial ~~m~~Master engaged in settlement negotiations with the parties to accomplish the tasks set forth in the court's order.

- DMH implemented the requirements of Senate Bill 785 (Chapter 469, Statutes of 2007) related to provision of specialty mental health services to children in ~~a~~ foster care, KinGAP, or Aid to Adoptive Parents aid codes.

- **SPA #10–012B relative to Targeted Case Management was approved on December 20, 2010 for an effective date of July 1, 2010. The SPA updates language on the "Mentally Disabled" target group to reflect current practice and align with federal regulations.**

- **SPA #10-016 which updates the State Plan service descriptions for Rehabilitative Mental Health Services and Psychiatric Inpatient Hospital Services~~), was~~ submitted to CMS on December 29, 2010. CMS approved this SPA on March 21, 2011. The effective date for SPA #10-016 was October 1, 2010.**

During the seventh waiver renewal July 1, 2011 – June 30, 2013, the SMHS consolidation waiver program included the following new and/or updated projects/processes.

- **Pursuant to Assembly Bill (AB) 102 Chapter 29 (Statutes of 2011), no later than July 1, 2012, the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions was transferred from DMH to DHCS. An amendment to the SMHS waiver necessary to reflect this change in administration was approved effective July 1, 2012. Modifications to the waiver document were made to reflect DHCS' assumption of responsibilities for FY 2012-2013 while retaining language indicating DMH's responsibilities for FY 2011-2012.**

  The SMHS program was transferred as it currently exists with no interruption in services. An extensive stakeholder process was conducted to provide information and to seek input on the transition. In order to retain the expertise necessary for optimal program functioning and administration, staff from DMH transitioned to DHCS. Further, all DMH regulations, notices, letters, etc. related to the program remain in place until amended, repealed, or readopted by DHCS. For this reason all references to DMH letters and/or information notices were retained in the waiver amendment.

- **As part of the 2011-2012 Governor's budget proposal, effective July 1, 2012, funding was realigned to the counties derived from dedicated funding sources rather than from the State's General Fund (SGF) which is allocated through the budget process. It is not anticipated that this change in funding source will have an impact on the current SMHS delivery system.**

- **MHP Contract**
  Because of the timing of the transfer of administration of mental health from DMH to DHCS, DHCS, DMH and the MHPs entered into three –party contracts~~.~~. ~~t~~The contracts went into effect April 2012 and will remain in effect for one year, through April 2013.

- **The EQRO contract was executed by DMH for FY 2009/10 through June 30, 2012 with an option to extend the contract for two additional one year extension periods covering FY 2012-2013 and FY 2013-2014. The State exercised the option of extending the contract. Effective July 1, 2012 the EQRO was under contract with DHCS rather than DMH.**

- **Transfer of responsibility for San Mateo pharmacy benefit**
  Effective July 1, 2010 the fiscal responsibility for the Medi-Cal pharmacy benefit was transferred from the San Mateo MHP to the Health Plan of San Mateo.

- **SD/MC Phase II (SD/MC II) Electronic Claims Processing System**
  The SD/MC Claims Processing System adjudicates Medi-Cal specialty mental health service claims from California's county MHPs. This new system began operations on February 11, 2010. The old system was phased out on March 31, 2010. The goals of the new SD/MC II system are to adjudicate Health Insurance Portability and Accountability Act (HIPAA) compliant claims in near "real time" in order to pay MHPs reimbursement funds more quickly and to return denied claims for correction within hours of being received. Another significant statewide system update took place during the 7th waiver period to comply with the federal HIPAA 5010 Transactions and Code Sets regulations.

- **SPA #09-004 which updates the State Plan reimbursement sections for Specialty Mental Health Services was submitted to CMS on March 31, 2009. The purpose of this SPA is to update the reimbursement sections to reflect current practice, align with federal regulations, and conform to CMS' financial management reviews. This SPA is currently "off the clock" and the State continues to work with CMS on the revisions proposed through this SPA. The effective date for SPA #09-004 is January 1, 2009.**

During the eighth waiver renewal which covers the time period July 1, 2013 – June 30, 2015, the SMHS consolidation waiver program ~~will~~ included the following new and/or updated projects/processes.

- **In accordance with California Senate Bill X1-1, which modified the Medi-Cal program to include benefits for the Medicaid adult optional expansion population as specified in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and modified the existing Medi-Cal benefit package to include certain mental health services provided in the essential health benefits package selected by California and approved by the federal Secretary of Health and Human Services pursuant to the Patient Protection and Affordable Care Act and 42 U.S.C. Sec 18022, Medi-Cal Managed Care Plans will provide those mental health benefits added to the State Plan to the extent such services are not provided through the SMHS waiver. SMHS will be provided to Medi-Cal enrolled optional adult expansion beneficiaries by the county MHPs. These changes will be effective January 1, 2014.**

- **MHP Contract**
  The State has finalized standard contract language between DHCS and the MHPs. The effective date of the contract is May 1, 2013. This contract will be in place for a period of five years and two months extending to June 30, 2018.

- **The EQRO contract was secured by the State for FY 2009/10 - June 30, 2012 with an option to extend the contract for two additional one year extension periods. The State exercised the option of extending the contract through FY 2012-2013. The State is in the process of extending the contract for FY 2013-2014. During waiver period 8, the State will conduct a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E commencing with Section 438.10.**

- **AB 1297 (Chapter 651, Statutes of 2011), enacted July 1, 2012, required the Department to 1) Develop a reimbursement methodology, that is consistent with federal Medicaid requirements 2) Require counties to certify that public expenditures have been incurred prior to reimbursement of federal funds and 3) Require MHPs to submit claims for federal reimbursement to the State within time frames that are consistent with federal Medicaid requirements. All of these provisions will be in effect during the 8th waiver period.**

  The new methodology establishes county interim rates that limit the interim reimbursement for services provided by county owned and operated providers. Claims for the cost of specialty mental health services provided by county owned and operated providers is limited to the lower of the amount claimed or the interim rate established for the service provided. The MHP may establish a county contract rate to limit interim reimbursement for services provided by contract providers. Claims seeking reimbursement for the cost of specialty mental health services provided by a contract provider are limited to the lower of the amount claimed or the county contract rate, if one has been established. All interim reimbursement is subject to retrospective cost settlement.

- **Healthy Families Program Transition**
  On December 31, 2012, California received federal approval from CMS to begin transitioning children from the Healthy Families Program (HFP) to the Medi-Cal program in phases pursuant to AB 1494 (Chapter 28 Statutes of 2012). The overarching goals of the transition include a smooth transition of HFP enrollees to Medi-Cal, minimizing any disruption in service, maintaining existing eligibility gateways, ensuring access to care and maintaining continuity of care.

