Briefing Paper

Oversight Hearing:

Medi-Cal Managed Care Program

Wednesday, October 23, 2013

State Capitol, Room 4202

9:30 a.m. to Noon

PART I - HEARING OBJECTIVES

1) Oversight. Since 2010, the Department of Health Care Services (DHCS) has been expanding the Medi-Cal managed care (MCMC) program to include most populations covered by California's publicly funded low-income health care programs. Between June 2011 and May 2012, DHCS transferred approximately 240,000 Medi-Cal-only seniors and people with disabilities (SPDs) from Medi-Cal fee-for-service (FFS) to MCMC as part of the 2010 Section 1115(b) Medicaid Demonstration Waiver entitled "A Bridge to Reform" approved by the Centers for Medicare and Medicaid Services (CMS). Enrollment was mandatory and phased in over a one-year period, in the 14 two-plan and two Geographic Managed Care (GMC) counties. In addition, DHCS has completed three phases in the transition of approximately 720,000 children into the MCMC program from the Healthy Families Program (HFP). These children are up to age 19, in families with incomes above the Medi–Cal eligibility thresholds but below 250% of the federal poverty level (FPL). The fourth and final phase, involving approximately 30,000 children, is currently in process and has been timed to coincide with the initiative to expand MCMC to the 28 rural counties that were previously served by FFS Medi-Cal.

   This hearing is part of an ongoing series of legislative oversight hearings intended to monitor these transitions and to inform the Legislature, stakeholders, and the public on the status of these initiatives. It is also intended as an opportunity to air issues between and for stakeholder feedback between the Brown Administration in a public forum. The timing of this hearing allows for a primary focus on reviewing data, reports, monitoring tools, surveys, and issue briefs released over the past year relating to the transition into MCMC of SPDs and HFP children.

These materials provide a unique opportunity to highlight the enrollee perspective, as well as the provider's point of view. The materials relied on have not previously been the subject of public discussion in the Legislature. With regard to HFP, this includes Monitoring Reports of the HFP transition, prepared monthly by DHCS as required by the implementing legislation, and Healthy Families Beneficiary Surveys, required as a condition of approval by CMS. With regard to the SPD population, the Legislature now has the benefit of a survey conducted jointly by the California HealthCare Foundation (CHCF) and DHCS and an Issue Brief prepared for the Kaiser Commission on Medicaid and the Uninsured that are based on extensive interviews with SPD enrollees, as well as information from providers, community based organizations, DHCS, and the Medi-Cal managed care plans (MCPs). However, because plan specific Healthcare Effectiveness Data and Information Set (HEDIS) reports and the revised MCMC dashboard are not yet available, an in-depth discussion of these issues may be more productive when they become available.

2) Prior hearings. It is not possible to conduct a comprehensive oversight hearing of the MCMC program today. This is one in a series that has been convened by this committee or jointly with other committees focused on other aspects of these managed care initiatives. For instance an October 2012 hearing focused on the enrollment of SPDs, the state's plans for monitoring and evaluating the effectiveness of the program changes with regard to quality and access to care, and how to evaluate the Coordinated Care Initiative (CCI) demonstration and pilot projects. A primary purpose of a hearing held in December 2011 was to provide an opportunity to use lessons learned from the current activities to inform and shape current and future policy decisions and program implementation. (See the briefing papers for the following two hearings: October 25, 2012 Oversight Hearing - *Managed Care Program Initiatives at the Department of Health Care Services, Assessing the Promise of Coordinated Care*; and, December 7, 2011 Joint Oversight Hearing with the Senate Health Committee - *The 2010 Medi-Cal Waiver and the Future of Seniors & People with Disabilities in the Medi-Cal Program* at http://ahea.assembly.ca.gov/committeehome). Other hearings, held jointly with the Assembly Budget Subcommittee on Health and Human Services, focused on issues in the HFP transition relating to dental, network adequacy, mental health services and services for children with autism.

3) Additional MCMC Initiatives. There are at least two other significant MCMC initiatives underway at DHCS, the CCI and implementation of the federal Patient Protection and Affordable Care Act (ACA). A positive outcome would be that the experience and lessons learned during the hearing are applied to these future implementations in a way that avoids past pitfalls and improves the consumer experience. Nonetheless, these other initiatives are not the primary focus of this hearing. Brief background related to these initiatives are as follows:

