State of California—Health and Human Services Agency
Department of Health Care Services

DEVELOPMENTAL CENTER CLOSURES: TRANSITIONING MEDI-CAL ELIGIBLE BENEFICIARIES TO MANAGED CARE

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1. INTRODUCTION

This Transition Plan was prepared pursuant to Welfare and Institutions Code (W&IC) section 4474.6[1] for submission to the Joint Legislative Budget Committee to outline transition requirements for Medi-Cal managed care health plans (MCPs) when transitioning Medi-Cal eligible beneficiaries from a developmental center (DC) into managed care in the community. These requirements cited in statute include processes such as referral practices, service authorizations, case management, education and training, records sharing, and monitoring.

The Department of Developmental Services (DDS) is in the process of closing three DCs: the Sonoma DC, Fairview DC and General Treatment Area (GTA) of Porterville DC. The populations in the DCs include some of the state's most vulnerable individuals who have unique and often complex medical needs. The Department of Health Care Services (DHCS) and DDS are coordinating efforts and responsibilities to provide a smooth transition for these individuals through a planned process. DHCS, in collaboration with DDS, will assist beneficiaries transitioning into the Medi-Cal fee-for-service (FFS) and managed care delivery systems both with respect to making a choice of MCP, when applicable, and maintaining services currently being provided by the DCs. DHCS will work closely with MCPs and DDS to provide continuation of medically necessary covered services by establishing transition requirements for contractors congruent with existing policies and procedures relating to individuals assigned to Medi-Cal managed care. DDS will work with the regional centers and DCs to provide services in accordance with each person's Individual Program Plan.

Individuals transitioning from the DCs require a full range of services and supports including health, dental, behavioral, specialty equipment, psychiatric and other services. Responsibility for medically necessary covered services currently being provided through the DCs will be transitioned to the Medi-Cal managed care and FFS delivery systems, as appropriate.

Within this plan, DHCS describes the managed care transition plan which provides for a seamless transition of medical services as individuals move from the DCs to their new community living options. In addition, this plan describes ongoing monitoring that will be conducted, incompliance with federal and State regulations, as well as the quality of service for the impacted beneficiaries.

[1] Assembly Bill (AB) 1606, Developmental Services: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1606

Fee-for-Service Beneficiaries

FFS processes are not addressed in this Transition Plan. However, a brief process description is provided here. The FFS system allows beneficiaries to seek services with any enrolled Medi-Cal providers. It covers benefits for all medically necessary services, and beneficiaries can go to any physician that accepts Medi-Cal regardless of location. If services require approval, providers must submit Treatment Authorization Requests (TARs) to DHCS or the MCP to receive permission for the service treatments.

2. Background and Overview

2.1 MEDI-CAL MANAGED CARE DELIVERY SYSTEM

The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. DHCS administers a variety of health programs for Californians, some of which are mandated by the federal government and others are required by State law. DHCS funds health care services for about 13.5 million Medi-Cal members. About one-third of Californians receive health care services financed or organized through the Medi-Cal delivery system.

Today, approximately 10.3 million Medi-Cal beneficiaries in California's 58 counties receive their health care through six models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial and San Benito. Enrollment into managed care can be either mandatory or voluntary depending on the beneficiary's aid code and county of residence. A managed care county map in Appendix A shows the layout of each model type by county. Under the COHS managed care model, non-profit and independent public agencies contract with the State; all beneficiaries are enrolled into the same health plan within a COHS county. In non-COHS counties beneficiaries have a choice of health plan and some may not be mandatorily required to enroll in managed care.

The State provides enrollment assistance to transitioning beneficiaries through local county field offices. Beneficiaries continue to receive services through the FFS system until they become health plan members. As beneficiaries enroll into managed care, their selected health plans will become effective on the first day of the month following enrollment. In counties where beneficiaries have the choice to select from different plans, they may dis-enroll from the current plan and enroll into a new plan. However, there will not be mid-month enrollments for managed care. Coverage will always start on the first day of the next month upon enrolling into a MCP.

