Programmatic Transition Plan

Coordinated Care Initiative Beneficiary Protections

Submitted by the Department of Health Care Services
In Partial Fulfillment of Requirements of Senate Bill 1008
(Chapter 33, Statutes of 2012)

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EXECUTIVE SUMMARY

As part of the Fiscal Year 2012-13 budget process, Governor Brown signed Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012), which enacted law to implement the Governor's Coordinated Care Initiative (CCI), effective as early as March 1, 2013. SB 1008 requires DHCS to submit a written programmatic transition plan for implementation of the beneficiary protection provisions of the CCI to the fiscal and applicable policy committees of the Legislature no later than ninety days after enactment, which is September 25, 2012.

The law directs DHCS to coordinate with the California Department of Social Services, California Department of Aging, and Department of Managed Health Care and convene at least two stakeholder meetings to obtain input that guides the development of the Transition Plan. Stakeholders include beneficiaries, providers, advocates, counties, managed care health plans and representatives of the Legislature. DHCS has scheduled two stakeholder meetings regarding the Coordinated Care Initiative (CCI) Transition Plan that will be submitted to the California Legislature in late September. Stakeholders will have an opportunity to review the Transition Plan and submit comments before a final version is sent to the Legislature.

As required by SB 1008, this Transition Plan provides:

A. A description of how access and quality of service shall be maintained during and immediately after implementation of the CCI, in order to prevent unnecessary disruption of services to beneficiaries;

B. Explanations of the operational steps, timelines, and key milestones for determining when and how the components of Welfare and Institutions Code Section 14182.17 (d), paragraphs (1) to (9), inclusive, shall be implemented. These paragraphs represent the core beneficiary protection provisions of the CCI;

C. The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

D. A description of how stakeholders were included in the various phases of the planning process to formulate the Transition Plan, and how their feedback shall be taken into consideration after transition activities begin.

INTRODUCTION

Coordinated Care Initiative

In January 2012, Governor Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities, while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI though SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012).

The three major components of the CCI addressed in this report are[1]:

- A three-year demonstration proposal for dual eligible Medi-Cal and Medicare beneficiaries to combine the full continuum of acute, primary, institutional, and home-and community-based services into a single benefit package, delivered through an organized service delivery system.
- Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries.
- The inclusion of Long-Term Services and Supports (LTSS) as Medi-Cal managed care benefits for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD beneficiaries eligible for both Medicare and Medi-Cal (dual-eligibles).

The CCI is effective in eight counties beginning as early as March 2013, although SB 1008 expresses the intent that these provisions be implemented statewide within three years of initial implementation. The eight counties for 2013 implementation are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

[1] SB 1036 also included authorization for a Statewide Public Authority for In Home Supportive Services (IHSS) and a county Maintenance of Effort for funding IHSS, but these provisions are not in the scope of this report.

Dual-eligible and Medi-Cal-only SPDs are among the state's highest-need populations. They tend to have many chronic health conditions and need a complex range of services from many providers. This fragmentation leads to beneficiary confusion, poor care coordination, inappropriate utilization and unnecessary costs.

The CCI includes the following goals, as specified in SB 1008:

1) Coordinate Medi-Cal and Medicare benefits across health care settings and improve the continuity of care across acute care, long-term care, behavioral health, including mental health and substance use disorder services, and home- and community-based services settings using a person-centered approach.
2) Coordinate access to acute and long-term care services for dual eligible beneficiaries.
3) Maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
4) Increase the availability of and access to home- and community-based services.
5) Coordinate access to necessary and appropriate behavioral health services, including mental health and substance use disorder services.
6) Improve the quality of care for dual eligible beneficiaries.
7) Promote a system that is both sustainable and person and family centered by providing dual eligible beneficiaries with timely access to appropriate, coordinated health care services and community resources that enable them to attain or maintain personal health goals.

The CCI will use a capitated payment model to provide both Medicare and Medi-Cal benefits through the state's existing network of Medi-Cal health plans. These plans also have experience providing Medicare managed care. The health plans will be responsible for delivering a full continuum of Medicare and Medi-Cal services, including medical care, behavioral health services, and long-term services and supports (LTSS), including home- and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), in addition to care in nursing facilities when needed.

The CCI will protect and improve the nation's largest personal care services program, IHSS, which serves over 430,000 individuals. IHSS is a prized program rooted in consumers' right to self-direct their care by hiring, firing and managing their IHSS provider. Throughout the stakeholder process for CCI, beneficiaries emphasized the critical role IHSS plays in their ability to have a high quality of life in the community. Additionally, they emphasized the need to self-direct their care. The CCI seeks to enhance the IHSS program's ability to help people avoid unnecessary hospital and nursing home admissions. IHSS will remain an entitlement program and serve as the core home- and community-based service. County social workers will continue

determining IHSS hours. The current fair hearing process for IHSS will remain in effect in the initial years of the demonstration. The principles of consumer-direction and continuity of care are and will remain key aspects of the beneficiary protections.

For the demonstration, the State will use a passive enrollment process through which dual-eligible beneficiaries may choose to opt out of the demonstration. Pending CMS approval, those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period, during which they will remain in the same health plan. Enrollment will be phased in starting in calendar year 2013.

Specific terms of the demonstration will be established in the Memorandum of Understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the State. The MOU will include the provisions of SB 1008, including the beneficiary protections described in this transition report.

The CCI will build on lessons learned during the 1115 waiver transition of Medi-Cal only seniors and persons with disabilities into managed care, including the following:

- *Continuity of care.* Beneficiaries and stakeholders have repeatedly emphasized the importance of care continuity when considering new delivery models. Beneficiaries will be informed about their enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information will be delivered in a format and language accessible to enrollees.

- *Person-Centered Care Coordination.* Health plans will be responsible for providing seamless access to networks of providers across this broader continuum of care, as well as upholding strong beneficiary protections established by the state through the stakeholder process. The model of care will include person-centered care coordination supported by interdisciplinary care teams.

- *Beneficiary Protections.* The demonstration will include unified requirements and administrative processes that accommodate both Medicare and Medicaid, including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes.

- *Plan Monitoring and Oversight.* The State will work closely with CMS, stakeholders and beneficiaries to provide strong monitoring and oversight of health plans, and to evaluate the CCI's impact on quality and satisfaction, service utilization patterns, and costs.

- *Provider Outreach and Engagement.* The State and CMS will coordinate

efforts to engage and educate providers about the CCI leading up to and during implementation. This work already is underway through the stakeholder work group focusing on provider outreach and engagement.

- *Transparency.* Transparency and meaningful involvement of external stakeholders, including beneficiaries, has been a cornerstone in the development of the CCI and will remain so throughout its implementation. California has embarked on a stakeholder workgroup process and will require proof of ongoing stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from beneficiaries and other external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.

For ongoing stakeholder input, DHCS has organized a series of stakeholder workgroups. These workgroups are co-lead by and involve departments throughout the California Health and Human Services Agency that have been developing policy recommendations in a team setting. Each workgroup is co-chaired by a public stakeholder (for example, an advocate, beneficiary, county or plan representative) and a State agency representative.

Health Plan Selection, Readiness, Contracts, and Oversight

The State held a rigorous joint selection process with the Centers for Medicare and Medicaid Services (CMS) to identify health plans with the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties. In February 2012 the state reviewed health plan responses to the state's Request for Solutions (RFS) for the demonstration. Later, in July 2012, the Model of Care for each health plan was independently evaluated by the National Committee for Quality Assurance (NCQA).

In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements. The readiness review will concentrate on the plan's operational capability to serve the Medicare-Medicaid beneficiaries, including the delivery of all Medicare Part A, B and D services, as well as all Medicaid long term services and supports, and behavioral health services. The readiness review will test the health plan's major systems, including the enrollment, claims processing, and payment systems and will review the health plan's processes related to enrollment, continuity of care, care coordination, and beneficiary protections, among others.

The readiness review process demonstrates the health plan's ability to:

- Provide timely access to medical care to beneficiaries, and measure the adequacy of the provider networks for medical, long-term care, and behavioral health services.
- Submit encounter data to the State on a routine basis.
- Administer an expanded model of care that reflects necessary changes in organizational structure, staffing, and policies and procedures.
- Demonstrate that sufficient infrastructure is ready to administer benefits and coordinate care for the beneficiaries.
- Identify and report performance and quality improvements.

The health plan readiness reviews are instrumental to the ongoing monitoring and oversight activity of the health plans that will be coordinated by the Department of Health Care Services (DHCS), involving the Department of Managed Health Care (DMHC) and other state departments and county agencies to ensure beneficiary care is being coordinated effectively.