a) CCI. With the enrollment of the SPD Medi-Cal-only population into Medi-Cal MCPs the following services were included: preventative and acute medical services including out-patient; primary care; specialty care; care coordination; in-patient services; durable medical equipment; drugs; and, medical transportation. Long-term Support Services (LTSS) were "carved out" and are largely provided through FFS. In the proposed 2012-13 Budget, the Brown Administration requested authority from the Legislature to implement a potentially statewide CCI to include LTSS for persons eligible for both Medi-Cal and Medicare (dual eligibles) and Medi-Cal only SPDs into a coordinated delivery system that would be delivered using managed care models. The LTSS proposed to be integrated included In Home Support Services, Community-Based Adult Services, Multipurpose Senior Services, and skilled-nursing facility services. The Legislature enacted a modified version of the Governor's proposal in SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012 and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012. Eight counties have been selected as demonstration counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI will use a capitated payment model to provide Medicare and Medi-Cal benefits through existing MCPs. A second component requires all Medi-Cal-only SPDs to enroll in an MCP to obtain LTSS. The implementation date has been pushed back a number of times, from June 2013 to January 1, 2014, and most recently to April 2014.

b) ACA. Last, but certainly not least, California has elected to adopt the option to expand its Medicaid program to cover low-income childless adults as offered by the ACA. Effective January 1, 2014, this population includes childless adults between the ages of 19 and 65, not pregnant or disabled, and with income up to 138% of FPL and this will also be a mandatory managed care population. According to the University of California (UC) Berkeley Labor Center, over 1.4 million Californians are estimated to be newly eligible for Medi-Cal under the ACA expansion.

Part II-BACKGROUND.

1) Scope of the MCMC Program. As of August 2013, MCMC in California serves almost 6 million enrollees in 30 counties, approximately 75% of the total Medi-Cal population. This is an increase of almost 1 million and up from 65% of the Medi-Cal population since October 2012, as a result of several initiatives to move more enrollees into MCMC. In California, the oldest model is the County Organized Health System (COHS). COHS plans serve approximately 1.3 million beneficiaries through six health plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. In the COHS model, DHCS contracts with a health plan established by the county's Board of Supervisors and all Medi-Cal enrollees are in the same health plan. Unlike other Medi-Cal MCPs, COHS are exempt from licensure

under the Knox-Keene Health Plan Services Act of 1975 and are therefore not regulated by the Department of Managed Health Care (DMHC), but are required to meet most of the Knox-Keene requirements by contract with DHCS.

Fourteen counties are part of the two-plan model. In most two-plan model counties, there is a "Local Initiative" (LI) and a "commercial plan" (CP). DHCS contracts with both plans. Local government, community groups, and health care providers were able to give input when the LI was established. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. The two-plan model serves approximately 4 million enrollees in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Sacramento and San Diego employ the GMC model in which DHCS contracts with several commercial plans. There are approximately 620,000 enrollees.

2) SPD Mandatory Enrollment. Between June 1, 2011, and June 1, 2012, a total of 340,085 SPDs were enrolled into managed care plans. The average monthly enrollment ranged between 25,000 and 30,000 enrollees, timed according to the beneficiary's birth month. There is a growing evidence base, that managed care may improve access to and coordination of care for beneficiaries. However, transition to managed care risks disrupting existing care arrangements, for this fragile, high-needs population. Implementing the transition, SPD beneficiaries are given a choice of the LI or CP in each of the two-plan counties, four plans in Sacramento GMC or five plans in San Diego GMC. In order to minimize this disruption for those who did not make a choice, DHCS searched FFS utilization data to identify physicians that the beneficiary had seen in the past. If a beneficiary's past provider was in the network of a particular plan, then DHCS assigned the beneficiary to that plan. DHCS also allowed beneficiaries with certain complex medical conditions to file a Medical Exemption Request (MER) to remain in FFS Medi-Cal. As required by CMS and the Legislature, DHCS closely monitored enrollment trends to identify potential issues with SPD enrollment.

   Following each mailing of 90-day and 60-day notices to enrollees, DHCS's Health Care Options (HCO) program placed phone calls to each SPD beneficiary expected to be enrolled in an MCP. These phone calls provided beneficiaries with further information about their enrollment and opportunities to ask questions. At least three attempts were made to contact each beneficiary. In November 2011, DHCS highlighted extended continuity of care for SPDs in a provider bulletin. DHCS requires health plans to provide newly enrolled SPDs with an opportunity to request continued access to an out-of-network provider for 12 months. New provider bulletins supported outreach efforts already in progress and were used to reinforce outreach and education efforts to SPDs and providers during the transition. In preparation for the transition, DHCS developed a provider linkage system relying solely on

HCO's provider data file. After reviewing the default enrollment data for the first month of enrollment, the data suggested that the percentage of beneficiaries enrolled into a Medi-Cal MCP through provider linkage was much lower than anticipated. DHCS requested provider data from the plan combined with additional provider data HCO was able to provide enhanced provider linkage for the default enrollment of SPDs, beginning in August 2011. For instance, in July 2011, only 3,454 SPDs were linked to a plan through a provider. In August 2011, after the enhanced provider file was used, 7,795 SPDs were linked to plan through a provider, more than double the previous month. Over the next eight months, averages of 6,200 SPDs per month were linked to a plan through a provider.