DHCS collaborates with various agencies for managed care enrollment and outreach services, and will continue to provide oversight and monitoring services throughout the enrollment process for these transitioning beneficiaries. In support of DHCS's mission, Health Care Options (HCO) provides Medi-Cal beneficiaries with resources to make informed choices about Medi-Cal benefits. The main functions of the HCO Program are designed to assist Medi-Cal beneficiaries in understanding, selecting, and using MCPs. The services provided by HCO to Medi-Cal beneficiaries include, but are not limited to, customer service, mailing of informing materials, education and outreach services in managed care counties, and enrollment/disenrollment processing.

Enrollment in managed care may be completed by using a Medi-Cal Choice Form or by contacting HCO via telephone by the beneficiary or his/her authorized representative. Beneficiaries with mandatory aid codes have thirty calendar days from the mailing of an "Intent to Assign" packet to select a health plan. If beneficiaries do not select a plan by the forty-fifth calendar day, they are default assigned to a MCP. Additional information about health plan options by county are listed in Appendix B.

2.2 DEVELOPMENTAL SERVICES SYSTEM

DDS provides services for persons with developmental disabilities through two programs – the Community Services Program and Developmental Centers Program[2]. In the Community Services Program, DDS contracts with 21 private, non-profit organizations called regional centers to develop, manage and coordinate services and resources for persons found to be eligible under the Lanterman Developmental Disabilities Services Act. In the Developmental Centers Program, DDS directly operates three DCs and one small community facility providing 24-hour residential care and clinical services. For both programs, service needs are determined through a person-centered planning approach involving the individual, an Interdisciplinary Team (ID Team) of professionals and the parents or other representatives of the individual. The needs of the individual and the services to be provided are formalized in an Individual Program Plan.

2.3 OVERVIEW OF DEVELOPMENTAL CENTERS CLOSURE

In 2015, DDS announced the future closures of the Sonoma DC, the Fairview DC and the Porterville DC GTA. On October 1, 2015, DDS submitted to the Legislature a proposed closure plan for Sonoma DC with a projected closure date of December 2018. On April 1, 2016, DDS submitted another closure plan to the Legislature for the Fairview DC and the Porterville DC GTA with projected closure dates of December 2021. With enactment of the Budget Act of 2016, the closure plans were approved. The closure plans are available at http://www.dds.ca.gov/DevCtrs/DCClosures.cfm and provide important information about the processes and activities involved with closing a DC. Additionally, in July 2016, DDS entered into settlement agreements with the Centers for Medicare and Medicaid Services (CMS) for the closure of Fairview DC and the Porterville DC GTA. Under the agreement terms, the ICF portion of Fairview is scheduled to close in October 2019 and Porterville in July 2021.

[2] Welfare and Institutions Code [W&IC], Divisions 4.1 and 4.5: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=4512.

DDS and DHCS have been working together since 2007 under special statutory provisions (W&IC sections 4474.4 and 4474.5) to provide managed care to Medi-Cal eligible beneficiaries transitioning from the DC's to the community under legislatively approved DC closure plans—first for Agnews DC and subsequently for Lanterman DC. Under these provisions, qualified individuals received access to specialized medical care, enhanced case management and expedited enrollment services during the Agnews closure. It was determined that extending the previous managed care benefits to current closures is no longer possible, given the experience with the Lanterman closure and many individuals choosing Fee-For-Service as their Delivery system with Medicare as the primary coverage. The strategy described in this plan reflects the health system as it operates today.

California's DCs currently provide services to the beneficiaries under three levels-of-care: General Acute Care Hospital, Intermediate Care Facility and Nursing Facility. Beneficiaries at these centers require significant health care services including intermittent pressure breathing, inhalation assistive devices, tracheotomy care, or treatment for recurrent pneumonias or apnea. Among the three centers, 27% of residents at the Sonoma DC have significant health care needs as their primary service need, 95% of Fairview DC residents have significant health care needs and 21% of the residents at the Porterville DC have significant health care needs. In addition, residents at the facilities require extensive personal care, behavioral support, high and low structured setting support for ongoing supervision and intervention to prevent self-injury.