  The first two groups of children transitioned from HFP to Medi-Cal on January 1, 2013 and March 1, 2013. Continued federal approval for the transition is contingent on meeting Special Terms and Conditions (STC) specified by CMS.

Many of the STCs involve mental health related activities including, monitoring the mental health aspects of the HFP transition; coordinating with MHPs, Medi-Cal managed care plans, and mental health stakeholders; coordinating with other DHCS Divisions; collecting and analyzing data; and preparing reports for CMS.

HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), provides health (including mental health), dental, and vision coverage to over 863,000 children. Children transitioning from the HFP to Medi-Cal will continue to receive health, dental, and vision benefits. MHPs will be responsible for all Specialty Mental Health Services including psychiatric inpatient hospitalization for beneficiaries that meet medical necessity criteria. Historically, MHPs served HFP members that were seriously emotionally disturbed (SED), which accounted for about 1 percent of all HFP members.

DHCS anticipates that MHPs will continue to serve SED HFP members when they become Medi-Cal beneficiaries, as well as other HFP members, and will serve new beneficiaries who enroll in Medi-Cal under the new Targeted Low Income Children's Program, the optional Medicaid program in which transitioning HFP members and new eligible enrollees will be assigned in Medi-Cal. Once the transition is complete, DHCS estimates that approximately 3.5 percent of the total number of transitioned and new Targeted Low Income Children's Program beneficiaries will receive SMHS. Beneficiaries that do not meet medical necessity criteria to receive SMHS may receive mental health services from their primary care physicians, within the primary care physician's scope of practice. Beneficiaries with mental health needs beyond those that a primary care physician car~~e~~n treat within their scope of practice, but that don't meet medical necessity criteria for SMHS will be referred by their Medi-Cal managed care plan to a fee-for-service/Medi-Cal provider to receive mental health services.

- **Katie A. Lawsuit**
  Katie A. v. Bonta is a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of entering the foster care system. In December 2011, a settlement agreement was reached to accomplish a systemic change for mental health services to children and youth by promoting, adopting, and endorsing three service approaches: Intensive Care Coordination (ICC), Intensive Home Based Service (IHBS) and Therapeutic Foster Care (TFC): It has been determined that ICC and IHBS fall within ~~in~~the parameter of existing SMHS. The Department is in the process of determining the model for TFC as well as discussing potential funding sources. It is anticipated that a decision on this matter will be reached during the 8th waiver period. An Implementation Plan was approved by the court in December 2012. The SD/MC II System was modified effective January 1, 2013 to allow MHPs to

claim for ICC and IHBS using a new procedure code. Full implementation of ICC and IHBS on a statewide basis is planned during the 8th waiver period

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)Performance and Outcomes System ~~Early and Periodic Screening, Diagnosis and Treatment (EPSDT)~~ for Mental Health Services
  Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012) added Section 14707.5 to the California Welfare and Institutions Code (WIC). It requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission and a stakeholder advisory committee to develop a plan for a performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

  The system will include objectives related to quality and access, individual, program and system level improvements, minimization of costs using existing resources, and collection of timely and reliable data.

  The legislation requires DHCS to provide an initial plan (for the performance outcomes system) to the Legislature by October, 2013 and to propose how to implement that plan no later than January 2014.

- Solano County
  Effective July 1, 2012, the Solano MHP terminated its previous contractual relationship with Partnership HealthPlan and assumed responsibility to provide or arrange for the provision of the full array of Medi-Cal specialty mental health services to eligible Medi-Cal beneficiaries, with the exception of Partnership HealthPlan enrollees who are Kaiser Permanente members. Partnership HealthPlan will continue to capitate Kaiser Permanente for specialty mental health services provided to Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership HealthPlan and Kaiser Permanente. Solano County MHP will use 2011 Realignment funds to reimburse the Department for payments it made to Partnership HealthPlan for specialty mental health services to Kaiser Permanente members..

- SD/MC Phase II (SD/MC II) Electronic Claims Processing System
  The SD/MC Claims Processing System adjudicates Medi-Cal specialty mental health service claims from California's county MHPs. The goals of the SD/MC II system are to adjudicate Health Insurance Portability and Accountability Act (HIPAA) compliant claims in near “real time” in order to pay MHPs reimbursement funds more quickly and to return denied claims for correction within hours of being received.

In waiver renewal Period 8, it is anticipated that the SD/MC system will be enhanced to support upcoming mandatory HIPAA and Affordable Care Act standards, including but not limited to:

- Standards and operating rules for electronic funds transfer (EFT)
- Operating rules for electronic remittance advice (ERA) transactions
- Use of the National Health Plan ID
- Replacement of the International Classification of Diseases, 9th Revision, (ICD-9) code set with the ICD-10 code set for the purposes of recording diagnoses
- Standards and operating rules for health claims
- Operating rules for health claims and equivalent encounter information

- Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
  The department is aware of the upcoming release of DSM-5 and has implemented a workgroup to study the changes to the diagnostic classification system and to make any recommendations which are necessitated by those changes. Any proposed substantive changes will be submitted to CMS for its approval prior to implementation.

During the ninth waiver renewal which covers the time period July 1, 2015 – June 30, 2020 the SMHS consolidation waiver program will include the following new and/or updated projects/activities.

- MHP Contract
  The State has finalized standard contract language and has contracts in place between DHCS and the MHPs. The effective date of the contract was May 1, 2013. This contract will be in place for a period of five years and two months extending until June 30, 2018, to conform to the State fiscal year.
  (see Attachment 2)

- EQRO Contracts
  The EQRO contract with Behavioral Health Concepts was secured by the State for FY 2014/15 through FY 2016/17 with an option to extend the contract for two additional one year extension periods. The EQRO has commenced its review of MHPs and is providing deliverables to DHCS as required by the contract scope of work
  (see Attachment 5).

- Affordable Care Act
  In accordance with California Senate Bill X1-1, which modified the Medi-Cal program to include benefits for the Medicaid adult optional expansion population as specified in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and modified the existing Medi-Cal benefit package to include certain mental health services provided in the essential health benefits package selected by California and approved by the federal Secretary of Health and Human Services pursuant

to the Patient Protection and Affordable Care Act and 42 U.S.C. Sec 18022, Medi-Cal Managed Care Plans (MCPs) provide those mental health benefits added to the State Plan to the extent such services are not provided through the SMHS waiver.