Following a successful health plan readiness review, DHCS and CMS will execute a three-way contract with the health plan for the demonstration that will reflect the MOU and the provisions of SB 1008. In addition, Medi-Cal contracts between the state and health plans will be amended to reflect the LTSS and other provisions of SB 1008 for dual eligible beneficiaries that do not participate in the demonstration and Medi-Cal-only beneficiaries.

Oversight of the health plans to ensure contract compliance for the demonstration will be carried out by a joint CMS-State contract management team. The contract management team will ensure access,quality, program integrity and financial solvency, including reviewing and acting on data and reports, conducting studies, and taking corrective action.

The Contract Management team will be responsible for day-to-day monitoring of each health plan. These responsibilities include, but are not limited to:

- Monitoring compliance with the terms of the three-way contract, including issuance of joint notices of non-compliance/enforcement;
- Coordination of periodic audits and surveys of the health plan;
- Receipt and response to complaints;
- Regular meetings with each health plan;
- Coordination of requests for assistance from health plans, and assignment of appropriate State and CMS staff to provide technical assistance;
- Coordinate review of marketing materials and procedures; and
- Coordinate review of grievance and appeals data, procedures, and materials.

State agencies will conduct similar oversight activities for the CCI Medi-Cal contracts for the LTSS and other managed care provisions for dual eligibles not in the demonstration and Medi-Cal only beneficiaries.

State Administrative Background

The California Department of Health Care Services (DHCS) is the State Medicaid agency in California. DHCS is partnering with the Department of Managed Health Care (DMHC), California Department of Social Services (CDSS), and the California Department of Aging (CDA) to implement the CCI. The California Health and Human Services Agency (Agency) is coordinating many aspects of the CCI that involve multiple departments. This collaboration will ensure the state has adequate capacity to implement and oversee the CCI in eight counties in 2013 and additional counties in future years.

Within DHCS, primary responsibility for the CCI lies within the Health Care Delivery Systems program. Within this program, the Medi-Cal Managed Care Division develops and administers health plan contracts, monitors contract compliance and health plan quality, administers the Medi-Cal managed care Ombudsman program, and oversees the state's beneficiary enrollment contractor. This division also administers an interagency agreement with DMHC for additional auditing and financial oversight services. The Long-Term Care Division operates, administers, monitors, and provides oversight for a number of home and community-based service waivers in California, including CBAS, MSSP, and IHSS. This division also administers PACE in California and a federal Money Follows the Person grant. Both of these divisions report to the Deputy Director of Health Care Delivery Systems and work is done collaboratively within this reporting structure

Additional divisions within DHCS provide critical functions for the CCI. Within the DHCS Health Care Financing program, the Capitated Rates Development Division develops and coordinates capitation rates and monitors health plan expenditures. For behavioral health, the DHCS Mental Health and Substance Use Disorder program provides statewide oversight and administration of county-administered mental health and substance use programs. For Medi-Cal pharmacy beneficiaries, the Pharmacy Benefits Division provides policy guidance and review of health plan formularies. The Audits and Investigations Division ensures the fiscal integrity, efficiency and quality of the health plans.

Among partner agencies, DMHC licenses and regulates managed care health plans, conducts routine and non-routine financial and medical surveys, and operates a Help Center where beneficiaries can lodge complaints and get assistance with problems they are having with their plans. Each health plan seeking to participate in the CCI holds a current license issued by the DMHC under the Knox-Keene Act. To maintain its license, each health plan is required to continuously meet defined regulatory standards, including timely access to care through adequate provider networks, care coordination, continuity of care, financial solvency, and treatment decisions unencumbered by fiscal or administrative considerations. The DMHC Help Center provides comprehensive beneficiary assistance, including:

- A toll-free complaint and assistance line;
- A process for quickly resolving routine health plan issues;

- An urgent nurse process for treatment denials that require immediate assistance;
- External review of medical necessity and experimental/investigational disputes; and
- A thorough review process for complaints concerning all other matters, including coverage denials.

CDSS provides state-level oversight and fiscal services for the county-administered In-Home Supportive Services Program. CDA administers MSSP and the Health Insurance Counseling and Advocacy Program (HICAP), which offers Medicare beneficiaries, as well as those about to become eligible for Medicare, consumer counseling on Medicare, Medicare supplement policies, health plans, and long-term care insurance.

Transition Plan Components

As required by SB 1008, in Welfare and Institutions Code (W&I) §14182.17 (d) (10) (B), this Transition Plan addresses each of the following:

A. A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

B. Explanations of the operational steps, timelines, and key milestones for determining when and how the components of Welfare and Institutions Code §14182.17 (d), paragraphs (1) to (9), inclusive, shall be implemented. These paragraphs represent the core beneficiary protection provisions of the CCI.

C. The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

D. A description of how stakeholders were included in the various phases of the planning process to formulate the Transition Plan, and how their feedback shall be taken into consideration after transition activities begin.

Note that while this Transition Plan mentions a select grouping of stakeholder comments, DHCS has carefully reviewed all submitted comments and will give each suggestion consideration in the process of implementing the components of the CCI.

PART A - ACCESS AND QUALITY OF SERVICE

SB 1008 requirement: A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

The provisions below will allow beneficiaries to maintain continued access to providers and services during and after implementation of the CCI.

Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government.

- Network adequacy reviews, conducted by the Centers for Medicare and Medicaid Services (CMS) and DHCS, are a key process to ensure that health plans have sufficient providers in their network to meet the needs of members and provide sufficient access to care. For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards. For Medi-Cal LTSS benefits, DHCS will review health plan networks in the fall of 2012, as part of the readiness review process, to ensure the plans meet the State's newly established LTSS network adequacy standards. Further details regarding network adequacy and the readiness review process are provided in Part B, paragraph 5 of this report.

- The CCI provides key continuity of care and network adequacy provisions, as noted below. Advance planning regarding continuity of care issues, coupled with dedication to resolving transitional care issues faced by each beneficiary, is central to meeting immediate care needs, while also ensuring optimal long-term outcomes. DHCS, CMS, and DMHC will monitor and enforce these provisions as part of the readiness review process, throughout implementation, and on an ongoing basis. Additional information on implementation of these provisions is described in Part B, paragraph 5 of this report.

    - Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)).
    - Medi-Cal Continuity of Care for Nursing Facility Care: For nursing facility care, managed care health plans will recognize any prior treatment authorization made by DHCS for at least six months after enrollment into the health plan. (W&I §14186.6 (c) (3)) Medicare Continuity of Care: Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment. (W&I §14132.275 (l)(2)(A)
    - Medicare Part D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions, to ensure that health plans provide an appropriate transition process for

newly enrolled beneficiaries who are prescribed Part D drugs that are not on the health plan's formulary. (W&I §14182.17 (d)(2)(F))
  - Health Plan Liaisons: Health plans will maintain liaisons to coordinate access for out of network Medi-Cal providers, and to coordinate with regional centers. The continuity of care liaison will ensure provider access and a smooth transition for each beneficiary into the demonstration. (W&I §14182.17 (5)(F) and (G))
  - Provider Physical Accessibility: Health plans will contract with providers that meet physical accessibility requirements. (W&I §14182.17 (d)(5)(A))
  - Alternative Format: Health plans will provide information in alternative formats. (W&I §14182.17 (d)(5)(A))
  - Listing of Providers' Ability to Accept New Patients: Health plans will maintain an updated, accurate, and accessible listing. (W&I §14182.17(d)(5)(C)).

- DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers.

- To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have. Provider engagement and participation in health plan networks is a key component of maintaining access for beneficiaries.

- DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions. DMHC recently promulgated regulations regarding Timely Access to Non-Emergency Health Care Services (California Code of Regulations Section 1300.67.2.2). DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project.

Quality of Services: *Please see information under Part B, paragraph 8 of this report for a description of how the department, in collaboration with other state agencies, will implement provisions that will help maintain the quality of services during and immediately after implementation of the CCI.*

PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI

SB 1008 requirement: Explanations of the operational steps, timelines, and key milestones for determining when and how the components of Welfare and Institutions Code Section 14182.17 (d), paragraphs (1) to (9), inclusive, shall be implemented.

The key operational steps to implement these provisions are listed below. Stakeholder input will be incorporated throughout, in an ongoing process.

1. State and federal review of health plans' Model of Care;
2. The Memorandum of Understanding (MOU) between the State and CMS;
3. The Readiness Review Process;
4. Three-way contracts and amended Medi-Cal contracts with the health plans;
5. Ongoing oversight through the contract management team.