The following information, by DC, is summarized from DDS's closure plans:

- As of May 1, 2015, 405 people were in continuing residence at the Sonoma facility with 181 individuals living on one of ten Nursing Facility residences and the remaining 224 residing on one of the facility's 11 Intermediate Care Facility residences. All of Sonoma DC's residents were Medi-Cal eligible, with 91% dually covered by Medicare, and a very small percentage having additional private insurance coverage as of July 1, 2015. As of February 28, 2017 there were 294 people in continuing residence at the Sonoma facility with 132 individuals in Nursing Facility residences and the remaining 162 in Intermediate Care Facility residences.

- Two hundred forty-eight (248) individuals were in continuing residence at the Fairview DC with 102 individuals living in one of six Nursing Facility residences and remaining 146 residing on one of the center's nine Intermediate Care Facility residences as of January 1, 2016. Of these beneficiaries, 75% are dually covered by Medicare, 2% having Medi-Cal supplemental insurance and all are Medi-Cal eligible. Unique to Fairview DC in Orange County, all Fairview residents are enrolled in the CalOptima MCP. As of February 28, 2017 there were 185 people in continuing

residence at the Fairview facility with 78 individuals in Nursing Facility residences and the remaining 107 in Intermediate Care Facility residences.

- As of January 1, 2016, 171 individuals were in continuing residence in the Porterville DC General Treatment Area with 49 living on one of four Nursing Facility residences and remaining 122 residing on one of the facility's seven Intermediate Care Facility residences. All but one of the residents at this center were Medi-Cal eligible as of January 1, 2016, 69% were dually covered by Medicare and 1% have additional private insurance coverage. As of February 28, 2017 there were 126 people in continuing residence at the Sonoma facility with 41 individuals in Nursing Facility residences and the remaining 85 in Intermediate Care Facility residences.

This Transition Plan focuses on persons who are moving from a DC to the community, are Medi-Cal eligible and have the choice of enrolling in or are required to enroll in an MCP. Our recent experience with the transition of persons who have transitioned from DCs and are dually covered by Medi-Cal and Medicare indicates that the vast majority are served through the FFS system with the regional center ensuring the provision of other needed services through the person-centered planning process. In collaboration, DDS and DHCS will issue guidance to MCPs and regional centers, consistent with existing policies and procedures to support the transition of beneficiaries from the DCs to community settings pursuant to statutory provisions (W&IC section 4474.6).

3. Transition Approach

DC residents typically receive their health and medical services directly from and through the DC and do not receive their care through the traditional FFS or managed care delivery systems. As an individual prepares to move out of a DC, DDS utilizes an individualized transition planning process, whereby an ID Team identifies each resident's unique service and support needs in the community and arranges for those services and supports to be in place prior to moving. The ID Team includes the consumer, their family, regional center and DC staff, as well as community service providers. As documented in the Individual Program Plan, all of the individual's needs are addressed, including his or her health and medical needs as a critical component. A detailed Individualized Health Transition Plan (IHTP) is developed by the ID Team as part of the transition planning process. The IHTP includes the person's health history, current status, and their health needs. It provides specific information on how each need will be met and the health transition services that will be provided. The IHTP will assist the ID Team in assuring all of the necessary health supports are in place prior to the residents' move from the DC. Before the individual moves and as part of the IHTP, the regional center assists the individual and his or her family/representative in evaluating and choosing appropriate health care delivery options, and when applicable, enrolling in a MCP.

DHCS and DDS have the shared goal of ensuring that health services are available and accessible in the community when the individual leaves the DC. Many organizations are involved in the enrollment processes, including the health plan, the regional center, the DC, the local county health and/or social services departments and the Social Security Administration. DHCS and DDS will play important roles, working within their respective systems, in educating the involved parties to so that normal processes are clear and working, and that relationships are established; providing the parties with the information that is pertinent to the individual and his or her circumstances and choices; and establishing procedures and timelines for handling enrollment.

The transition approach described below will vary depending on what area of the State DC residents will move to and if they are moving from Fairview DC, where residents are already enrolled in a MCP. DDS will share prospective enrollment information with DHCS to expedite enrollment processes with the MCPs.