As a result of these law changes, starting on January 1, 2014, the Department of Health Care Services (DHCS) expanded the array of Medi-Cal mental health services available to Medi-Cal beneficiaries. The following outpatient mental health benefits are available through MCPs for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from any mental health condition defined by the current Diagnostic and Statistical Manual:

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies and supplements (excluding medications that continue to be covered through the fee-for-service Medi-Cal Program).

Medi-Cal specialty mental health services historically provided by the MHPs continue to be provided by the MHPs for Medi-Cal beneficiaries that meet the medical necessity criteria pursuant to Title 9, California Code of Regulations (CCR), Chapter 11, Sections 1820.205, 1830.205, and 1830.210.

County MHPs also provide SMHS to the newly eligible Medi-Cal enrolled optional adult expansion beneficiaries. This change also became effective January 1, 2014.

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Performance and Outcomes System for Mental Health Services
  In 2012, the California State Legislature enacted a process for the DHCS to develop a plan for an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program and system levels and to inform fiscal decision-making related to the purchase of services.

  After two years of research and development, the project will move into its implementation phase during waiver renewal period 9. The Performance Outcomes System implementation will establish a process for bringing together information from multiple sources (e.g., encounter, claims, functional assessment data, pharmacy, child welfare, education status) in order to measure outcomes in the areas of access, engagement, service appropriateness to need, service effectiveness, linkages, cost and satisfaction, at the individual, provider, system,

and community levels. The intent of the system is to gather information relevant to particular mental health outcomes from current and enhanced county reporting and state databases to provide useful summary reports for ongoing quality improvement processes and decision-making, to determine if individuals, providers, and service delivery systems are improving, and implement appropriate changes based on the results of data analysis.

DHCS continues to make progress in the areas of working with stakeholders on the development of Performance Outcomes System (POS) domains, indicators and measures; identifying appropriate functional assessment tools and developing quality improvement plans.

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5): Information to be added prior to submission of formal draft waiver.**

- **Katie A Lawsuit: Information to be added prior to submission of formal draft waiver.**

- A. Statutory Authority

1. Waiver Authority. **The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):**

a.___ 1915(b)(1) – **The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.**

b. ___ 1915(b)(2) - **A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.**

c. ___ 1915(b)(3) - **The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.**

d. _**X**_ 1915(b)(4) - **The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).**

The 1915(b)(4) waiver applies to the following programs

___ MCO
_X_ PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. Sections Waived. **Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):**

a. X Section 1902(a)(1) - **Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.**

b. X Section 1902(a)(10)(B) - **Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.**
The State requests a waiver of these two sections, if determined necessary, based on the facts below:

The SMHS Consolidation Program waiver population is defined as all Medi-Cal beneficiaries and therefore includes special needs populations defined as adults who have a serious mental disorder (California W&I Code Section 5600.3(b)) and children with a serious emotional disturbance (California W&I Code Section 5600.3(a)).

All Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to the services provided through the waiver if they meet the medical necessity criteria for SMHS ~~as~~ described below:

A. For Medi-Cal reimbursement for psychiatric inpatient hospital services, the beneficiary shall meet the following medical necessity criteria:

(1) Have one or more of the following diagnoses
(A) Pervasive Developmental Disorders ; (B) Disruptive Behavior and Attention Deficit Disorders; (C) Feeding and Eating Disorders of Infancy or Early Childhood ; (D) Tic Disorders; (E) Elimination Disorders; (F) Other Disorders of Infancy, Childhood, or Adolescence; (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood); (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder; (I) Schizophrenia and Other Psychotic Disorders; (J) Mood Disorders; (K) Anxiety Disorders; (L) Somatoform Disorders; (M) Dissociative Disorders; (N) Eating Disorders; (O) Intermittent Explosive Disorder; (P) Pyromania; (Q) Adjustment Disorders; (R) Personality Disorders

(2) Meet both of the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.

d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.

b. Medication treatment.

c. Other treatment that can reasonably be provided only if the patient is hospitalized.

B. For Medi-Cal Reimbursement for out of hospital SMHS, the beneficiary shall meet the following medical necessity criteria:

(1) Diagnosis. Medi-Cal beneficiaries must have one or more of the following diagnoses: (A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder;(R) Medication-induced movement disorders related to other included diagnoses.

(2) Have at least one of the following impairments resulting from the above included diagnoses.

(A) A significant impairment in an important area of life functioning;

(B) A reasonable probability of significant deterioration in an important area of life functioning or;

(C) For children under 21, a reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness or condition of a child.

(3) Meet each of the intervention criteria listed below:

(A) the focus of the proposed intervention is to address the impairment/condition identified above;

(B) The expectation is that the proposed intervention will

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health casere based treatment.

C. Medical Necessity Criteria for Medi-Cal Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements for outpatient SMHS as described above. All of the following criteria must be met.

(1) The beneficiary has one or more of the following diagnoses: A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder; (R)Medication-induced movement disorders related to other included diagnoses.

(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

Treatment for the health care conditions of Medi-Cal beneficiaries who do not meet the medical necessity criteria for specialty mental health services (for example, excluded diagnoses as well as all non-mental health medical conditions and services) is ~~therefore~~ not covered under the waiver program. Services for these "excluded" conditions may be provided through other California Medi-Cal programs – primarily the Fee-for-Service Medi-Cal (FFS/MC) program or Medi-Cal Managed Care Plans (MCPs).

Please note that when a Medi-Cal beneficiary has co-occurring diagnoses, i.e. an included and an excluded diagnosis, the beneficiary will be eligible to receive specialty mental health services from the MHP for the included diagnosis provided that the other components of the specialty mental health services' medical necessity criteria are also present. MHPs coordinate care with other providers delivering services for excluded diagnoses. For example, MHPs may coordinate with primary care physicians, regional centers, community based organizations, etc., depending on the beneficiary's unique needs, to ensure that the beneficiary receives appropriate services to address all aspects of general health and well-being.

SMHS are those State Plan approved services provided through the delivery system authorized by the SMHS waiver to beneficiaries who meet the SMHS medical necessity criteria.

The following are specific distinctions in the mental health care delivery system relative to comparability of services and statewideness.