a) Continuity of Care. DHCS established a process in which SPD beneficiaries could request continued access to a preferred FFS provider. According to DHCS this process was developed specific for the SPD transition; therefore no historical data is available for comparison. To ensure that SPD beneficiaries were aware of their rights to continuity of care, DHCS distributed a notice in the enrollment packet and posted on the DHCS website explaining how SPDs could request to continue to see a specified provider after the transition. DHCS reported that health plans initially received 6,787 continuity of care requests and of these 80% (5,433) were approved. DHCS further states that the trend of continuity of care requests increased over time with 570 received in June 2011 and 2,408 and 3,809 received for the third and fourth quarter of 2011, respectively. DHCS attributes the increase of requests to a continuity of care letter that was developed after the beginning of the SPD transition. Of the remaining 20% continuity of care denials, (1,354), the most common reasons included: 1) No link between the beneficiary and provider: 3.9% (265); 2) The provider would not accept health plan rate: 3.75% (254); and, 3) The provider refused to work with the health plan: 4.1% (275). DHCS reported in May 2012 that most continuity of care issues involve the UC facilities and their unwillingness to work with managed care plans. There are other providers outside of the UC system that are also unwilling to work with managed care plans. Approximately 47.7% of the requests stem from Los Angeles County. DHCS reports that it monitors overall continuity of care requests, including approval and denial rates, and conducts follow-up with the health plans as necessary.

   Based in part on testimony from consumer advocates and providers at the December 11, 2011 Oversight Hearing, the Legislature revised the provisions relating to continuity of care in SB 1008 (Committee on Budget and Fiscal Review) in June 2012. On October 4, 2013, an All Plan Letter was issued reiterating these provisions and enrollee rights with regard to continuity of care. MCPs are required to consider an enrollee's request for a medical exemption that is clinically denied as a request to complete a course of treatment with an existing FFS provider. The MCP must make every effort to ensure that enrollees are allowed to continue to receive ongoing medical care through their FFS provider.

MCPs must immediately refer SPDs for a health risk assessment and an individual care plan must be developed within ten days of enrollment in the MCP, including authorization for 30 days of continuity for prescription drugs. MCPs must permit the enrollee to continue the use of a single-source drug that was prescribed immediately prior to their date of enrollment, whether or not the drug is covered by the MCP, until the prescribed therapy is no longer prescribed by the contracting physician or until a new care plan is established by the MCP that does not include the drug. There is no limit to the number of drugs that may be subject to this requirement, as long as the drug(s) is part of a prescribed therapy in effect for the beneficiary prior to the date of enrollment.

b) SPD Monitoring and Reports. CMS requires that states, through their contracts with MCPs, measure and report on performance to assess the quality and appropriateness of care and services provided to members. In response, DHCS implemented a monitoring system that is intended to provide an objective, comparative review of health plan quality-of-care outcomes and performance measures called the External Accountability Set (EAS). DHCS designates EAS performance measures on an annual basis and requires plans to report on them. DHCS uses HEDIS as the primary tool. HEDIS is a national, standardized set of measures developed by the National Committee for Quality Assurance. DHCS selects which HEDIS measures to use after consultation with the plans and with input from an External Quality Review Organization (EQRO). All current measures are applicable across populations. For example, well child visits, immunizations, comprehensive diabetes care and annual monitoring of patients on persistent medications are just a few of the currently required HEDIS measures that are applied equally to all Medi-Cal MCP enrollees. In 2011 the EAS consisted of 11 performance measures. The EAS for 2012 consisted of 13 HEDIS and one DHCS developed measures. For 2013, MCPs will be reporting on 14 HEDIS measures. DHCS in collaboration with MCPs and the EQRO, developed a methodology by which to stratify several measures (comprehensive diabetes care, children and adolescent access to primary care providers, annual monitoring for persistent medications, ambulatory care utilization, and all cause readmissions) into SPD and non-SPD population groups.

   i) Use of HEDIS. Performance measurement results are reported and published annually and are used to rank MCPs and as a basis for required quality improvement projects. The evaluation methodology and data collection process for all measures is adherent to National Committee for Quality Assurance (NCQA) standards as assured by the EQRO during annual MCP audits to validate data accuracy and completeness prior to submission to the NCQA. According to DHCS because stratified reporting for SPDs didn't begin until 2013, it will take several years before SPD performance measurement scores fully reflect member health outcomes in managed care. For children, health plan metrics will include, but will not be limited to, child-only

HEDIS measures indicative of performance in serving children and adolescents and existing MCMC performance metrics and standards including timely access, network adequacy, linguistic services, and the use of surveys to measure beneficiary satisfaction and network adequacy post transition. These findings are publicly reported and posted on the DHCS website. The 2012 HEDIS Aggregate Report was posted in February 2013. However the plan-specific reports have not yet been posted.