3.1 COUNTY ORGANIZED HEALTH SYSTEMS (COHS) MODEL

When a beneficiary transitions from the DC to a COHS county, enrollment is mandatory and automatic. Up until the beneficiary establishes residence within the COHS County, the beneficiary will receive services through the FFS system. Enrollment into the COHS plan will occur concurrently when the

individual transitions to their new county of residence, the county updates the beneficiary's address and assigns an aid code and coverage by that COHS plan begins. As part of the transition planning process at the DC, the ID Team will identify interim medical services in the person's Individual Program Plan until coverage begins.

For beneficiaries at Fairview DC who currently reside in a COHS county and move to a new community living option in the same COHS county, they will continue to be enrolled in their current COHS plan after the transition to community setting. If a beneficiary living at Fairview DC transfers residence to another COHS county, the beneficiary will be automatically enrolled into the COHS plan of the new county on the first day of the following month.

3.2 NON-COUNTY ORGANIZED HEALTH SYSTEMS (NON-COHS) MODELS

When beneficiaries move from a DC into any non-COHS county, beneficiaries who are Medi-Cal only eligible (not Medicare eligible) may choose a health plan that is available within their county of residence. Upon DDS's notification to DHCS of a planned transition, choice materials will be mailed to the beneficiary or authorized representative with enrollment options and choice forms to provide options which can be reviewed, and allow decisions to be made before an individual moves to the community. DHCS and DDS will work in collaboration to bring local enrollment assistance to the DCs to answer any questions and assist in plan selection. If a health plan is not chosen within the allotted timeframe, the beneficiary will be mandatorily assigned to a health plan.

In non-COHS counties, most dual eligibles (individuals eligible for both Medi-Cal and Medicare) are not mandatorily required to enroll in an MCP and may choose Medi-Cal FFS.

3.3 COORDINATED CARE INITIATIVE (CCI) COUNTIES

In 2014, the State and CMS partnered to create a demonstration program to promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare. This duals demonstration, also called Cal MediConnect (CMC) Program, is in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Eligible beneficiaries in these counties receive coordinated medical, behavioral, long term institutional and home-and-community based services through a single organized delivery system.

Although the 2017-18 Governor's Budget estimates that CCI will no longer be cost-effective and the program will discontinue in 2017-2018 pursuant to the provisions of current law, the CMC plans are currently operational and the Governor's Budget proposes to reauthorize the CMC program and the integration of certain long term services and supports into managed care. Dual beneficiaries moving from the DCs to one of the above seven CCI counties have the option to join a Cal MediConnect health

plan operating in these counties and would receive their Medicare and Medi-Cal benefits from a single plan. Dually eligible individuals may choose not to participate in CMC and can receive their Medicare and Medi-Cal benefits from different delivery systems; however, under most circumstances, Medi-Cal eligible individuals residing in CCI counties, regardless if they are dually eligible or not, are required to receive their Medi-Cal benefits from a Medi-Cal managed care plan.

4. Transition Requirements

To provide beneficiaries transitioning from a DC into the community access to specialized care and case management, DHCS has outlined the following transition requirements for individuals assigned to a Medi-Cal MCP, pursuant to section 4474.6 of the W&IC.

4.1 IDENTIFICATION OF PROVIDERS AND REFERRAL PROCESS

During the transition planning process, decisions regarding what services the individual will receive and where or how those services will be provided, will be made before an individual moves to the community. During the transition period, the MCPs will work with regional center staff to ensure they are aware of the referral processes and tracking procedures. Plans will communicate these referral processes to beneficiaries as well.

DHCS will provide existing provider information and beneficiary utilization, diagnosis and assessment data to each MCP prior to a beneficiary transitioning. This data is intended to prepare MCPs for the transition of the beneficiary. DHCS will share this data with the MCPs 45 days in advance of the transition so that MCPs will utilize it to determine beneficiary service needs.