1. ***DHCS Special projects***
   Enrollees in several small special projects continue to receive most Medi-Cal specialty mental health services through contracts between DHCS and the special projects rather than receiving these services from their respective county MHPs. The special projects involved are the State's projects under the Program for All-Inclusive Care for the Elderly (PACE) and the Senior Care Action Network (SCAN), a health maintenance organization operating under the authority of

1915(a) of the Social Security Act. Enrollees in these programs may receive rehabilitative mental health services under the Medi-Cal SMHS Consolidation waiver program from their county MHPs

2. *MCP Specialty Mental Health Services Benefit: Sacramento County*
The specialty mental health services for Kaiser beneficiaries that remain the responsibility of the Sacramento County MHP are the following:
   - Psychiatric inpatient hospital services in SD/MC hospitals, rehabilitative mental health services, and specialty mental health related targeted case management.

~~The 2011 Realignment removed State General Fund as a non-federal funding source for specialty mental health services and provided revenues directly to the counties for the non-federal share of funding. For this reason, the contractual and financial relationships of the following programs have or will change during the 8th waiver period as described below.~~

3. ~~1)~~*Solano County*
~~Effective July 1, 2012,~~ tThe Solano County MHP is now responsible for providing or arranging for the provision of the full array of Medi-Cal specialty mental health services to eligible Medi-Cal beneficiaries, with the exception of Partnership HealthPlan enrollees who are Kaiser Permanente members.

   To assure continuity of care, the Partnership HealthPlan ~~will~~ continues to capitate Kaiser Permanente for ~~specialty mental health services~~ SMHS provided to its Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership HealthPlan and Kaiser Permanente.

   The Solano County MHP ~~will use 2011 Realignment funds to reimburses the Department~~ DHCS with funds from its 2011 Realignment allocations associated with the capitated amount provided by DHCS ~~for payments it made~~ to Partnership HealthPlan that covers ~~for specialty mental health services~~ SMHS ~~to Kaiser Permanente members.~~ for Partnership's Kaiser Permanente members.

4. ~~2~~ *Family Mosaic*
~~The contract between the City and County of San Francisco and DHCS for the Family Mosaic Project (a small special project that receives a per-member, per-month capitated rate to provide specialty mental health services to multi-system-involved children and adolescents with serious emotional disturbances (SED) who are at~~

~~**serious risk of out-of-home placement), has been extended through June 30, 2014. As a condition of the contract, San Francisco County, Department of Public Health, Community Behavioral Health Services is at risk for all specialty mental health services with the exception of psychiatric health facility services, adult residential treatment service, crisis residential treatment services and TBS. The San Francisco County MHP is also responsible for all non-contracted services for enrolled members.**~~

~~**Consideration is being given to transitioning children and adolescents with SED receiving SMHS from the Family Mosaic Project to the San Francisco County MHP during waiver period 8.**~~
The Family Mosaic Project (FMP) is a small special project that provides specialty mental health services, intensive case management, and wraparound services to seriously emotionally disturbed children and youth, and their families, in order to reduce the risk of out-of-home placement. If a child is residing outside of the home, the FMP attempts to provide services that will either maintain or reduce the current level of care in order to avoid institutionalization, juvenile detention, or other restrictive treatment settings.

The FMP operates via contract between the City and County of San Francisco and DHCS under which the City and County of San Francisco receives a per-member, per-month capitated rate for each FMP enrollee. As a condition of the contract, San Francisco County, Department of Public Health, Community Behavioral Health Services is at risk for all specialty mental health services for FMP enrollees with the exception of psychiatric health facility services, adult residential treatment service, crisis residential treatment services, and TBS. The San Francisco County MHP is also responsible for all non-contracted services for FMP enrollees.

The current FMP contract was extended through June 30, 2015, however DHCS is considering transitioning children and adolescents with SED receiving specialty mental health services from the FMP to the San Francisco County MHP during waiver period 9.

c. X Section 1902(a)(23) - **Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.**
In the Medi-Cal SMHS Consolidation waiver program, beneficiaries must receive services through a MHP in their county.

d. X__ Section 1902(a)(4) - **To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).**

The State requests that the plan for complying with Title 42, CFR, Section 438.10(f)(3) regarding the distribution of informing materials as specified in a letter from CMS dated April 26, 2005 (see attachment 3) be continued for the duration of the ~~eighth~~ ninth waiver period.

Also attached is a letter from CMS dated August 22, 2003 (see attachment 4) that describes variations from specific regulations for which CMS has indicated that waivers were not required. As has been the case in previous waiver periods, the State plans to use these variations during the ~~eighth~~ ninth waiver period.

e. X__ Other Statutes and Relevant Regulations Waived - **Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.**

1.) Waivers of the following sections of Title 42, CFR, have been requested and granted for the Medi-Cal SMHS Consolidation waiver program in previous waiver renewals. The State requests that these waivers again be granted as circumstances relevant to enrollment and disenrollment remain unchanged.

- **Section 438.56 in its entirety along with waivers of related references to disenrollment in other regulations.**
- **Section 438.52 for enrollment of beneficiaries in a single MHP in each county.**

2) Section 438.10 (f)(3)—Information requirements: This section establishes specific requirements for the types, content and distribution of information describing the MHP program. The State requests that the waiver of the distribution requirements of subsection (f)(3), granted in previous waiver renewal requests, be continued. This allows MHPs to provide informing materials and provider lists that meet the content requirements of Section 438.10 to beneficiaries when they first access SMHS through the MHP and on request. The waiver of subsection (f)(3) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution.

To the extent necessary, the continuation of waivers previously granted are requested of all sections of the these federal regulations that mention the obligation to inform all enrollees,

instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though an MHP.

B. Delivery Systems

1. Delivery Systems. **The State will be using the following systems to deliver services:**

a.___ MCO: **Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.**

b._X_ PIHP: **Prepaid Inpatient Health Plan means an entity that:**
(1) **provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.**

__ The PIHP is paid on a risk basis.

_X_ The PIHP is paid on a non-risk basis. The PIHPs are not at risk for FFP for the cost of services.

In 1994, Medi-Cal mental health managed care statutes were enacted. ~~(California W&I Code, Sections 5775 et seq (subsequently amended and renumbered as §14712)) and 14680 et seq.).~~ In accordance with California W&I Code sections14680 et seq and 4712 ~~these statutes,~~ specialty mental health services are provided by the MHP. Accordingly, the SMHS Consolidation waiver program is administered locally by each county's MHP and each county's MHP provides, or arranges for, specialty mental health services for Medi-Cal beneficiaries.

CMS has indicated that capitation is the definition of "at risk." MHPs are not paid on a capitated basis; instead, MHPs are paid on a fee-for-service basis.

For ~~FY 2013-2014 and~~ FY ~~2014~~-2015-2016 through FY 2019-2020, counties will utilize realignment funds, MHSA and/or local county funds to pay for services which counties will then certify as public expenditures.