AB 411 (Pan) of 2013 would have required any new contract between DHCS and an EQRO to include a requirement that patient-specific HEDIS measures, or their EAS performance measure equivalent, be stratified by geographic region, primary language, race, ethnicity, gender, and, to the extent reliable data are available, by sexual orientation and gender identity, in order to assist with the identification of health care disparities in the care provided to MCMC enrollees based on these factors. Governor Brown vetoed AB 411 stating that nothing in current law prevents DHCS from requiring the EQRO to provide more detailed data by geography, race, ethnicity, or other demographic attribute. According to Governor Brown if DHCS sees a need or benefit that justifies the costs of procuring this additional data, he is confident that they will procure it.

ii) Transition Monitoring. During the first quarter of 2011, DHCS solicited input from the CMS before finalizing a transition monitoring report. The elements were used to track and report the transition of SPDs into MCPs. DHCS published the resulting monthly monitoring report including monitoring activities from June 2011 through the completion of the SPD transition in April 2012. The final report was published in January 2013. DHCS also files quarterly reports on its MCMC program with the Legislature. The most recent report covers the period from March to June 2013 and submits semi-annual reports to the Legislature on the mandatory enrollment of SPDs, the most recent being the January to June 2013 period.

iii) Dashboard. DHCS is in the process of creating a MCMC dashboard. Through funding from CHCF, DHCS and CHCF have engaged a vendor, Navigant, to help facilitate the dashboard process. According to DHCS the first internal iteration of the dashboard was to be finalized in the spring of 2013; however nothing has been publicly released. According to DHCS, the dashboard will be used to monitor Medi-Cal MCPs to gain a better understanding of what is occurring at individual MCPs, as well as assess the MCPs on a statewide aggregate level. The dashboard will report on measures including enrollment, appeals and grievances, network adequacy, financial standing, and quality. In addition, the data will include breakouts of subsets of the Medi-Cal population, for example, SPDs and HFP populations. DHCS reported in early 2013, that though the initial version was to be finalized in June of 2013, DHCS

intended to continue to expand and evolve the dashboard following completion of this initial version based on stakeholder feedback and an assessment of the initial measures.

A Medi-Cal Managed Care Dashboard Technical Advisory Group (TAG) was created to ensure that the dashboard reflects stakeholder input. This group is comprised of DHCS and CHCF staff, legislative staff, health plan representatives, and a group of key stakeholders representing the broad range of beneficiaries who access care through MCMC. The TAG has been meeting via conference call and once in person. The TAG is currently identifying goals for the DHCS dashboard, which will influence which measures are included or excluded from the initial version of the dashboard.

As mentioned, CHCF has contracted with Navigant Consulting for this project. Navigant is developing the specifications for the tool to monitor the performance of the managed care program as a whole and compare the performance of participating health plans. These specifications will identify the measures, sources of data, frequency of reporting, benchmarks and thresholds, and key comparative indicators. Navigant, with input from the TAG, will consider numerous measures of managed care program and health plan performance including: Quality measures (e.g., HEDIS); Member experience/satisfaction (e.g., Consumer Assessment of Healthcare Providers and Systems); Other data on quality, access and experience (e.g., ombudsman reports; disenrollment rates; Medi-Cal enrollee survey, complaints/grievances/appeals; data collected by DMHC); Other measures of performance (e.g., measures of safety net participation); Financial performance indicators (e.g., operating margin; medical loss ratio); and, Process measures (e.g. choice rate, opt-out and MER rates, utilization of LTSS and behavioral health care).

In addition to performance measures, this dashboard will provide basic facts about the program, such as number of enrollees in each plan, demographics by county and plan (language, age, aid categories, etc.). Navigant will prepare two versions of a performance dashboard. One version will be for publication by CHCF as a snapshot, the second version of the dashboard will be prepared in a format to be determined by DHCS for ongoing monitoring. Navigant will prepare a memorandum with recommendations for future improvements to the dashboard that will address important limitations in available data. For example, Navigant might recommend specific data be collected for future versions or it might recommend changes in the way data are reported to DHCS that would allow for more flexible aggregation (e.g., across plans) and disaggregation of data (e.g., by enrollee characteristics). Navigant will prepare a report for publication by CHCF and present its findings at a briefing in

Sacramento. The final report will summarize research findings, present final design specifications, and provide recommendations for ongoing monitoring.