Furthermore, information will be shared among DHCS, DDS, regional centers and MCPs, as appropriate, on transitioning beneficiaries, potential choice information, existing specialist referrals, Treatment Authorization Requests related to specialist services, and durable medical equipment. Prior to the individual's transition, once a health plan and/or a primary care physician has been selected, the regional center will work with the MCP's medical case manager and the beneficiary's primary care physician to identify any known eligible conditions for referral services in order to provide continuity of services with the contracted managed care providers.

4.2 SERVICE AUTHORIZATIONS

MCPs are required to have an established system to track and monitor services requiring prior authorization as part of the contractor's Utilization Management (UM) program in accordance with Health and Safety Code section 1363.5 and 28 CCR 1300.70 (b)(2)(H) and (G) and pursuant to the MCPs' contracts with DHCS. MCPs will communicate these procedures with the beneficiaries' health care providers so they are aware of the process and timeframes to obtain prior authorization for these services.

In addition, MCPs will work with the regional centers prior to enrolling the beneficiaries to managed care to provide regional centers with an understanding of authorization requirements and timeframes for routine or urgent authorization requests. This is important so that pre-authorizations are received

in such a manner that the beneficiaries' care will not be interrupted during the transition period. The MCPs will authorize services in accordance with requirements as outlined in the plan's provider manuals, All Plan and Policy letters, and in DHCS Medi-Cal managed care contracts.

4.3 COORDINATION OF CASE MANAGEMENT SERVICES

Case management services are provided through MCPs and include a health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources to meet a beneficiary's health care needs.

When the enrollment process begins, the MCP and RC will review and establish an agreement for the care plan of the beneficiary. Both entities will coordinate and provide oversight of the individualized health services identified as medically necessary by their primary care physician and/or other health plan providers.

4.4 EDUCATION AND TRAINING

HCO currently provides in-person education and outreach services in managed care counties throughout California. The services are provided in HCO presentation sites located in county Social Services offices throughout the state. Enrollment service representatives make education presentations at these sites and assist beneficiaries in making informed choices. The HCO Program was created in response to various State and federal mandates requiring either the State itself, or an entity under contract with the State, to provide Medi-Cal beneficiaries, residing in certain Medi-Cal managed care service areas, with full and objective information about the health care options available to them.

In addition, DHCS also has a contractual agreement with an enrollment broker to provide education and enrollment broker services to managed care beneficiaries. The contract authorizes DHCS to contract with an independent contractor to provide information and outreach services to Medi-Cal applicants and beneficiaries.

To conduct effective education and outreach, DHCS and DDS will provide targeted opportunities to have HCO make presentations to DC residents and their families.

4.5 DATA SHARING

DHCS and DDS will share specific identified data elements to MCPs and regional centers, respectively, in regards to each applicable DC resident to facilitate those who choose, or are mandatorily enrolled into a Medi-Cal MCP. The regional centers will work cooperatively in sharing information with the

MCPs to the extent allowable under statutory and other requirements for confidentiality and using methods that maintain data security.

5. Continuity of Services

DDS will continue to provide key specialized health care services at each DC, currently being received by the beneficiaries, on an ongoing basis throughout the transition process, and until the necessary services are established and operational in the community. These services include, but are not limited to, medical, dental, adaptive engineering, physical therapy, orthotics, mental health and behavioral services.

When appropriate, MCPs, the DCs and regional centers will share beneficiaries' medical records, consistent with confidentiality provisions. Once an individual's ID Team decides on the community physicians a person will be seeing for care, the DC provides a packet of key medical records, as appropriate and summary information to the new physician(s). The DC physicians attempt to contact each new community physician by phone to and review the information sent over about each patient to facilitate effective case management and coordination of ongoing care.

DHCS will provide beneficiary-specific utilization, diagnosis and assessment data to each MCP 45 days prior to a beneficiary transitioning. This data will serve to prepare MCPs for the transition of the beneficiary. It includes information about services currently accessed by beneficiaries and the providers offering them. Per Health and Safety Code section 1373.96, beneficiaries will maintain their same level of services post-transition until no longer medically necessary.

6. Communication Plan and Outreach

6.1 Engagement with Stakeholders

In accordance with the W&IC section 4474.6, DHCS and DDS will seek public comment from stakeholders and advocates on this Transition Plan. DHCS and DDS welcome feedback on the Transition Plan and transition requirements pertaining to the DC closures prior to finalization.