1. Realignment funds: Realignment funds are continuously appropriated to counties and are not subject to appropriation in the State Budget. Funding is derived from dedicated funding sources. Funding was first realigned to the counties in 1991, through the Bronzan-McCorquodale Act (W&I Code Section 5600) and again as part of the 2011-2012 Governor's budget effective July 1, 2012.

- 1991 Realignment
  Realignment funds (which originate from a sales tax increase and a vehicle license fee increase) are collected by the State Controller's Office and allocated to various accounts and sub-accounts in a State Local Revenue Fund. Each county has three program accounts: mental health, social services and health. Each month the state distributes funds from the Local Revenue Fund to counties' local health and welfare trust funds for the provision of mental health, social services and health care program(s). State law (W&I Code, Section 14714(j)) specifies that counties must fulfill their Medi-Cal contract obligations before funding other non-Medi-Cal programs with Realignment funds.
- 2011 Realignment
  Established a Local Revenue Fund 2011 into which a percentage of sales tax and vehicle license fee revenue is deposited. A percentage of sales tax revenue deposited into the Local Revenue Fund 2011 is allocated to a behavioral health subaccount and distributed to counties to provide specialty mental health services, Drug Medi-Cal services, and Substance Use Disorder services (W&I Code Section 14712) .

2. MHSA funds: ~~Enactment of the MHSA in 2004,~~The Mental Health Services Act of 2004 as amended in 2012 imposed a 1 percent income tax on personal income in excess of $1 million for each taxable year beginning in 2005 (Revenue and Tax (R&T) Code Section 17043). The funds imposed by R&T Section 17043 are deposited into the MHS Funds by the State Controller's Office monthly (R&T Section 19602.5)

To the extent that a county mental health system receives MHSA funds (intended for new and innovative programs), counties may provide services to Medi-Cal beneficiaries through these new or transformed programs. Medi-Cal reimbursable services to eligible beneficiaries may be funded with county MHSA funds, at county discretion. However, the funds may not be used to supplant existing state or county funds utilized to provide mental health services.

3. Other County funds: At county discretion, other county funds may also be used to administer the SMHS waiver program and for the provision of specialty mental health services.

c.___ PAHP: **Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)**
does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ PCCM: **A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.**

e. ___ Fee-for-service (FFS) selective contracting: **A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:**
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ Other: **(Please provide a brief narrative description of the model.)**

2. Procurement. **The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):**

___ Competitive **procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)**
___ Open **cooperative procurement process (in which any qualifying contractor may participate)**
_X_ Sole source **procurement**
___ Other **(please describe)**

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

___ **The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.**

_X_ **The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.**

The State continues to contractually require MHPs to ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis as stated in the MHP Contract (Exhibit A, Attachment 1).

Access continues to be assured and monitored through state regulations (Title 9, CCR, Section 1810.405), the State's review and approval of any amendments to the MHPs implementation plans for the program (Title 9, CCR, Section 1810.310(c)), on-going contract management by the State; and formal triennial reviews of the MHPs.

Beneficiaries are provided with a choice of providers within the MHP and an opportunity to change providers whenever feasible under Title 9, CCR, Section 1830.225. Although the regulation allows MHPs to limit the beneficiary's choice to two (2) providers, the beneficiary may request an additional change if not satisfied. The regulation also states that the opportunity for choice may be limited by feasibility. In most cases, feasibility is linked to the number of providers in the MHP's network. An MHP in a very small county or in any one geographic area may have a limited number of providers for a particular service. If additional providers are not needed to meet general access requirements, MHPs are not obligated to contract with additional providers to provide more choices for an individual beneficiary. In a very small number of cases, the MHP may deny a request for a change of provider when a change is clinically contraindicated.

2. Details. **The State will provide enrollees with the following choices (please replicate for each program in waiver):**

___ **Two or more MCOs**
___ **Two or more primary care providers within one PCCM system.**
___ **A PCCM or one or more MCOs**
___ **Two or more PIHPs.**

___ Two or more PAHPs.
_X_ Other: (please describe) Beneficiaries are automatically enrolled in the single MHP in their county.

3. Rural Exception.

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f) (1) (ii)):

4. 1915(b)(4) Selective Contracting

___ Beneficiaries will be limited to a single provider in their service area (Please Define Service Area)

___ Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. General. **Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.**