iv) Enrollee Surveys. Health Research for Action (HRA), a research center in UC Berkeley's School of Public Health conducted two evaluations of the transition of SPDs. In one study, HRA researchers worked in collaboration with the DHCS and CHCF to conduct a telephone survey evaluating the experiences of beneficiaries who were recently transitioned. The evaluation was to determine the prevalence of positive, neutral, and negative experiences among SPDs who were mandatorily transitioned from FFS Medi-Cal to MCMC. It was intended to suggest means to identify categories of beneficiaries who are likely to have more difficulties with such transitions. It was also intended to evaluate whether efforts made to link beneficiaries with a plan network that includes providers seen in the past had any statistically significant effect on continuity of care or beneficiary satisfaction. Finally, the evaluation examined whether the profile and experiences of beneficiaries who filed and were denied MERs differed significantly from those of other MCMC enrollees. The evaluation utilizes both telephone survey and focus group methodologies. The telephone survey—conducted in English and Spanish—documented the experiences of 1,515 randomly selected Medi-Cal beneficiaries who transitioned to MCMC between June 2011 and May 2012. Survey staff received special training for conducting interviews with persons with disabilities. Persons using sign language can take the survey through video relay or instant messaging technology. Other accommodations, such as the use of proxies, or completion of the survey in installments, are available as needed. Focus groups supplement the telephone survey, allowing researchers to document the experiences of additional language groups, hard-to-reach populations, and small but medically vulnerable groups. The evaluation includes focus groups with the population's three largest language groups after English and Spanish. These are Armenian, Vietnamese, and Chinese. Additional focus groups documented the experiences of beneficiaries who are homeless or marginally housed, those on dialysis, and those with developmental disabilities.

3) Healthy Families Program.

a) Plan for Transition to Medi-Cal. HFP is the state's version of the federal Children's Health Insurance Program (CHIP) and when originally established was administered by the Managed Risk Medical Insurance Board (MRMIB). MRMIB provided coverage by contracting with plans to provide health, dental, and vision benefits to HFP enrollees. At implementation, California chose to provide benefits that were equivalent to those benefits provided to state employees through the California Public Employees'

Retirement System, with certain exceptions for mental health benefits over the option to expand its Medicaid program. The Governor's January 2011-12 and 2012-13 Budget proposed to shift over 860,000 children from HFP into Medi-Cal. The ACA requires all children in families with income up to 133% of the FPL to be enrolled in Medi-Cal by 2014. However, the Brown Administration proposed to also move beyond this requirement and to shift the remainder of the children (with incomes up to 250% FPL) to Medi-Cal. Upon implementation, all newly enrolled children would also go into Medi-Cal. The Legislature adopted a modified version as part of the 2012-13 Budget. AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012, provided for the transition of children from HFP to Medi-Cal in four phases, starting no earlier than January 1, 2013. This transition was projected to yield $13.1 million General Fund savings in 2012-13, $58.4 million General Fund savings in 2013-14, and $72.9 million General Fund savings annually thereafter.

The HFP had a tiered premium structure with lower premiums for families below 150% of the FPL, and higher premiums for higher-income families. The premiums ranged from $4 to $24 per child per month depending on family income, with a maximum monthly family premium of $72. After the transition, families with income between 150% and 250% of the FPL will be subject to premiums of $13 per month per child with a maximum of $39 monthly per family. Families with income under 150% of the FPL would no longer be required to pay a premium and would be eligible for free Medi-Cal. DHCS maintained the same premium payment collection processes and management services as were utilized by MRMIB.

The HFP shift included a change in dental and vision benefits. In Sacramento County, if the individual is enrolled in a dental plan that is not a Medi-Cal dental managed care plan, the individual is assigned to a plan with preference to a plan with which their current provider is a contracted provider. In Los Angeles County, if the individual is enrolled in a dental plan that is not a Medi-Cal dental managed care plan, the individual may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal FFS for dental coverage. In all other counties, dental coverage for these children transitioned to Medi-Cal FFS dental coverage. Additionally, children are being moved out of their HFP vision plan and will receive vision services through their MCMC health plan.

For behavioral health services, DHCS requested data from MRMIB to assess utilization of mental health and substance use disorder treatment services to facilitate continuity of care to the Medi-Cal delivery. HFP provided basic mental health services through the child's primary care provider or through a specialist in the plan's network. A child that was diagnosed as "seriously emotionally disturbed" (SED) was referred to the county mental health department for services through the county mental health plan (MHP).

There was no change to this component of mental health services. However Medi-Cal MCPs covered only basic mental health services that could be provided by primary care providers and the plan was for children to be referred, through the county, to Medi-Cal FFS mental health providers for any additional services. During the transition, it became apparent there was insufficient capacity to serve all the needs of the children in the FFS mental health system and there was little overlap between providers in the two systems. DHCS attempted to identify HFP mental health providers and encouraged them to become Medi-Cal providers. In addition children with autism who did not qualify for developmental disability services through a Regional Center lost access to Applied Behavioral Analysis services because these are not covered by Medi-Cal, previously provided under HFP. Medi-Cal alcohol and drug treatment services are also administered at the county level. According to the transition plans, less than 1% of the HFP enrollees were accessing substance abuse disorder services. DHCS worked with county Alcohol and Other Drug Program Administrators to transition children to the counties for services. For children with special health care needs who qualified for the California Children's Services (CCS) program there was no change and they continued to receive services through CCS as it is a "carved-out" service in Medi-Cal and in HFP.