6.2 Guidance to Medi-Cal managed care health plans

DHCS will work closely with MCPs to put the necessary structures in place prior to full implementation of this Transition Plan. DHCS holds weekly calls with MCPs to facilitate regular communication and allow for sharing of information and best practices.

6.3 Inter-Department Communication

DHCS and DDS have regular ongoing communication and will establish regular calls specifically to assist with transitions and troubleshoot issues that are not being addressed at the local level. A smooth and timely transition to community-based care for all beneficiaries continues to be the primary goal for both Departments.

6.4 Regional Center Communication

DDS is in regular communication with all 21 regional centers and also conducts monthly calls with the regional centers that have 10 or more individuals transitioning from the DCs to community living. The monthly calls allow for the discussion of current issues related to the health and welfare of individuals who are transitioning and the housing being developed in the community, and provide an additional avenue to share key information. Regional centers are also encouraged to contact DDS between calls if they are experiencing issues. DDS may also conduct meetings, webinars and conference calls with regional center staff to disseminate information related to the transition of Medi-Cal individuals to managed care.

7. MONITORING

Consistent with previous DC closures, DHCS will continue oversight and plan monitoring to maintain service adequacy and value-based quality care as these beneficiaries transfer their services to managed care. DHCS utilizes myriad monitoring processes to evaluate access to services for beneficiaries accessing care through the Medi-Cal managed care delivery system. These processes include, but are not limited to: information from calls to the Medi-Cal Ombudsman and DMHC Call Center; Independent Medical Reviews and State Hearings; encounter data; grievances and appeals; ad hoc data requests; utilization reports; medical audits and surveys; stakeholder input; secret shopping; and other monitoring tools to monitor the transition and subsequent activities relating to the benefit.

MCPs are contractually required to submit reports to DHCS on transitioning populations. These reports are submitted monthly through the initial transition and then quarterly. The Department reviews report submissions for purposes of monitoring provider networks, grievances filed, and the number and nature of grievances and appeals. The information provides a snapshot of MCP utilization data and beneficiary satisfaction.