(1) Ensure timely and appropriate communication with beneficiaries.

To ensure timely and appropriate communication with beneficiaries, DHCS is undertaking the following activities.

Enrollment and Notification Strategy:

Beneficiaries will be sent an informing notice at least 90 days prior to the health plan enrollment effective date, followed by a 60-day notice with plan information and selection materials and a 30-day reminder notice. A final confirmation letter will be sent to the beneficiary confirming his/her plan choice and the effective enrollment date.

- All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries. DHCS will collect comments and update the material as appropriate. The release of notices will be scheduled by population groups. The standard notification process will be based on a 12-month enrollment schedule for the two-plan and GMC plan types.

- All beneficiary notices and enrollment materials will require a reading proficiency no higher than sixth grade level and will be available in all the Medi-Cal threshold languages required under current state law, as well as in alternative formats, all of which are culturally, linguistically, and physically appropriate.

- For in-person enrollment, disability accommodation such as assistive listening systems, sign language interpreters, captioning, and written communication will be available.

- DHCS is working with the enrollment contractor, Maximus, to clarify the process for authorizing legal representatives, such as a caregiver, family member, conservator, or a legal services advocate, to communicate with the contractor on enrollment issues and make elections on the beneficiary's behalf when necessary and appropriate.

- Beneficiary notices will be made available for public view through the website www.CalDuals.org and made available to providers before they are mailed to beneficiaries.

Transition of Care for Part D Benefits
Through the readiness review process, CMS and the State will ensure that health plans have policies and procedures to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration.

Outreach Plan: DHCS is developing an outreach and education program informing beneficiaries of their enrollment options and rights, including specific steps for working with consumer and beneficiary community groups. Contingent on available funding, this plan will include contracting with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting beneficiaries in understanding their health care coverage options.

Communication Plan: DHCS is developing, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices, including the enrollment notice time frame, alternative formats, accessible formats, and ensuring the materials are culturally and linguistically appropriate. This communications plan will build on the experience gained during the Medi-Cal-only Seniors and Persons with Disabilities (SPD) program transition process.

Health Plan Oversight for Enrollment Communication: DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures. Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.

(2) Initial Assessment Process

Health plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health and functional needs. The multi-tiered process will begin with a health risk assessment of each beneficiary conducted upon enrollment.

Health plans will use the assessment information for risk stratification of members, using a mechanism or algorithm developed by the health plan and reviewed and approved by DHCS. This will serve as a triage for further assessment needs in a variety of areas including, but not limited to, mental health concerns, substance abuse concerns, chronic physical conditions, and potential needs related to key activities of daily living, dementia, cognitive status and the capacity to make informed decisions.

This assessment will help inform the interdisciplinary care team to assist in creating an appropriate individual care plan, and beneficiaries in accessing all necessary resources. Individual care plans will be used to address risk factors, prevent health disparities, and reduce the effect of multiple co-morbidities. Care plans will be developed for beneficiaries that include member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified in a comprehensive risk assessment.

Building on what was learned from the transition of the Medi-Cal-only SPD population into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information via various modes (phone, mail, interactive voice by phone) and web-based care planning tools that allow providers and beneficiaries to view and add to the care plan.

Strategies will also include review of fee-for-service utilization data to prioritize assessment and care planning, and to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary. DHCS is developing data files for health plans for this purpose.

(3) Primary Care Physician Assignment

This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to:

- Not interfere with a beneficiary's primary care physician choice under Medicare;
- Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances;
- Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan; and
- Provide a mechanism for partial-benefit dual eligible beneficiaries to request a specialist or clinic as the primary care provider.

Some of these provisions will be incorporated into existing Medi-Cal managed care health plan contracts as early as October 1, 2012. DHCS will ensure that the remaining provisions are incorporated into the contracts, effective upon mandatory enrollment of dual eligible beneficiaries, and will monitor and enforce these contract provisions.

(4) Care Coordination

DHCS is operationalizing the care coordination provisions of SB 1008 through five steps: a) review of the health plans' Models of Care, b) establishing care coordination standards, c) confirmation that care coordination standards are met during the readiness review process, d) reiterating the ongoing requirements in the contract terms and conditions, and e) monitoring compliance and outcomes. DHCS is currently developing care coordination standards for the health plans. These standards will incorporate the following approaches in conjunction with the provisions specified in W&I §14182.17 (d) (4).

The Interdisciplinary Care Team

An Interdisciplinary Care Team (ICT) is formed for the care management of medical, LTSS and behavioral services. For individuals identified as needing such care management, the ICT functions will include assessment, care planning, service authorization, coordinating delivery of needed services (plan covered Medicare/Medi-Cal benefits or other community resources), monitoring health status and service delivery. The ICT will also be responsible for care transitions between community and institutional settings (hospital and nursing facilities).

In keeping with the goals of the Demonstration, plans will promote and encourage a ICT that is both sustainable and person- and family-centered. This means getting the member, to the extent possible, directly involved in their care delivery. If the member agrees, immediate family or authorized representatives can also be members of the ICT.

Composition and leadership of the ICT

To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members. Based on the assessed need of the members, the core ICT will involve IHSS social workers, CBAS' Interdisciplinary team, behavioral health specialists, pharmacists, and other specialty providers in the development of comprehensive care plans, when appropriate. In keeping with the "person-centered"

goals of the demonstration, when possible the member will be a major factor when deciding the make-up and direction of the ICT.

For members in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians to work with NF staff to manage medical conditions in nursing facilities and to facilitate nursing facility-hospital transitions. Health plans will also develop care plans to successfully transition beneficiaries into the community to the extent possible without jeopardizing the safety, health and welfare of the beneficiary.

ICTs will be under the oversight of the plan's medical leadership or Medical Director. The State expects plans to designate individuals with experience working with seniors and persons with disabilities to lead the care management effort.

Frequency of ICT meetings

Frequency of the ICT meetings will be based on complexity and acuity of the medical, behavioral, and LTSS needs. Plans will need to establish policies and procedures guiding assessments and reassessments according to the approach and intensity of care management. ICT meeting frequency can range from once annually for stable, self-directed individuals, to daily interaction during an acute episode or transitional care process.

Identifying beneficiaries requiring an ICT

Individual plan members who require complex care coordination or case management are those who have multiple acute and chronic diagnoses, functional impairments (vision, hearing, upper/lower extremities, bowel and bladder), cognitive impairments, behavioral problems, ADL/IADL needing human assistance, and/or high utilization of medical, behavioral health and LTSS resources.

Specific criteria will be established by the plans and approved by DHCS. The beneficiary's medical conditions will be assessed and ranked as low, medium or high complexity, each requiring a different approach and intensity of care management. Beneficiaries with ICTs could range from disabled individuals who are able to direct their own care to individuals with highly complex conditions needing intensive case management. Each ICT team will reflect the complexity and intensity of care management appropriate to the individual case.

Recording and storage of documentation and data

The State requires the plan to ensure a care management system that documents, for each managed care member: the member's completed health assessment, care plan, care notes, service provided, utilization pattern and record of claims paid. This

documentation/data may be subjected to random sampling and detailed case review by state reviewers or auditors for accuracy.

Case follow-up and monitoring

The health plans will develop policies and procedures to implement an array of methods for follow-up and monitoring of cases. These may include face to face visits, telephone calls or direct e-mail contact as appropriate.

Behavioral Health Care Coordination

Health plans will enter into an MOU with county behavioral health agencies, which will address joint behavioral health care coordination roles and responsibilities. In addition, the readiness review process will require health plans to provide policies and procedures for joint care coordination between health plans and behavioral health agencies and providers.

(5) Network Adequacy

State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.

Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012, including the following:

In Home Supportive Services (IHSS): Demonstration plans are required to have an MOU or contract with their respective county social services agencies to provide IHSS for their beneficiaries. Such agreements will require the county to provide

- IHSS eligibility assessment and authorization of IHSS hours;
- Coordination of IHSS delivery with other Demonstration plan covered benefits;
- Quality assurance;
- IHHS Provider enrollment and training;
- IHHS Background checks and registry services;
- Data sharing; and

- A local IHSS advisory committee.

Demonstration plans must contract with the California Department of Social Services to perform the following:

- Pay wages to IHSS providers and perform provider payroll obligations and related technical assistance;
- Share beneficiary and provider data; and
- Provide an option for Demonstration plans to participate in quality monitoring activities.