Federal Medicaid law requires states to make their Medicaid benefits package available to all eligible individuals regardless of location of residence and as a general rule, the benefits must be comparable or equal for all those eligible individuals in a particular population or category. The transition from a HFP product to Medi-Cal MCP on a county-by-county basis meant that for a period of time there would be different benefits and premiums, depending on a child's county of residence. California was therefore required to obtain a time-limited authority to amend the Bridge to Reform Demonstration from CMS in order to obtain a waiver of these requirements. Upon completion of the transition, the state will convert the federal approval to a State Plan Amendment as the children will be fully incorporated into the Medi-Cal program as optional targeted low-income children. Federal approval of the waiver request was granted on December 31, 2012 and as is generally the case, came with a number of Special Term and Conditions (STCs) including requirements for reporting, monitoring to document network adequacy, active engagement of the stakeholder community, performance metrics, continuity of care, dental program metrics and requirements for access to specialty and basic mental health and alcohol and drug treatment services.

The ACA includes a "maintenance of effort" (MOE) provision that requires, as a condition of receiving federal Medicaid funding, states maintain CHIP "eligibility standards, methods, and procedures" that are no more restrictive than those that were in effect on March 23, 2010. In reviewing the HFP transition to Medi-Cal, CMS determined that while procedural differences did exist, there was no MOE violation.

According to CMS, by expanding Medicaid eligibility, the state had exercised its discretion to change the operation of its CHIP from a separate program to a Medicaid expansion. CMS also stated that most importantly, their expectation was that children would not lose eligibility for coverage as a result of this transition and that transferred children will automatically be enrolled in Medi-Cal, and new applicants who would have been eligible for HFP will now be enrolled in Medi-Cal. The state developed specific eligibility categories for transitioning children, and assured CMS it would have the ability to track and provide eligibility reports about these children. CMS stated that it planned to monitor these reports to ensure that children are not disenrolled from coverage as a result of the transition, which could be considered a violation of the MOE.

As modified by the Legislature in AB 1494 (Committee on Budget), the transition breaks up the transfer to Medi-Cal into four phases. Phase one was to begin no earlier than January 1, 2013 and included approximately 415,000 children who are in a HFP plan that is also a Medi-Cal MCP. Phase two was to begin no earlier than April 1, 2013 and included approximately 249,000 children enrolled in a HFP plan that subcontracts with a Medi-Cal MCP and required, to the extent possible, the child to be enrolled in the Medi-Cal MCP that sub-contracts with the same plan. Phase three was to begin no earlier than August 1, 2013, and consisted of approximately 173,000 children enrolled in a HFP plan that is not a Medi-Cal MCP and does not contract with a Medi-Cal plan in that county. Plan enrollment for these children was to include consideration of whether the child's primary care provider is available through the new plan. Phase four was to begin no earlier than September 1, 2013, with approximately 43,000 children in HFP, residing in counties without MCMC, transitioning into Medi-Cal FFS.

There have been a number of modifications to the original transition plan. Based on network adequacy reviews conducted by DMHC, stakeholder input and to ensure an orderly transition, DHCS revised Phase one into three sub-phases. The two most significant changes to the original Phase one plan resulted from findings of the network adequacy assessments related to Health Net and CalViva. CalViva, the LI health plan that serves Fresno, Kings, and Madera counties, did not have a HFP line of business and contracted with Health Net. CalViva was unable to secure assurances that the HFP-only providers would continue to treat the children in Medi-Cal post-transition. The departments expressed significant concerns about the adequacy of the CalViva network and found that key pieces of data were unavailable. Consequently, DHCS decided to reschedule CalViva from Phase one to Phase two. With regard to Health Net, the original assessment raised enough concerns to warrant requests for additional information and required a reassessment before the departments could determine the adequacy of the network for transition. For instance, the overlap between HFP providers and Medi-Cal providers was very low and at that time, the plan was unable to secure assurances that the

HFP-only providers would continue to see the children after transition. Conversely, the plan was unable to secure assurances that its Medi-Cal providers who also treated HFP enrollees would continue to treat the children after transition. As a result, the Health Net transition became Phase one Part C. Upon subsequent network adequacy review, DHCS and CMS felt it was important to provide Health Net with more time in which to contact and assist HFP enrollees in Los Angeles and San Diego counties in selecting a new primary care provider and ensuring continuity of care of existing services and the implementation date moved from April 1 to May 1, 2013.