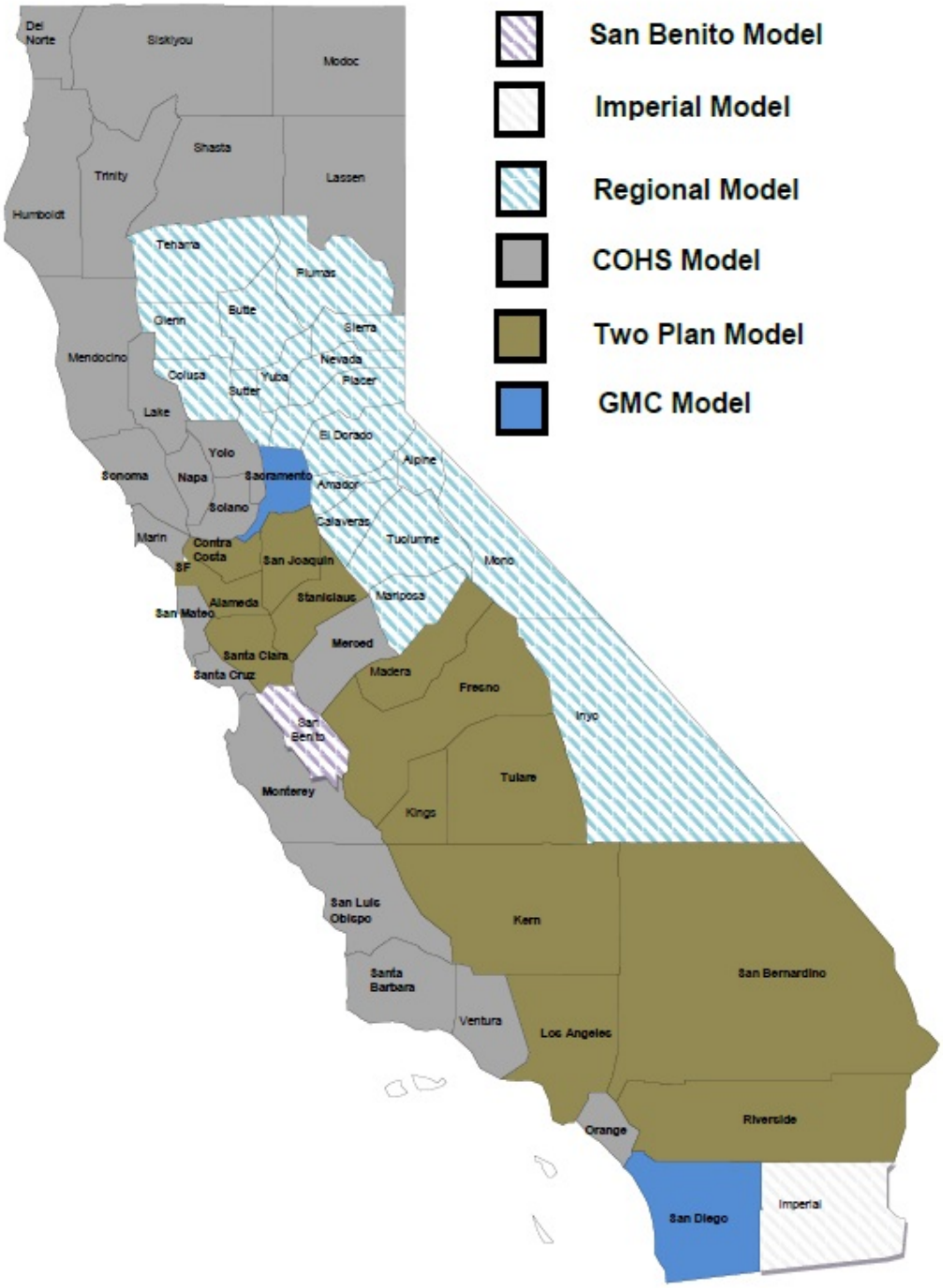
DHCS utilizes data and information from existing monitoring processes and conducts regular reviews of MCP performance. DHCS will work with DDS to quickly resolve any systemic or person-specific issues that arise. Should an area of concern be identified for an individual MCP, MCP model, or across all MCPs, DHCS will provide technical assistance to ameliorate the issue. Should technical assistance not fix the issue, corrective action may be imposed on an MCP. Additional details on the monitoring processes utilized on MCPs can be found at www.dhcs.ca.gov/services/Documents/MCAG/MMCMonitoringRpt.pdf.

8. APPENDICES

A. Sonoma Developmental Center Population by Regional Center
B. Fairview Developmental Center Population by Regional Center
C. Porterville Developmental Center Population by Regional Center
D. Managed Care County Map
E. List of Health Plan Options by County