Demonstration plans may contract with other agencies to provide emergency backup personal care services, or in cases where a beneficiary cannot find a provider, for so long as such agencies are certified by the California Department of Social Services.

Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration and, to the extent possible, in adjacent zip code areas.

Multipurpose Senior Services Program (MSSP): Demonstration plans must contract with MSSP organizations in good standing with the California Department of Aging (CDA) in the covered zip code areas included in the Demonstration, and to the extent possible, in the adjacent zip code areas. The contract will cover the provision of MSSP case management and waiver services for waiver participants, and beneficiary data sharing. Health plans may contract with an MSSP organization to provide care coordination and MSSP-like services to non-waiver beneficiaries as needed. Health plans must allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with CDA.

Community Based Adult Services (CBAS): Demonstration plans must contract with all willing, licensed, and certified CBAS centers, without encumbering citations that are located in the covered zip codes areas and in adjacent zip code areas, not more than 60 minutes driving time away from the eligible individual's residence. If a CBAS center does not exist in the targeted zip code areas, does not have service capacity, or does not have cultural competence to service specific Demonstration plan beneficiaries, Demonstration plans must coordinate IHSS and home health care services for CBAS-eligible enrollees.

The State will require that health plans ensure that each health plan has non-emergency, accessible medical transportation available in sufficient supply and so that individuals have timely access to scheduled and unscheduled medical care appointments.

The state will require that health plans contract with a sufficient number of providers of durable medical equipment.

(6) Medical and Social Needs

Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development. If these services are required, the scope of benefits will be described in the health plan contract. If they are not required, health plans may choose to offer these benefits.

Health plans will be required to incorporate referrals to community resources into their Models of Care and to provide other activities or services needed to assist beneficiaries in optimizing their health status. These services will be specified in the health plan contract requirements.

Health plans will be required to use the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) Grievance and Appeals Process

For the demonstration, the grievance and appeals process is jointly managed by the State of California, County Social Services Agencies, and the Center for Medicare and Medicaid Services (CMS). The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals. The unified process will be reviewed with stakeholders and will be communicated to beneficiaries and providers.

The grievance and appeals process for beneficiaries not enrolled in the demonstration will be the current Medi-Cal process, which complies with W&I §14450, and Health and Safety Code Sections 1368 and 1368.01.

The In-Home Supportive Services (IHSS) grievance and appeals process will remain as it currently is, comprised of the following:

- A state fair hearing is conducted by the Department of Social Services (DSS) and the county;
- Following a final decision, a request for a rehearing review must be submitted within 30 days;

- If required, a state court hearing must be filed within one year of the final decision.

The grievance and appeals process for prescription drugs under Medicare Part D remains the same, and requires beneficiaries to coordinate with their health plan and CMS.

For additional information please see "Process for Addressing Consumer Complaints" section below.

(8) Monitor Health Plan Performance and Accountability Through Performance Measures, Quality Requirements, Joint Reports, and Utilization Results

DHCS, DMHC, and CDSS will implement the monitoring requirements of this subdivision by doing the following:

- The State and CMS will jointly: 1) review the health plan's provider network to ensure an adequate number of providers are available to beneficiaries; 2) examine financial solvency of the health plans; 3) verify that requirements of timely access to medical care being met; and 4) conduct medical surveys with beneficiaries and onsite surveys of health plans on a recurring basis.
- DMHC and DHCS will submit an annual joint report on financial audits performed on health plans.
- DHCS will coordinate with DMHC, DSS, and CMS to monitor corrective action plans and performance of the health plans.
- DHCS will continue to work with stakeholders and CMS to develop ongoing quality measures for health plans for the demonstration, which will include primary and acute care, LTSS, and behavioral health services.
- The State will continue to contract with an External Quality Review Organization (EQRO) to audit health plans for quality measures and will contract with a EQRO to audit encounter data as well.
- In conjunction with the demonstration evaluation efforts, DHCS and CDSS will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share any significant changes in aggregate or average utilization among beneficiaries participating in the demonstration or the CCI.

(9) Local Stakeholder Advisory Groups Established by Health Plans

With CMS, DHCS is developing joint readiness review standards for health plans, which will include requirements for local stakeholder advisory groups. As noted below, all health plans have already met with local stakeholders, and most have established ongoing stakeholder advisory groups.

Examples of health plan stakeholder meetings are provided below. Complete information from each health plan will be provided in the final transition plan.

- Hospital and Provider Groups: Health plans throughout the state have convened advisory committee and town hall meetings with hospitals and provider groups.
    - San Mateo County example: Health Plan of San Mateo has been meeting regularly with hospital and provider groups since the fall of 2010, to discuss the dual demonstration and address provider and hospital concerns.

- Stakeholder Workgroups – Health plans have conducted workgroup meetings with a broad spectrum of community advocates and LTSS providers to engage them in the duals planning process.
    - San Diego County example: The County of San Diego Department of Aging and Independence Services and health plans collaborated to develop the Duals Advisory Group meetings. Meetings have discussed specific activities that were taking place within San Diego health plans to prepare for Duals. All meetings are scheduled for the first Wednesday of the month at the County of San Diego Administration Center

- County Collaboration – Health plans have ongoing meetings with county social service agencies and local public authorities.
    - Los Angeles County example – L.A. Care and Health Net have formed a Duals Steering Committee with the LA County Chief Executive Office, Departments of Health Services, Public Health, Public Social Services, Mental Health, and the LA City Department on Aging. The group meets on a near weekly basis and has formed subcommittees dedicated to exploring mental health services and also, LTSS coordination for duals.

- LTC Facility Outreach – Health plans have been meeting with the California Association of Health Facilities, as well as individual facilities, to further establish a dialogue on long-term services and supports for dual eligible and Medi-Cal only beneficiaries.

Key Milestones and Timeline

See Appendix A for timeline chart

Enrollment in CCI will occur no sooner than March 1, 2013. However, a number of steps must occur well before that date, constituting the key milestones for implementation of the CCI. Other milestones indicate key dates for monitoring quality and outcomes after implementation.

(Not in priority order)

1. Develop and maintain stakeholder distribution list.

- DHCS has developed and is maintaining a stakeholder list that includes beneficiaries, advocates, health plan representatives and other interested parties. This list currently has over 2,000 participants. (Ongoing)
- DHCS shall continue to augment the stakeholder list as it receives new contact information and will continue to send notices to these stakeholders as needed.(Ongoing)

2. Plan and conduct stakeholder meetings with beneficiaries; advocates; Health plans; providers and their representatives; and Counties/County Representatives, both before and after enrollment begins. Key components include:

- DHCS workgroup meetings
  - Beneficiary Enrollment, Notification, Appeals, and Protections (Met April 12, April 25, May 10, May 24, June 7, June 21 and August 7, 2012)
  - Provider Outreach and Engagement (Met April 19 and June 13, 2012)
  - In-Home Supportive Services Coordination (Met May 11, May 17 and June 14, 2012)
  - Long-Term Services and Supports Integration (Met May 3, June 28, and August 8, 2012)
  - Behavioral Health Integration (Met April 18, May 16, June 20, and August 15, 2012)
  - Fiscal and Rate Setting (Met June 5, 2012)
  - Quality and Evaluation (Met May 17, June 19, July 26, and August 14, 2012)

- Ongoing communications:
  - Continuous consultation with stakeholders
    All CCI materials will continue tobe posted online at www.CalDuals.org

- Stakeholder Review of Transition Plan:
  - DHCS will consult with stakeholders at least twice following production of a draft of the implementation plan and before submission to the Legislature. (Meetings scheduled for August 29 and September 4, 2012)

3. Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices. (Expected by October 2012)

4. Conduct Request for Solutions (RFS) Process for Dual Demonstration
   - Share draft for public comment (Completed December 23, 2011)
   - Publish final (Completed on January 27, 2012)
   - Health Plan Submissions (received February 2012)

- Review health plan submissions (Completed March 9, 2012)
- Announce selection (Completed March 21, 2012)

5. Prepare and Submit Dual Demonstration Proposal
    - Draft for public comment (Completed May 4, 2012)
    - Publish final and submit to CMS (Completed May 31, 2012)
    - CMS approves California's Demonstration Proposal by way of approving the MOU. Any changes to the Demonstration Proposal will be included in the MOU and as an addendum to the proposal.