b) Kaiser Foundation Health Plan. The transition for children enrolled in the Kaiser Foundation Health Plan also was modified slightly so that children in some counties could remain enrolled in Kaiser even though it was not a contracted Medi-Cal plan in the county. These children are now enrolled in Kaiser Medi-Cal through sub-contracts with Alameda Alliance for Health, Contra Costa Health Plan, Santa Clara Family Health Plan, Partnership Health Plan, San Francisco Health Plan, CalOptima, and Inland Empire Health Plan. Children enrolled in Kaiser in Sacramento, San Diego and Los Angeles also transitioned from Kaiser HFP to Kaiser Medi-Cal through existing contracts or sub-contract arrangements. DHCS recently announced that children enrolled in Kaiser in Placer, Calaveras, Madera and El Dorado counties will also be able to stay with Kaiser.

c) Impact of Rural Expansion. Phase four has also been modified as a result of the rural expansion. In February 2013, DHCS announced that Anthem Blue Cross and California Health and Wellness Plan, were awarded contracts for the expansion of MCMC to Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba counties. In addition, DHCS entered into an exclusive MCMC contract with Partnership HealthPlan of California for expansion in Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, Lake, and Trinity counties. San Benito County will be served by Anthem Blue Cross and in Imperial County; enrollees will have a choice between Anthem Blue Cross and California Health and Wellness Plan. As a result of the rural expansion, Phase four was subdivided into Parts A and B. Approximately 7,000 children in the COHS counties transitioned on September 1, 2013, along with the rest of the Medi-Cal population in those counties. The approximately 24,000 children in the remaining 20 counties will transition on November 1, 2013, along with the rest of the mandatory population in those counties, excluding SPDs until sometime in 2014. In many of the non-COHS Part B rural counties, Anthem Blue Cross was the HFP plan and children there will be able to remain with the same plan.

d) Continuity of Care. Continuity of care is another critical element in ensuring a smooth transition of children from the HFP to Medi-Cal. All transitioning subscribers will be

eligible for continuity of care in accordance with the completion of covered services protections required under the Knox-Keene Health Care Services Act which governs the regulation of health plans. Knox-Keene provisions require plans to continue to cover treatment by non-network treating physicians when the treatment is a covered benefit under the plan and the patient is being treated for specific conditions, as specified. In addition to the protections in Knox-Keene, the DHCS contracts require plans to provide ongoing care, for contracted Medi-Cal covered services, with a non-network treating primary care provider for up to 12 months following the transition, if the primary care provider accepts the Medi-Cal payment rate and there is no quality of care concerns with regard to that provider. Therefore, subscribers whose primary care provider does not contract with the Plan may still continue to see their primary care provider for 12 months post-transition under those circumstances. Another requirement added to the Medi-Cal contract was a new Continuity of Care report that the plans had to submit to DHCS in a specified format and timeframe. This report includes the number of continuity of care requests received by the plan, how they responded to the requests, and how they had been resolved.

e) HFP Transition Reporting and Monitoring Requirements. The California Health and Human Services Agency was required to work with MRMIB, DHCS, and DMHC to develop a strategic plan for the transition of children from HFP to Medi-Cal no later than October 1, 2012 (delivered to the Legislature on October 2, 2012). DHCS is required to submit an implementation plan for each phase prior to transitioning children into Medi-Cal to ensure access and continuity of care for transitioning individuals. AB 1494 requires the Administration to consult with stakeholders when developing these implementation plans. All have been submitted, as well as Network Adequacy Assessments Reports, jointly submitted by DHCS and DMHC. Monthly transition status reports must also be submitted to the Legislature and CMS. These reports are required to include information on health plan grievances related to access to care, continuity of care, requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment). CMS is also requiring the reporting of performance, health plan, and dental program metrics, and individual tracking of transitioned children and newly eligible children as a risk mitigation strategy in order to monitor any disruption in access to services, to assure that existing gateways and access and continuity of care are maintained.

DHCS has also conducted an outbound call survey of recently transitioned enrollees after each phase, as required by CMS. The survey was developed in accordance with the California Bridge to Reform Waiver STCs. The intent of the survey is to assess the overall transition and to gauge family perceptions of continuity of care with providers as well as overall satisfaction with their move to Medi-Cal. The survey was intended take

no more than three to five minutes to answer. The first survey was required to be conducted within 60 days of the beginning of Phase one Part A. The first outbound call survey was completed in March 2013.