_X__ Statewide **-- all Counties, zip codes, or regions of the State**

___ Less than Statewide

2. Details. **Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Alameda	**PIHP**	**Alameda Behavioral Health Care Services**
Alpine	**PIHP**	**Alpine County Behavioral Health Services**
Amador	**PIHP**	**Amador County ~~Mental~~ Behavioral Health**
Butte	**PIHP**	**Butte County Department of Behavioral Health**
Calaveras	**PIHP**	**Calaveras County Behavioral Health Services**
Colusa	**PIHP**	**Colusa County Department of Behavioral Health ~~Services~~**
Contra Costa	**PIHP**	**Contra Costa County Mental Health Services**
Del Norte	**PIHP**	**Del Norte County Mental Health Branch**
El Dorado	**PIHP**	**El Dorado Health and Human Service Agency**
Fresno	**PIHP**	**County of Fresno, Department of Behavioral Health**
Glenn	**PIHP**	**Glenn County Department of Mental ~~Behavioral~~ Health**
Humboldt	**PIHP**	**Humboldt County Health and Human Services**
Imperial	**PIHP**	**Imperial County Behavioral Health Services**
Inyo	**PIHP**	**Inyo County Mental Health**
Kern	**PIHP**	**Kern County Mental Health ~~Services~~ Department**
Kings	**PIHP**	**Kings County Behavioral Health ~~Administration~~**
Lake	**PIHP**	**Lake County ~~Mental~~ Behavioral Health Department**
Lassen	**PIHP**	**Lassen County Health and Social Services**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Los Angeles	**PIHP**	**Los Angeles County Department of Mental Health**
Madera	**PIHP**	**Madera County Behavioral Health Services**
Marin	**PIHP**	**Marin County ~~Community Mental~~ Health and Human Services**
Mariposa	**PIHP**	**Mariposa County Mental Health**
Mendocino	**PIHP**	**Mendocino County Mental Health**
Merced	**PIHP**	**Merced County Mental Health**
Modoc	**PIHP**	**Modoc County ~~Mental~~ Health Services**
Mono	**PIHP**	**Mono County Behavioral Health**
Monterey	**PIHP**	**County of Monterey**
Napa	**PIHP**	**Napa County Health & Human Services**
Nevada	**PIHP**	**Nevada County Behavioral Health**
Orange	**PIHP**	**Orange County Healthcare Agency Behavioral Health Services**
***Placer/Sierra**	**PIHP**	**Placer County Adult Systems of Care**
Plumas	**PIHP**	**Plumas County Mental Health ~~Services~~**
Riverside	**PIHP**	**Riverside Department of Mental Health**
Sacramento	**PIHP**	**Health & Human Services**
San Benito	**PIHP**	**San Benito County Behavioral Health**
San Bernardino	**PIHP**	**San Bernardino County Behavioral Health**
San Diego	**PIHP**	**San Diego County Behavioral Health ~~Division~~**
San Francisco	**PIHP**	**San Francisco Community Behavioral Health Services**
San Joaquin	**PIHP**	**San Joaquin County Behavioral Health Services**
San Luis Obispo	**PIHP**	**San Luis Obispo County Behavioral Health ~~Department~~**
San Mateo	**PIHP**	**San Mateo County Behavioral Health & Recovery Services**
Santa Barbara	**PIHP**	**Santa Barbara County Alcohol, Drug & Mental Health Services**
Santa Clara	**PIHP**	**Santa Clara County Valley Health and Hospital Systems Mental Health Department**
Santa Cruz	**PIHP**	**Santa Cruz County Mental Health and Substance Abuse Services**
Shasta	**PIHP**	**Shasta Mental Health, Alcohol and Drug**
Siskiyou	**PIHP**	**Siskiyou County Health and Human Services Agency**
Solano	**PIHP**	**Solano County Health and Social Services**
Sonoma	**PIHP**	**Sonoma County ~~Mental~~ Department of**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Stanislaus	**PIHP**	**Health Services Stanislaus County Behavioral Health and Recovery Services**
Sutter/Yuba	**PIHP**	**Sutter/Yuba Mental Health Services**
Tehama	**PIHP**	**Tehama County Health Services Agency, Mental Health Division**
Trinity	**PIHP**	**Trinity County Behavioral Health Services**
Tulare	**PIHP**	**Tulare County Health and Human Services Agency~~, Mental Health Division~~**
Tuolumne	**PIHP**	**Tuolumne County ~~Behavioral~~ Health and Human Services ~~Department~~**
Ventura	**PIHP**	**Ventura County Behavioral Health Department**
Yolo	**PIHP**	**Yolo County Department of Alcohol, Drug, and Mental Health Services**

*** Please Note: Placer County Adult Systems of Care manages the MHP for both Placer and Sierra counties.**

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. Included Populations. **The following populations are included in the Waiver Program:**

_X_ Section 1931 Children and Related Populations **are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_ X_ Section 1931 Adults and Related Populations **are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Blind/Disabled Adults and Related Populations **are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Blind/Disabled Children and Related Populations **are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.**

X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Aged and Related Populations **are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Foster Care Children **are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.**

X__ Mandatory enrollment
___ Voluntary enrollment

_X__TITLE XXI SCHIP **is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.**
California has operated its CHIP program through a combination of CHIP and Medicaid expansion coverage. The State ~~is in the process of~~ has transition~~ing~~ed children from Healthy Families Program (California's CHIP) to Medi-Cal as a Medicaid expansion.

__X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Section 1902 (a)(10)(A)(i)(VIII) Adult beneficiaries are nonpregnant adults ages 19 through 64 who are not otherwise mandatorily eligible for Medicaid and with income at or below 133 percent of the federal poverty level

_X_ Mandatory enrollment
___ Voluntary enrollment

2. Excluded Populations. **Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:**
Note: Although Medicare Dual Eligible individuals and individuals with other health coverage (OHC) are included in the waiver program, Medi-Cal SMHS delivered by the MHPs reimbursable by either Medicare or OHC will be billed first to Medicare and/or OHC with Medi-Cal being the payer of last resort in accordance with W&I Code section 14005(a)"..

___ Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))**

___ Poverty Level Pregnant Women -- **Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.**

___ Other Insurance--**Medicaid beneficiaries who have other health insurance.**

___ Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).**

___ Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program**

___ Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.**

___ Participate in HCBS Waiver--**Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).**

___ American Indian/Alaskan Native--**Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.**

___ Special Needs Children (State Defined)--**Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.**

___ SCHIP Title XXI Children **– Medicaid beneficiaries who receive services through the SCHIP program.**

___ Retroactive Eligibility – **Medicaid beneficiaries for the period of retroactive eligibility.**

___ Other **(Please define):**

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

__X__ **The State assures CMS that services under the Waiver Program will comply with the following federal requirements:**

- **Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).**
- **Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.**
- **Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b) (Note: Family planning services are not covered by the MHPs.)**

___ **The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).**

__X__ **The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

___ **This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.**

__X__ *The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.*

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. Emergency Services. **In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.**

___ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. Family Planning Services. **In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:**

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___ The State will pay for all family planning services, whether provided by network or out-of-network providers.

__ Other (please explain):

_X__ Family planning services are not included under the waiver.

4. FQHC Services. **In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:**

__ The program is voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.**

___ **The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:**

_X_ **The program is** mandatory **and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.** ~~**Note: FQHC services are not covered by the MHPs under the waiver program.**~~

5. EPSDT Requirements.

_X_ **The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.**

The Medi-Cal SMHS Consolidation waiver program is a program that covers only specialty mental health services. MHPs, therefore, are not responsible for the screening function of EPSDT. MHPs may perform the diagnosis function through assessments of beneficiaries requesting services. With respect to the requirements of 1902(a)(43), therefore, MHPs are responsible only for subsection C with respect to arranging for or providing "corrective treatment" identified by a screening and referral or by the MHP's own assessment process. MHP informing materials include information about the State's Child Health and Disability Prevention (CHDP) program, which is the State's formal process for meeting the requirements of 1902(a)(43).

6. 1915(b)(3) Services.

___ **This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.**

7. Self-referrals.

_X_ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Under the waiver program, referrals to the MHP for specialty mental health services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to physical health care providers, schools, county welfare departments, other MHPs, conservators, guardians, family members, and law enforcement agencies. MHPs may not deny an initial assessment to determine whether a beneficiary meets the medical necessity criteria for receiving services from the MHP; however, the MHP may require beneficiaries to request these initial assessments through a formal system at the MHP. MHP informing materials provide beneficiaries with the information needed to obtain services from the MHP.

MHPs are, as stipulated in their contracts, prohibited from requiring prior authorization of emergency services. Each MHP may decide whether or not to require prior authorization of all other SMHS and are obligated to require prior authorization of day treatment intensive and day rehabilitation services if those services will be provided more than five days a week.