6. Review Health Plans' Models of Care and Plans Benefits Packages
    - Review health plan applications, identify deficiencies, and confirm that deficiencies have been corrected. (Completed July 20, 2012)
    - Review formulary-file submissions, identify deficiencies, and confirm that deficiencies have been corrected. (Completed August 31, 2012)
    - Review plan benefit package, identify deficiencies, and confirm that deficiencies have been corrected (Completed on August 31, 2012)
    - Review a unified model of care, identify deficiencies, and confirm that deficiencies have been corrected. (Completed on August 31, 2012)

7. Execute Memorandum of Understanding with CMS
    - CMS submit draft MOU language (Completed July 2, 2012)
    - CMS/DHCS conduct MOU negotiations (July – September, 2012)
    - DHCS and CMS sign MOU (Anticipated September, 2012)

8. Develop Enrollment Process
    - Draft enrollment process and timelines (Completed July 2012)
    - Share draft enrollment phase-in timeline with stakeholders (Completed August 7, 2012)
    - Finalize enrollment phase-in process and timeline (August 30, 2012)
    - Coordinate with CMS systems (September-October 2012)
    - Submit final enrollment specifications to ITSD and Maximus (October 15, 2012)

9. Develop Beneficiary notices
    - Develop joint notices and enrollment materials with CMS (July – September 2012)
    - Share beneficiary Notices and Enrollment materials with Stakeholders (September -October, 2012)
    - Submit final notification specifications to Maximus (October 15, 2012),
    - Prepare DHCS website for posting enrollment/notification material (October 2012)
    - Maximus finalize notices and program into systems—including translations (November 2012)
    - Begin initial notification mailings for December notices (November 20, 2012)

10. Prepare Beneficiary and Provider Outreach and Education Plan:
    - Draft Plan and share with stakeholders (complete by October 15, 2012).
    - Finalize plan (November 2012)
    - Conduct outreach activities (webinars, forums, presentations, etc.) (November 2012 – June 2013)

11. Develop LTSS Provider Network Adequacy Standards:
    - Draft standards (Completed July – August 2012)
    - Post draft for public comment. (Completed on August 15, 2012)
    - Finalize standards (September 2012)

12. Complete Readiness Reviews
    - Develop tool and consult with stakeholders (September - October 2012)
    - Share with plans (September – October 2012)
    - Conduct plan reviews (Fall 2012)
    - Identify deficiencies and communicate to plans (Fall 2012)
    - Follow up with plans to ensure deficiencies are corrected (Fall/Winter 2012)
    - Finalize reviews and summarize findings (Fall/Winter 2012)

13. Determine Supplemental Benefits Policy
    - Develop draft guidelines for the scope, duration, and intensity of HCBS Plan Benefits and share with stakeholders (August - September 2012)
    - Review rates with CMS and determine whether Dental, Vision, Chiropractic, and HCBS Plan Benefits will be required or optional for health plan benefit package (September 2012)
    - Finalize guidelines and standards for HCBS Plan Benefits (September-October 2012)

14. Amend 1115 Waiver
    - DHCS will determine which changes are necessary to the Waiver (August 2012)

15. Provide Tribal notification
    - DHCS will provide tribal notification on any changes to the Waiver and obtain input as required by federal law (August 2013)

16. By February 2013, implement fully executed Managed Care Health Plan Contracts.
    - Coordinate with CMS to finalize demonstration contract boilerplate (Fall 2012)
    - Amend existing Medi-Cal health plan contracts to add LTSS benefits and dual-eligible beneficiaries enrollment-related provisions of SB 1008 (Fall 2012)

- Fully execute all contracts (Winter 2012/2013)
- Submit contracts to State Controller's Office (Winter 2012/2013)

17. Develop Interagency Agreement between DHCS and DMHC (September 2012)
    - Develop Technical Assistance Guidelines for surveys
    - Medical Surveys to be conducted every three years
    - Financial Audits for CCI health plans every three years
    - Network adequacy assessments every quarter

18. Plan and Complete IT System Changes
    - MEDS Eligibility/ITSD Enrollment Systems (Winter 2013)
    - Capitation Payment System (CAPMAN) (Winter 2013)
    - Paid Claims Encounter System (Winter 2013)
    - CA-MMIS (Winter 2013)
    - Maximus System Changes
        - Notice release systems (Fall 2012)
        - Enrollment systems (Winter 2013)
    - DSS CMIPS II Transition– (Complete in eight counties by May 1, 2013)

19. Implement IHSS Managed Care Coordination
    - Develop Template MOUs between health plans and county social service organizations, and local public authorities. (August 31, 2012)
    - Provide technical assistance regarding data sharing and care coordination (September – October 2012)
    - Develop fiscal accounting processes (October 2012)
    - Ensure health plan and county MOUs are in place prior to initial enrollment (February 2013)

20. Implement Behavioral Health Managed Care Coordination
    - Develop template MOU between health plans and county mental health agencies, and county substance use agencies. (Fall 2012)
    - Provide technical assistance regarding data sharing and care coordination (Fall 2012)

21. Implement MSSP First Year Managed Care Coordination
    - Develop draft template contract between health plans and MSSP sites and share with stakeholders (Fall 2012)
    - Finalize contract template (Fall 2012)
    - Develop fiscal accounting processes (Fall/Winter 2012/2013)

22. Implement Ongoing Monitoring and Oversight of Health Plans
    - Joint CMS/DHCS contract management team monitors compliance with the terms of the three-way contract. (upon implementation)

- DMHC will conduct network adequacy assessments on a quarterly basis, and financial solvency audits and medical surveys on a 3-year recurring basis. (after implementation)

23. Develop and Implement Quality Measurement and Evaluation Plan
    - Develop draft quality withhold measures and unified quality metrics (August 10, 2012)
    - Share draft measures for stakeholder review (August 10, 2012)
    - Finalize quality withhold measures for MOU (September, 2012)
    - Develop thresholds for quality measures for health plan contracts (Fall 2012)
    - Develop Rapid-Cycle Quality Improvement Process for CCI (Fall/Winter 2012)
    - Develop Process Indicators Dashboard for CCI (Winter/Spring 2013)
    - Develop Evaluation Plan with CMS, and stakeholder input (January 2013)
    - Collect data from health plans (July 2013 and ongoing)
    - Publish dashboard measure results (July 2013 and ongoing)
    - Review and verify data, and publish results (January 2014 and ongoing)

24. Reports to Legislature
    - Programmatic Transition Report – October 1, 2012
    - Department Readiness Report - First report January 1, 2013/Second Report March 1, 2013.
    - Health Plan Readiness Report – March 1, 2013
    - Annual Duals Enrollment Status, Quality Measures and State Costs Report – May 1, 2013 and annually thereafter
    - Annual LTSS Enrollment Status, Quality Measures and State Costs Report – May 1, 2013 and annually thereafter
    - MSSP Waiver Transition Plan – January 1, 2014 (Initial report)
    - Health Plan Quality Compliance Report – January 10, 2014
    - Annual Plan Audit and Financial Summary Report – June 1, 2014 (first report)
    - Annual Demonstration Evaluation Outcome Report - October 1, 2014 (first report)

PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS

SB 1008 requirement: Describe the process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour

hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

The State currently has several avenues for receiving beneficiary complaints about managed care health plans. In accordance with the provisions of SB 1008 in W&I §14182.17 (d) (10) (B) (iii) and (E)(vii), DHCS will work with DMHC, other departments, health plans, and stakeholders to develop a tracking mechanism for complaints, and will post information on the department's website about the types of issues that arise and any data available on the resolution of complaints. Additional information is provided below about the current complaint resolution process.

Beneficiaries who are not satisfied with the quality of care received, experience an error in their medical treatment, or encounter a delay in service, have the option to file a complaint. The beneficiary's assigned health plan is the primary resource for initiating and managing the complaint process (except for complaints regarding quality of care delivered by an IHSS provider).

- For complaints other than those concerning IHSS, assistance is provided to the beneficiary with personalized assistance from a health plan customer service agent, or through the completion of online electronic forms. In either case, the following response times apply to the processing of consumer complaints:

- Within 30 days of receiving the complaint from the beneficiary, the health plan must respond with a decision.
- For urgent medical problems, health plans must respond to the beneficiary within 3 days of receiving the complaint.

In addition to the health plans, beneficiaries have the choice to initiate a complaint directly with the State of California or the Centers for Medicare and Medicaid Services (CMS) under the following conditions:

- The beneficiary does not agree with the health plan's decision.
- The response time has exceeded 30 days (or 3 days in the case of an urgent medical problem).
- The beneficiary has an urgent medical condition that does not allow for the health plan to respond within the specified timeframes.
- In certain cases, beneficiaries may request an independent medical review as part of their complaint filing process.