DHCS collected a random sample of former HFP subscribers and contacted their families to ask about their experiences during the transition to Medi-Cal. Out of the 10,000 families contacted, 349 completed the survey. The survey consisted of six core questions. Follow up questions were asked only if the beneficiary answered "Yes" to the core question (i.e. "Has your child been scheduled for an appointment to see a Medical Doctor, since your move to Medi-Cal?"). If beneficiary answered "Yes", a follow up question, such as, "Was your experience with making or keeping an appointment with your Medical doctor the same, better or worse?" A Rating scale of one through five was used to rate the beneficiaries experience in changing their provider. A rating of one equaled "hard" to change providers, and five equaled "easy" to change providers. A rating scale of same, better, or worse was used to rate the beneficiaries experience with making or keeping an appointment. Similar surveys are repeated quarterly and submitted to CMS for review and feedback. Surveys have been completed of Phase one, Parts A, B, and C, Phase two, and Phase three. DHCS is attempting to obtain at least 400 responses for each survey. After the first survey, modifications were made to the call times because of the difficulty in reaching that number of respondents. In the first survey 10,000 calls were made before achieving the desired response rate, but since the changes DHCS has been able to obtain the desired number after 5,000 calls. Most respondents have reported their experience since the transition to be the same or better. One glaring exception has been in the area of mental health. In most of the surveys a third to a half of the respondents reported difficulty in obtaining a mental health provider. Phase three is specific to children who were enrolled in a HFP plan that is not a MCP and does not contract with an MCP. If the plan does not choose to sub-contract with the MCP in the county, the child is required to change plans. The results of the survey of this Phase show a much higher degree of difficulty in selecting a medical doctor as well as a mental health provider.

f) HFP Advisory Panel. The HFP Advisory Committee was established statutorily to advise MRMIB on HFP policies, regulations, operation, and implementation. It is comprised of 15 members, appointed by MRMIB, who serve three year terms, and consists of subject matter experts such as providers, health care delivery organizations, medical and dental providers, a business representative and subscriber parents. Effective January 1, 2014, the Advisory Committee transitions to DHCS along with the rest of HFP. The role of the Advisory Committee after transition is currently under discussion. Stakeholders and the Advisory Committee itself have made suggestions regarding the future role. These include more frequent meetings, direct reporting to the Director of DHCS and expansion

of the role, to advice on all children in Medi-Cal. The Advisory Committee also recommends maintaining the existing scope which includes advising on all policies, regulations and operations, submitting recommendations formally in writing and a written response, when not implemented on the reasoning for the non-implementation. In addition the Advisory Committee would have responsibilities with regard to monitoring and performance reports including evaluating aspects of the program and making recommendations.

Policy Questions.

1. Governor Jerry Brown established the "LET'S GET HEALTHY CALIFORNIA TASK FORCE" to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity. The Executive Order directed the Task Force to issue a report by mid-December 2012, with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade. Many of the recommendations relate to the collection of additional data and refer to metrics similar to those used in HEDIS data such as childhood asthma. For instance, the Task Force Report states there are significant disparities in asthma prevalence and in the utilization of health services resulting from asthma. African American children utilize the emergency department more than eight times as frequently as Asian American children for asthma. Does DHCS have plans to stratify data by demographic characteristics in order to reduce these disparities similar to the way the HFP program did?

2. In view of the veto of AB 411 (Pan), what are the DHCS plans to incorporate the recommendations of the goals regarding health disparities into the Medi-Cal program?

3. DHCS recently developed its Strategy for Quality Improvement in Health Care. What is the status of the proposed multi-year implementation plan?

4. What lessons has DHCS learned to date from the SPD transition process and how are they informing future MCMC enrollment efforts?

5. Has transitioning SPDs to MCMC achieved measurable improvement in access to care, care coordination, and cost control?

6. Incomplete or out of date contact information for SPDs has undermined communication with beneficiaries. Community based organizations and provider groups may help to disseminate notification materials to hard-to-reach beneficiaries before future transitions. What efforts is DHCS making to coordinate outreach efforts with these groups in the

future?

7. What steps are being taken to enable more timely, efficient, and reliable transfer of new SPD enrollee data to health plans and providers?

8. Have recent education strategies, such as provider bulletins and all plan letters improved access to continuity of care for SPDs and transitioning children? Does DHCS have plans to issue any regulations on these requirements?

9. What has been the effectiveness of the continuity of care provisions and what options are available for patients who are unable to locate a willing provider?

10. What is the current wait time for access to county mental health services? What steps are being taken to improve access for SPDs and children to mental health services?

11. What will be the expected impact of the expanded mental health benefit after January 1, 2014?

12. Recent studies have highlighted specific patient populations that have experienced the most difficulty with the SPD transition including patients with HIV, end-stage renal disease, cancer, and mental illness. What specific steps are being taken to better serve each of these patient groups? Are there any additional vulnerable patient groups that are facing unexpected challenges with their transition to MCMC?

13. What are the Department's plans for the future of the Healthy Families Advisory Panel?