Each MHP's informing material contains general information regarding their requirements. MHPs provide additional information to beneficiaries on request.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.**

a. ___ Availability Standards. **The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. ___ Appointment Scheduling **means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ In-Office Waiting Times: **The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ Other Access Standards **(please describe)**

3. Details for 1915(b)(4) FFS selective contracting programs: **Please describe how the State assures timely access to the services covered under the selective contracting program.**

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

_X__ **The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

_X__ **The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.**

a.___ The State has set enrollment limits **for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.**

b.___ The State ensures that there are adequate number of PCCM PCPs with open panels**. Please describe the State's standard.**

c.___ The State ensures that there is an adequate number **of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.**

d.___ The State compares numbers of providers **before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.**

Providers	**# Before Waiver**	**# In Current Waiver**	**# Expected in Renewal**
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

***Please note any limitations to the data in the chart above here:**

e.___ The State ensures adequate geographic distribution **of PCCMs. Please describe the State's standard.**

f.___ PCP: Enrollee Ratio. **The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.**

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ Other capacity standards **(please describe):**

3. Details for 1915(b)(4) FFS selective contracting programs: **Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.**

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

Under the SMHS waiver program, there is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the medical necessity criteria for specialty mental health services. MHPs are required to ensure that all beneficiaries who meet the medical necessity criteria have an assessment and a treatment plan that meet specific standards included in the MHP Contract (Exhibit A, Attachment 1, Item 11).

The waiver program is limited to the coverage of specialty mental health services~~. provided by specialists~~.

b. _X_ Identification. **The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.**

For the purposes of the SMHS waiver program, persons with special health care needs are adults who have a serious mental disorder and children with a serious emotional disturbance. These beneficiaries are identified through the assessment process by the MHP as meeting the SMHS medical necessity criteria.

c. ___ Assessment. **Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.**

d. ___ Treatment Plans. **For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:**

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.__ In accord with any applicable State quality assurance and utilization review standards.

e. ___ Direct access to specialists. **If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.**

3. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.**

a. ___ Each enrollee selects or is assigned to a primary care provider **appropriate to the enrollee's needs.**

b. ___ Each enrollee selects or is assigned to a designated health care practitioner **who is primarily responsible for coordinating the enrollee's overall health care.**

c. ___ Each enrollee is receives health education/promotion **information. Please explain.**

d. ___ Each provider maintains, for Medicaid enrollees, health records **that meet the requirements established by the State, taking into account professional standards.**

e. ___ There is appropriate and confidential exchange of information **among providers.**

f. ___ Enrollees receive information about specific health conditions that require follow-up **and, if appropriate, are given training in self-care.**

g. ___ Primary care case managers address barriers **that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.**

h. ___ Additional case management **is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).**

i. ___ Referrals: **Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.**

4. Details for 1915(b)(4) only programs: **If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.**

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

_**X**__ **The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

_**X**__ **The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

_**X**__ **Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on August 19, 2004.**

_**X**__ **The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):**

~~**Beginning in FY 2004-2005, a contract with APS Healthcare Midwest for the provision of EQRO activities has been in effect. . Most recently, a contract (Contract Number 09-79002-002) was entered into for the period covering FY 2009/10 through FY 2011-2012 with an option to extend the contract for two additional one year extension periods covering FY 2012-2013 and FY**~~

~~2013-2014. The State exercised the option of extending the contract covering FY 2012-2013 and the process to exercise that extension has been completed (DHCS# 12-89103). The State is in the process of extending the contract to cover FY 2013-2014. During waiver period 8, the State will conduct a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E.(see attachment 5 for the contract work plan.)~~

The EQRO contract with Behavioral Health Concepts, Inc. was secured by the State for FY 2014/15 through FY 2016/17 on August 11, 2014, with an option to extend the contract for two additional one year extension periods. The EQRO has commenced its FY 2014/15 review of MHPs and is providing deliverables to DHCS as required by the contract scope of work.

Copies of the EQR schedules are available. ~~can be found on the APS web site at: http://caeqro.com/webx?293@780.zhxhaibQmK9.1@.ee845a5 and http://caeqro.com/webx?293@780.zhxhaibQmK9.1@.ee8465f (see~~ attachment 6).

The table below summarizes the State's EQR activities

Note: APS Health Care West conducted EQR activites though FY 2013/2014. Therefore some of the activities noted below were performed by APS.

Program	Name of Organization	Activities To be Conducted FY 2015/2016 – 2019/2020 ~~2013/2015~~		
		EQR Study	Mandatory Activities	Optional Activities
	~~APS Healthcare Midwest~~ Behavioral Health Concepts	The results of the Performance Measure for ~~2010/11~~ 2012/2013are specified in results of monitoring activities for EQRO section -11 page ~~126~~ (will insert correct page in final draft) below.	Validation that the MHP meets federal data integrity requirements Validation of performance measures Validation of PIPs Validation that the MHP meets quality requirements by conducting focus	Participation in statewide QIC meetings and the annual meeting of QI Coordinators Review of the Cultural Competence Plan and/or Update Focus Groups with beneficiaries

Program	Name of Organization	Activities To be Conducted FY 2015/2016 – 2019/2020 ~~2013/2015~~		
		EQR Study	Mandatory Activities	Optional Activities
		The Performance Measures for FY ~~2011/12~~ 2013/2014 includes analyses of claims data including the following data elements: Gender Race/Ethnicity Service Activity Eligibility Category (Aid group) Age Groups by Gender Performance Improvement Projects (PIPs): Two studies, one clinical and one non-clinical, are selected by each MHP and reviewed by the EQR in every MHP.	groups to obtain client and family member perspective and conducting interviews with providers and other stakeholders Review of the procedures the MHP has in place for collecting and integrating mental health service, financial, eligibility and service provider information covering service related data, from internal and external sources Participation of a diverse group of consumers and family members as part of the on-site review Validation of consumer satisfaction surveys Recommendations based on observed strengths and	Consultation with State and MHP information technology personnel on issues that impact State and MHP Information Systems and EQR activities

Program	Name of Organization	Activities To be Conducted FY 2015/2016 – 2019/2020 ~~2013/2015~~		
		EQR Study	Mandatory Activities	Optional Activities
			weaknesses of the MHP's Quality Management Program **Technical assistance to each MHP** **Development of a statewide summary report after FY 2012/2013 ~~2011/2012~~ and FY 2013/2014 ~~2012/2103~~ is completed.** **Participation in statewide meetings as required to provide information on EQRO activities** **Recruit and train a diverse group of consumers and family members from around the state who shall participate as part of each on-site review team**	