- For complaints concerning services delivered by an IHSS provider, county social services offices or public authorities are responsible for responding to the beneficiary. As quality of care complaints regarding delivery of IHSS might impair the consumer's ability to remain safely at home, county social services agencies, which beneficiaries are accustomed to contacting regarding these issues, will continue to be the primary contact for these complaints. If the

health plan becomes aware of an IHSS quality of care issue, it must make a referral to the county social services agency responsible for addressing these issues in accordance with the terms specified in the MOUs between the health pan and the county social services agency and/or public authority.

The following state agencies currently provide consumer assistance and complaint processing for covered medical services administered by the State of California:

- Department of Health Care Services (DHCS)
  - Assists Medi-Cal beneficiaries with complaints about contracted health plans and physicians.
  - Medi-Cal Managed Care Division (MMCD) Office of the Ombudsman is available Monday to Friday, 8AM to 5PM PST.
  - Health Care Options (HCO) is available Monday to Friday, 8AM to 5PM PST.

- Department of Managed Health Care (DMHC)
  - Assists beneficiaries with complaints about health plans under jurisdiction* on treatment of medical care, prescriptions.
  - DMHC Help Center is available Monday to Friday, 7AM to 7PM PST.

  **includes HMO plans and certain PPO health plans.*

- California Department of Aging (CDA)
  - Health Insurance Counseling and Advocacy Program (HICAP) assists Medicare beneficiaries with questions and issues regarding their Medicare benefits.
  - HICAP assistance is available Monday to Friday, 8AM to 5PM PST.

- California Department of Public Health (CDPH)
  - Assists beneficiaries with complaints about licensed facilities in the State of California, including hospitals, nursing homes, hospice, clinics, intermediate care facilities.
  - Consumer complaints are processed by the DMHC Help Center, and through the Health Facilities Consumer Information System (HFCIS) website.

- Department of Social Services (DSS)
  - Assists with complaints regarding county-based adult residential services.
  - Assists with complaints from beneficiaries and providers about IHSS
  - CDSS is available by phone, Monday to Friday, 8AM to 5PM PST.

- California Department of Consumer Affairs (DCA) Medical Board
  - Assists with complaints about county-based adult residential services.
  - DCA is available by phone, Monday to Friday, 8AM to 5PM PST.

The following federal agency provides consumer assistance and complaint processing for Medicare services:

- Centers for Medicare and Medicaid Services (CMS)
    - Assists beneficiaries with complaints about hospital (inpatient and outpatient) services, mental health services, and other services covered by Medicare.
    - CMS Customer Service Center is available 24 hours per day, 7 days per week.

See Appendix D for a contact list for State of California agencies that process consumer complaints.

PART D – STAKEHOLDER ENGAGEMENT[2]

SB 1008 requirement: A description of how stakeholders were included in the various phases of the planning process to formulate the Transition Plan and how their feedback will be taken into consideration after transition activities begin.

Stakeholder meetings:

Starting in April 2010, DHCS has supported a broad stakeholder engagement process to inform the design and implementation of the CCI and demonstration. DHCS has organized numerous opportunities to learn directly from beneficiaries about their health care experiences, needs, preferences and reactions to proposed system changes. Additionally, DHCS has organized dozens of stakeholder meetings focused on specific topics pertaining to the CCI. DHCS's Legislative and Governmental Affairs staff has relayed all critical information to key legislative staff members. DHCS released "save-the-date" meeting announcements, meeting invitations, and other related meeting materials via an email distribution list and also utilized the DHCS website www.dhcs.ca.gov. DHCS also posted this information on an additional website, www.calduals.org. This stakeholder distribution list has grown throughout the process, as DHCS received numerous requests from individuals interested in the issues. As of early August 2012, over 2,000 individuals and organizations are on the Cal Duals email distribution list.

As required in SB 1008, DHCS hosted two stakeholder meetings during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. These meetings are scheduled for August 29 and September 4, 2012.

Website

To ensure and facilitate easy public access to information about the dual eligible demonstration project and CCI, DHCS supported the development of a new website dedicated to the California Duals Demonstration, www.calduals.org. The focus of this effort is to enable a transparent process and foster constructive, two-way dialogue among stakeholders.

Email inbox:

DHCS created two dedicated email addresses and inboxes to receive written stakeholder comments on the duals demonstration: duals@dhcs.ca.gov and info@calduals.org. DHCS staff members review the inbox daily and refer comments to the appropriate person for response.

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[2] See Appendix E for the DHCS timeline related to stakeholder participation and transition plan development.

Working with Stakeholders after the Transition is Underway

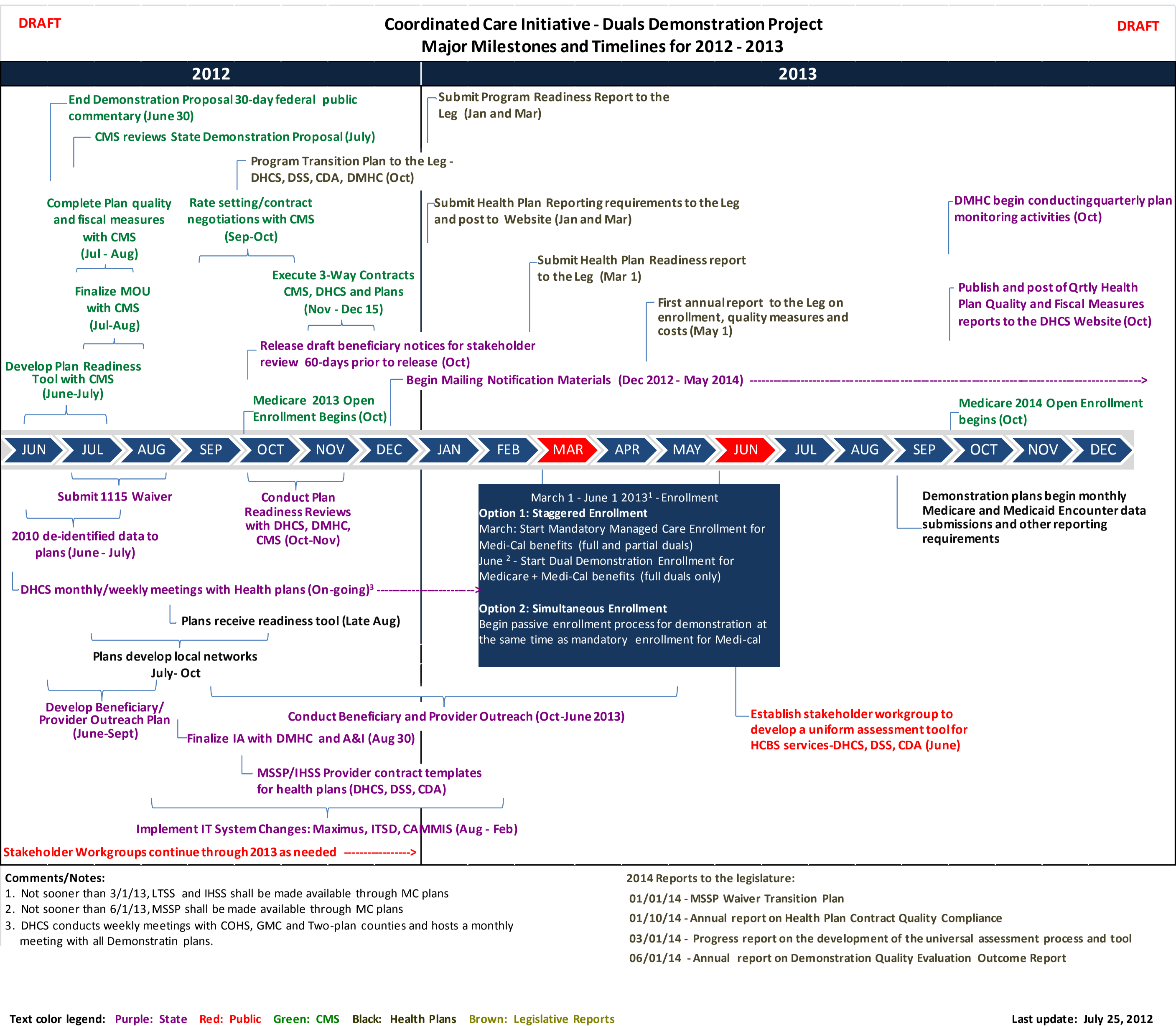
DHCS has obtained valuable input in this initial transition phase, and it will continue to engage stakeholders throughout the implementation and beyond. As previously mentioned, some of the recommendations represent efforts that DHCS cannot immediately implement and must address in future phases; therefore, DHCS expects to continue stakeholder engagement on an ongoing basis.