APPENDIX A

Managed Care County Map



APPENDIX B

LIST OF HEALTH PLANS BY COUNTY

County Name	Health Plan	County Name	Health Plan
Alameda	Alameda Alliance For Health	Los Angeles	CareMore Cal MediConnect
Alameda	Anthem Blue Cross Partnership Plan	Los Angeles	Care 1st Cal MediConnect
Alpine	Anthem Blue Cross Partnership Plan	Los Angeles	Health Net Comm Solutions
Alpine	CA Health & Wellness	Los Angeles	Health Net Cal MediConnect
Amador	Anthem Blue Cross Partnership Plan	Los Angeles	LA CARE
Amador	CA Health & Wellness	Los Angeles	L.A. Care Cal MediConnect
Amador	KP Cal	Los Angeles	Molina Dual Options
Butte	Anthem Blue Cross Partnership Plan	Madera	Anthem Blue Cross Partnership Plan
Butte	CA Health & Wellness	Madera	CalViva
Calaveras	Anthem Blue Cross Partnership Plan	Marin	Partnership HP
Calaveras	CA Health & Wellness	Mariposa	Anthem Blue Cross Partnership Plan
Colusa	Anthem Blue Cross Partnership Plan	Mariposa	CA Health & Wellness
Colusa	CA Health & Wellness	Mendocino	Partnership HP
Contra Costa	Anthem Blue Cross Partnership Plan	Merced	Central Coast Alliance
Contra Costa	Contra Costa HP	Modoc	Partnership HP
Del Norte	Partnership HP	Mono	Anthem Blue Cross Partnership Plan
El Dorado	Anthem Blue Cross Partnership Plan	Mono	CA Health & Wellness
El Dorado	CA Health & Wellness	Monterey	Central Coast Alliance
El Dorado	KP Cal	Napa	Partnership HP
Fresno	Anthem Blue Cross Partnership Plan	Nevada	Anthem Blue Cross Partnership Plan
Fresno	CalViva	Nevada	CA Health & Wellness
Glenn	Anthem Blue Cross Partnership Plan	Orange	CalOPTIMA
Glenn	CA Health & Wellness	Orange	OneCare Connect
Humboldt	Partnership HP	Placer	Anthem Blue Cross Partnership Plan
Imperial	CA Health & Wellness	Placer	CA Health & Wellness
Imperial	Molina Healthcare	Placer	KP Cal
Inyo	Anthem Blue Cross Partnership Plan	Plumas	Anthem Blue Cross Partnership Plan
Inyo	CA Health & Wellness	Plumas	CA Health & Wellness
Kern	Health Net Comm Solutions	Riverside	Inland Empire HP
Kern	Kern Hlth System	Riverside	IEHP DualChoice
Kings	Anthem Blue Cross Partnership Plan	Riverside	Molina Healthcare of CA Partner Plan
Kings	CalViva	Riverside	Molina Dual Options
Lake	Partnership HP	Sacramento	Anthem Blue Cross Partnership Plan
Lassen	Partnership HP	Sacramento	Health Net Comm Solutions

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County Name	Health Plan	County Name	Health Plan
Sacramento	Molina Healthcare of CA Partner Plan	Stanislaus	Health Net Comm Solutions
San Benito	Anthem Blue Cross Partnership Plan	Stanislaus	HP of San Joaquin
San Bernardino	Inland Empire HP	Sutter	Anthem Blue Cross Partnership Plan
San Bernardino	IEHP DualChoice	Sutter	CA Health & Wellness
San Bernardino	Molina Healthcare of CA Partner Plan	Tehama	Anthem Blue Cross Partnership Plan
San Bernardino	Molina Dual Options	Tehama	CA Health & Wellness
San Diego	Care 1st Partner Plan	Trinity	Partnership HP
San Diego	Care 1st Cal MediConnect	Tulare	Anthem Blue Cross Partnership Plan
San Diego	Community Health Group	Tulare	Health Net Comm Solutions
San Diego	CommuniCare Advantage	Tuolumne	Anthem Blue Cross Partnership Plan
San Diego	Health Net Comm Solutions	Tuolumne	CA Health & Wellness
San Diego	Health Net Cal MediConnect	Ventura	Gold Coast Health Plan
San Diego	KP Cal	Yolo	Partnership HP
San Diego	Molina Healthcare of CA Partner Plan	Yuba	Anthem Blue Cross Partnership Plan
San Diego	Molina Dual Options	Yuba	CA Health & Wellness
San Francisco	Anthem Blue Cross Partnership Plan		
San Francisco	San Francisco HP		
San Joaquin	Health Net Comm Solutions		
San Joaquin	HP of San Joaquin		
San Luis Obispo	CenCal Health		
San Mateo	HP of San Mateo		
San Mateo	Care Advantage CMC		
Santa Barbara	CenCal Health		
Santa Clara	Anthem Blue Cross Partnership Plan		
Santa Clara	Anthem Blue Cross CMC		
Santa Clara	Santa Clara Family HP CMC		
Santa Clara	Santa Clara Family Health Plan		
Santa Cruz	Central Coast Alliance		
Shasta	Partnership HP		
Sierra	Anthem Blue Cross Partnership Plan		
Sierra	CA Health & Wellness		
Siskiyou	Partnership HP		
Solano	Partnership HP		
Sonoma	Partnership HP		