2. Assurances For PAHP program.

___ **The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

___ **The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

3. Details for PCCM program. **The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.**

a. ___ The State has developed a set of overall quality improvement guidelines **for its PCCM program. Please attach.**

b. ___ State Intervention: **If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.**

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ Selection and Retention of Providers: **This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.**

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

___ The utilization management system.
___ The complaint and appeals system.
___ Enrollee surveys.
___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ Other quality standards **(please describe):**

4. Details for 1915(b)(4) only programs: **Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:**

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing **includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).**

1. Assurances

_X__ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

The Medi-Cal SMHS Consolidation waiver program provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single MHP operating in the county of the beneficiary. Since there is no enrollment process or choice of plan, marketing by the MHP or the State is not necessary. Accordingly, the remainder of Part IV, Section A has not been completed.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. **Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.**

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

- **i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.**
- **ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.**
- **iii.__ Other (please explain):**

B. Information to Potential Enrollees and Enrollees

1. Assurances.

_X__ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages

_X__ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages **listed below (If the State does not require written materials to be translated, please explain):**

The State defines prevalent non-English languages as: (check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3. X Other (please explain): Title 9, CCR, Section 1810.410(a) (3) describes the process for determining "prevalent non-English languages" (referred to in the specialty mental health program as "threshold languages") which are defined as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the

beneficiary population, whichever is lower, in an identified geographic area. The most current information notice can be found at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice11-07.pdf (see attachment 7).

_X__ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

- **All MHPs must have a toll-free telephone number that is available 24 hours a day, seven days a week to provide information about SMHS in all languages spoken by beneficiaries of that county. Additionally, MHPs must provide oral translation services at key points of contact to assist beneficiaries to access and maintain services. This may be accomplished through translation or "language line" services accessed through a remote telephone services provider. The MHP's process for meeting these requirements must be included in the MHP's Cultural Competence Plan. MHPs are required to comply with their Cultural Competence Plans by Title 9, CCR Section 1810.410. The requirements of the Cultural Competence Plan are detailed in DMH Information Notice No. 02-03 which can be found at http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03.pdf (see attachment 8).**
  Cultural Competence P ~~p~~lan requirements were updated in 2010 and can be found at http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf and http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf. (see attachments 9 and 10)

_X__ The State will have a mechanism **in place to help enrollees and potential enrollees understand the managed care program. Please describe.**
The State continues to assist enrollees to understand the managed care program through compliance with the requirements of Title 42, CFR, Section 438.10 to the extent applicable to the program. All Medi-Cal beneficiaries receive an annual notice that provides basic information about the program, the toll-free telephone number of their MHP and the other information required by Section 438.10(f)(2). New Medi-Cal beneficiaries will receive similar basic information about the program at the time they apply for Medi-Cal or at the time their eligibility is determined and upon request.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

_X__ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State. (The State is responsible for the annual notice required by Title 42, CFR ,Section 438.10(f) (2) and a related notice to new beneficiaries.)

(ii) ___ State contractor (please specify):_____

(ii) X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider. (MHPs are responsible for providing information to enrollees upon request and when enrollees first access service but they are not required to provide information contained in notices provided by the State.)

C. Enrollment and Disenrollment

1. Assurances.

_X__ **The State assures CMS that it complies with section 1932(a) (4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.**

_X__ **The State seeks a waiver of section 1902(a) (4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)**
As mentioned previously (see pages ~~21 -22~~ ~~28 and 29~~)) (insert correct page number in final draft), waivers of the following sections of Title 42, CFR, have been requested and granted for the Medi-Cal SMHS Consolidation waiver program in all previous waiver renewals. The State requests that these waivers again be granted as circumstances relevant to enrollment and disenrollment remain unchanged.

- **Section 438.56 in its entirety along with waivers of related references to disenrollment in other regulations.**
- **Section 438.52 for enrollment of beneficiaries in a single MHP in each county.**

___ **The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. (Note: This section is not applicable given the nature of the waivers requested. CMS Regional Office has reviewed and approved the MHP contracts for compliance with applicable provisions of section 1932(a)(4) and Title 42, CFR, Chapter IV, Subchapter C, Part 438. Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.)**

___ **This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.**

2. Details. **Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.**

a. Outreach.

____ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

b. Administration of Enrollment Process.

_X_ State staff conducts the enrollment process.

___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

___ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: _____

Please list the functions that the contractor will perform:
___ choice counseling
___ enrollment
___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. **The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.**

___ This is a new program. Please describe the implementation schedule (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

___ This is an existing program that will be expanded during the renewal period. Please describe the implementation schedule (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

___ If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. ___ Potential enrollees will have____days/month(s) to choose a plan.

ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

_X_ The State automatically enrolls **beneficiaries**

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

_X_ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides guaranteed eligibility **of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.**

___ The State allows otherwise mandated beneficiaries to request exemption **from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:**

___ The State automatically re-enrolls **a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.**

d. Disenrollment:

___ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i.___ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

_X__ **The State** does not permit disenrollment **from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.**

___ **The State has a** lock-in **period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).**
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

___ **The State** does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.**

___ **The State permits** MCOs/PIHPs/PAHPs and PCCMs to request disenrollment **of enrollees. Please check items below that apply:**

___ **MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:**

___ **The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.**

___ **If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.**

___ **The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.**

D. Enrollee rights.

1. Assurances.

_X__ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

__X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. Assurances for All Programs. **States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:**

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X__ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. Assurances For MCO or PIHP programs. **MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.**

_X__ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

_X__ The State requires **enrollees to** exhaust **the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.**

___ **The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.**

b. Timeframes

_X__ **The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an** appeal **is 90 days (between 20 and 90). (NOTE: This time frame only applies if a Notice of Action was required.)**

__ **The State's timeframe within which an enrollee must file a grievance is days.**

c. Special Needs

___ **The State has special processes in place for persons with special needs. Please describe.**

4. Optional grievance systems for PCCM and PAHP programs. **States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.**

___ **The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):**

___ **The grievance procedures is operated by:**

- ___ **the State**
- ___ **the State's contractor. Please identify: _____**
- ___ **the PCCM**
- ___ **the PAHP.**

___ **Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)**

___ **Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.**

___ **Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)**

___ **Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)**

___ **Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____**

___ **Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.**

___ **Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.**

___ **Other (please explain):**

F. Program Integrity

1. Assurances.

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X_ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

Employs or contracts directly or indirectly with an individual or entity that is

precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

_X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

_X_ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.