DHCS has a grounding philosophy to work with stakeholders to keep abreast of how the program and its services are functioning and identify needed corrections or improvements. DHCS created six work groups dedicated to specific areas of the demonstration. As the project moves forward, DHCS will continuously reassess the input and strengths of these existing stakeholder groups. DHCS acknowledges the importance of stakeholder input regarding all aspects of Medi-Cal services and business practices and commits to having ongoing communication with its external partners.

Stakeholder input has shown to be an invaluable part of this process, bringing to light concepts and issues that worthy of further examination. Stakeholder comments have been sought at various points of this process and all have been posted to the DHCS website: http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx. DHCS, DSS, CDA, DOR and DMHC will continue to collaborate on all issues related to the CCI.

APPENDIX A

CCI Timeline



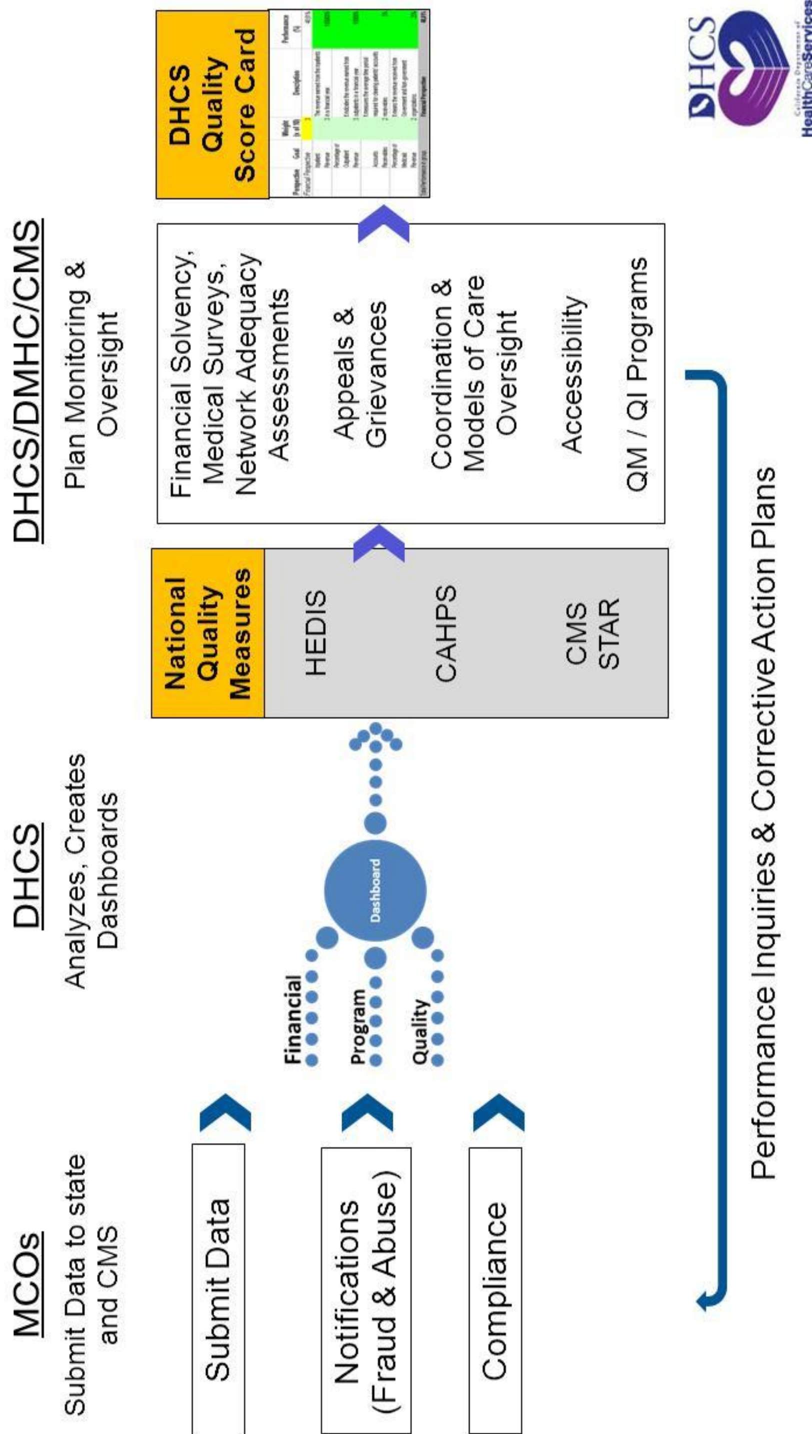
APPENDIX B

Operational Readiness Principles

The joint readiness standards for demonstration health plans are currently being developed, and will be shared with stakeholders when available. DHCS intends to include a summary of the principles for the joint operational readiness process in the final version of the Transition Plan.

APPENDIX C

Health Plan Monitoring and Oversight



APPENDIX D

Consumer Complaints

Additional Information for Section C

Sources and contact information for State of California agencies that process health care-related consumer complaints.

California Department of Aging (CDA)
http://www.aging.ca.gov/
http://www.aging.ca.gov/Programs/call_for_services.asp#LTC
By County: http://www.aging.ca.gov/ProgramsProviders/AAA/AAA_Listing.asp

HICAP/Department of Aging
800-434-0222
https://www.aging.ca.gov/hicap/countyList.aspx
California Health and Human Services Agency/Office of the Patient Advocate (OPA)
http://www.opa.ca.gov/

California Department of Public Health (CDPH)
http://www.cdph.ca.gov/Pages/DEFAULT.aspx
https://hfcis.cdph.ca.gov/LongTermCare/ConsumerComplaint.aspx
Licensing/certification: http://www.cdph.ca.gov/programs/LnC/Pages/LnC.aspx

California Department of Managed Health Care (DMHC)
888-466-2219
(7A-7PM, M-F, excluding holidays)
http://www.dmhc.ca.gov/default.aspx
http://www.dmhc.ca.gov/aboutthedmhc/gen/gen_contactus.aspx
*referrals to department of labor (jurisdication over self-insured plans, federal cobra), HCO, CDI, Medi-Cal hotline (800)541-5555, CMS – HICAP (800)434-0222

California Department of Insurance (CDI)
For PPOs not under DMHC jurisdiction, beneficiaries are referred to DOI
800-927-4357

California Department of Consumer Affairs (CDA), Medical Board
http://www.dca.ca.gov/
http://www.mbc.ca.gov/consumer/complaint_info.html
800-633-2322

California Department of Social Services (DSS)
http://www.ccld.ca.gov/PG400.htm
http://www.dss.cahwnet.gov/cdssweb/default.htm
800-952-5253

California Department of State Hospitals (DSH)
http://www.dmh.ca.gov/
The Health Facilities Consumer Information System (HFCIS) website is made available by the California Department of Public Health (CDPH), Center for Health Care Quality (CHCQ), Licensing and Certification Program (L&C) to provide immediate access to information about L&C's licensed long-term care facilities and hospitals throughout California.

DHCS/MMCD – Health Care Operations
http://www.healthcareoptions.dhcs.ca.gov/HCOCSP/Home/default.aspx
800-430-4263

DHCS/MMCD – Office of the Ombudsman
888-452-8609
http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

DHCS-MMCD
http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx
916-449-5000

DHCS – Main website
http://www.dhcs.ca.gov/
http://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Audits and Investigations
DHCS/A&I
http://www.dhcs.ca.gov/individuals/Pages/auditsinvestigations.aspx

CMS
http://www.medicare.gov
800-633-4227 or 1-800-MEDI-CAID

Medicare Nursing Home Finder
www.medicare.gov/nursinghomecompare/search.aspx?bhcp=1

CMS/Quality Improve Organization – Hospitals, Doctors.
Quality Improve Organization (CA = 866-800-8749, 8-4:30, M-F).
CMS Health Services Advisory Group
http://hsag.com/home.aspx

CMS/Calfiornia Department of Public Health (CDPH) - Nursing Facilities.
State Survey Agency (CDPH = 800-236-9747, 8-5, M-F).
State Health Insurance Assistance Programs (SHIPs) (CA = 800-434-0222, 8-5, M-F)

APPENDIX E

Legislative Reporting Requirements

Report Name	SB 1008 Citation	Reporting Requirements	Frequency	Initial Report Date[3]
Evaluation Outcome Report	Sec. 1, W&I 14132.275(m)	The department shall conduct an evaluation, in partnership with CMS, to assess outcomes and the experience of dual eligibles in these demonstration sites and shall provide a report to the Legislature after the first full year of demonstration operation, and annually thereafter.	Annual	October 1, 2014
Duals Enrollment, Quality Measure and Cost Report	Sec. 1, W&I 14132.275(q)(1)	Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this section.	Annual	May 1, 2013
Health plan quality compliance report	Sec. 4, W&I 14182.17(d)(8)(C)	Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.	Annual	January 10, 2014

[3] Initial Report Date is based on March 1, 2013 state date for Mandatory Medi-Cal enrollment for Medi-Cal only benefits and June 1, 2013 start date for the Demonstration Project

Report Name	SB 1008 Citation	Reporting Requirements	Frequency	Initial Report Date[3]
Plan Audit and Financial Examination Summary Reports	Sec. 4, W&I 14182.17(d)(8)(D)	Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a joint report, from the department and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following: (i) The independent audit report required to be submitted annually to the Department of Managed Health Care by managed care health plans participating in the demonstration project authorized by Section 14132.275. (ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and completed for the previous calendar year by the Department of Managed Health Care and the department.	Annual	June 1, 2014
Programmatic Transition Plan	Sec. 4, W&I 14182.17(d)(10)(B)	Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic Transition Plan, and submit that plan to the Legislature within 90 days of the effective date of this section	One time based on the June 27, 2012 bill chapter date	October 1, 2012
Health Plan Readiness Report	Sec. 4, W&I 14182.17(d)(10)(D)	No later than 90 days prior to the initial plan enrollment date of the demonstration project, assess and report on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9).	One time	March 1, 2013

Report Name	SB 1008 Citation	Reporting Requirements	Frequency	Initial Report Date[3]
Program Readiness Report	Sec. 4, W&I 14182.17(d)(10)(E)	The department shall submit two reports to the Legislature, with the first report submitted five months prior to the commencement date of enrollment and the second report submitted three months prior to the commencement date of enrollment, that describe the status of all of the following readiness criteria and activities that the department shall complete.	2 reports	January 1, 2013 March 1, 2013
MSSP Waiver Transition Plan	Sec. 6, W&I 14186.3(b)(4)(B)(C)	No later than January 1, 2014, the department, in consultation with the California Department of Aging and the Department of Managed Health Care, and with stakeholder input, shall submit a Transition Plan to the Legislature to describe how subparagraph (A) shall be implemented. The plan shall incorporate the principles of the MSSP in the managed care benefit, and shall include provisions to ensure seamless transitions and continuity of care. Managed care health plans shall, in partnership with local MSSP providers, conduct a local stakeholder process to develop recommendations that the department shall consider when developing the Transition Plan.	2 Reports	January 1, 2014 90-days prior to implementation
LTSS Enrollment, quality measure and cost report	Sec. 6, W&I 14186.4(g)	Beginning with the May Revision to the 2013–14 Governor's Budget, and annually thereafter, the department shall report to the Legislature on the enrollment status, quality measures, and state costs of the actions taken pursuant to this article.	Annual	May 1, 2013

APPENDIX F

CCI Beneficiary Protections Statute

Welfare and Institutions Code Section 14182.17
(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:
(1) Ensure timely and appropriate communications with beneficiaries as follows:
(A) At least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at not more than a 6th-grade reading level that includes, at a minimum, how the Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with problems they encounter.
(B) Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.
(C) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices. (D) Ensure that managed care health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.
(E) Ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures, that are offered by the plan or are available through the Medi-Cal program.
(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a non formulary drug.
(G) Contingent upon available private or public funds other than moneys from the General Fund, contract with community-based, nonprofit consumer, or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.
(H) Develop, with stakeholder input, informing and enrollment materials and an enrollment process in the demonstration site counties. The department shall ensure all of the following prior to implementing enrollment:

(i) Enrollment materials shall be made public at least 60 days prior to the first mailing of notices to dual eligible beneficiaries, and the department shall work with stakeholders to incorporate public comment into the materials.

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

(iii) The materials shall plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan.

(iv) The materials shall plainly state that the beneficiary shall be enrolled in a Medi-Cal managed care health plan even if he or she chooses to stay in fee-for-service Medicare.

(v) The materials shall plainly explain all of the following:

(I) The plan choices.

(II) Continuity of care provisions.

(III) How to determine which providers are enrolled in each plan.

(IV) How to obtain assistance with the choice forms.

(vi) The enrollment contractor recognizes, in compliance with existing statutes and regulations, authorized representatives, including, but not limited to, a caregiver, family member, conservator, or a legal services advocate, who is recognized by any of the services or programs that the person is already receiving or participating in.

(I) Make available to the public and to all Medi-Cal providers copies of all beneficiary notices in advance of the date the notices are sent to beneficiaries. These copies shall be available on the department's Internet Web site.

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.

(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.

(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.

(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(3) Ensure that the managed care health plans arrange for primary care by doing all of the following:

(A) Except for beneficiaries enrolled in the demonstration project pursuant to Section 14132.275, forgo interference with a beneficiary' s choice of primary care physician under Medicare, and not assign a full-benefit dual eligible beneficiary to a primary care physician unless it is determined through the risk stratification and assessment process that assignment is necessary, in order to properly coordinate the care of the beneficiary or upon the beneficiary's request.

(B) Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan.

(C) Provide a mechanism for partial-benefit dual eligible enrollees to request a specialist or clinic as a primary care provider if these services are being provided through the Medi-Cal managed care health plan. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollees.

(4) Ensure that the managed care health plans perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(A) Reflect a member-centered, outcome-based approach to care planning, consistent with the CMS model of care approach and with federal Medicare requirements and guidance.

(B) Adhere to a beneficiary's determination about the appropriate involvement of his or her medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(C) Develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system, including transitions among levels of care and between service locations.

(D) Develop individual care plans for higher risk beneficiaries based on the results of the risk assessment process with a particular focus on long-term services and supports.

(E) Use nurses, social workers, the beneficiary's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or receiving long-term services and supports.

(F) Consider behavioral health needs of beneficiaries and coordinate those services with the county mental health department as part of the beneficiary's care management plan when appropriate.

(G) Facilitate a beneficiary's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorders treatment services.

(H) Monitor skilled nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. Plans shall monitor and support beneficiaries in the community to avoid further institutionalization.

(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows:

(A) Provide access to providers that comply with applicable state and federal law, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(B) Meet provider network adequacy standards for long-term services and supports that the department shall develop.

(C) Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and the Internet, and in accessible formats, upon request.

(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.

(E) Contract with and assign patients to safety net and traditional providers as defined in subdivisions (hh) and (jj), respectively, of Section 53810 of Title 22 of the California Code of Regulations, including small and private practice providers who have traditionally treated dual eligible patients, based on available medical history to ensure access to care and services. A managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(F) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible

beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

(I) Employ care managers directly or contract with nonprofit or proprietary organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

(6) Ensure that the managed care health plans address medical and social needs as follows:

(A) Offer services beyond those required by Medicare and Medi-Cal at the managed care health plan's discretion.

(B) Refer beneficiaries to community resources or other agencies or needed medical or social services or items outside the managed care health plan's responsibilities.

(C) Facilitate communication among a beneficiary's health care and personal care providers, including long-term services and supports and behavioral health providers when appropriate.

(D) Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the beneficiary, including referrals to address any physical or cognitive barriers to access.

(F) Utilize the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) (A) Ensure that the managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process that does both of the following:

(i) Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the department. Each managed care health plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(ii) Complies with a Medicare and Medi-Cal grievance and appeal process, as applicable. The appeals process shall not diminish the grievance and appeals rights of IHSS recipients pursuant to Section 10950.

(B) In no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program.

(8) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(C) Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.

(D) Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a joint report, from the department and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following:

(i) The independent audit report required to be submitted annually to the Department of Managed Health Care by managed care health plans participating in the demonstration project authorized by Section 14132.275.

(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and completed for the previous calendar year by the Department of Managed Health Care and the department.

(E) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(9) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(10) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(B) Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic transition plan, and submit that plan to the Legislature within 90 days of the effective date of this section. The plan shall include, but is not limited to, the following components:

(i) A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

(ii) Explanations of the operational steps, timelines, and key milestones for determining when and how the components of paragraphs (1) to (9), inclusive, shall be implemented.

(iii) The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

(iv) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plan, and how their feedback shall be taken into consideration after transition activities begin.

(C) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.