



Healthy Families Program Transition to Medi-Cal Strategic Plan

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2012, Welfare and Institutions Code § Section 14005.27 (d) and (e).

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A. Proposal Overview, Requirements, and Legislative Oversight

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of Healthy Families Program (HFP) subscribers to the Medi-Cal program commencing no sooner than January 1, 2013. HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), currently serves over 863,000 children with health, dental, and vision coverage. Children enrolled in the HFP will be transitioned into the Medi-Cal program, administered by the Department of Health Care Services (DHCS), where they will continue to receive their health, dental, and vision benefits.

Throughout the transition, DHCS, MRMIB, and the Department of Managed Health Care's (DMHC) main focus will be to work collaboratively to facilitate a smooth transition, ensure minimum disruption in services, maintain existing eligibility gateways, and ensure access to and continuity of care.

This Strategic Plan fulfills the requirements of Welfare and Institutions Code Section 14005.27(d) and (e)--AB 1494 requires the California Health and Human Services Agency (CHHS) to submit a strategic plan by October 1, 2012, and an Implementation Plan for Phase 1 90 days prior to the start of Phase 1. Since there would be significant content overlap between the Strategic Plan and a Phase 1 Implementation Plan, this document will also serve as the Phase 1 Implementation Plan. DHCS will update it to further address Phase 1 readiness based upon the Phase 1 Network Adequacy Assessment due to the Legislature on November 1, 2012.

The Strategic Plan will serve as an overall guide for the transition and the implementation plans for Phases 2 – 4 of this transition, pursuant to Welfare and Institutions Code, Section 14005.27, paragraphs (1) to (8), inclusive, of subdivision (e). It will describe the approach to ensuring continuity of care and primary and specialty care provider network adequacy.

Pursuant to AB 1494, the transition will consist of four phases. Based on significant input received from stakeholders to date, the Administration proposes to separate Phase 1 into two distinct sub-phases. The first group of children will transition to Medi-Cal effective January 2, 2013, given the New Year holiday, and the second group will transition on March 1, 2013. We will work collaboratively with our partner Medi-Cal managed care plans and DMHC to assess plan readiness and network adequacy in order to determine which plans are most ready to proceed with the transition. Throughout the transition, the Administration will continue to request and consider input from consumers, stakeholders, and legislative staff and, based on the outcomes of the pre-implementation analysis of network adequacy and provider capacity, DHCS may consider alternative phasing approaches within each phase.

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Phase 1: No sooner than January 1, 2013, children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence shall be enrolled in the same plan. This phase includes approximately 409,000 children.

Phase 2: No sooner than April 1, 2013, children enrolled in a HFP health plan that is also a subcontractor of a Medi-Cal managed health care plan, in their county of residence, to the extent possible, shall be enrolled into a Medi-Cal managed care health plan that includes the child's current plan. This phase includes approximately 259,000 children.

Phase 3: No sooner than August 1, 2013, children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan shall be enrolled in a Medi-Cal managed care health plan in that county. Enrollment shall include consideration of the child's primary care providers pursuant to the requirements of statute. This phase includes approximately 151,000 children.

Phase 4: No sooner than September 1, 2013, children residing in a county that is not currently a Medi-Cal managed care county shall be transitioned into Medi-Cal managed care health plans, provided the successful completion of efforts to expand Medi-Cal managed care statewide by the State. Pursuant to AB 1467, Chapter 23, Statutes of 2012, DHCS is in the process of expanding Medi-Cal managed care into the 28 counties that do not currently have managed care. The department intends to complete this expansion prior to September 1, 2013. This phase includes approximately 42,000 children.

Each of the four phases will be preceded by scheduled mailings, in the Medi-Cal threshold languages, explaining the transition, describing changes in health, dental, and vision benefit delivery system, where applicable, and giving HFP families an overview of their health and dental plan options and contact information for resources to answer questions and provide any additional assistance.

Dental Coverage

Dental services will transition at the same time as the medical coverage transition. For instance, if a child is being transitioned in Phase 1 for their medical services, they will also have their dental services transitioned. The phase in which the child will receive their dental services relies on their medical transition. A child will only be transitioned into Medi-Cal one time to include all their services. All children, with the exception of children residing in Sacramento and Los Angeles Counties, as described below, will be provided dental services under Denti-Cal, the Medi-Cal Fee-for-Service dental program.

All children residing in Sacramento County will transition into a Medi-Cal Dental Managed Care (DMC) plan during the phase in which their medical benefits transition. If the child's HFP dental plan is a Medi-Cal DMC plan, the child will be

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automatically enrolled into that plan. If the child's HFP dental plan is not a Medi-Cal DMC plan, the child will be automatically enrolled into a plan based on where their HFP primary care dentist is an in-network provider. All transitioning children will have the choice to change dental plans once they are transitioned. Additionally, if these children experience difficulty accessing timely dental services after being transitioned into DMC, these children may receive dental services under the Fee-for-Service Denti-Cal program under the Beneficiary Exception Process.

All children residing in Los Angeles County currently enrolled in a Medi-Cal DMC plan will be automatically enrolled into the same dental plan if the HFP plan is also a Medi-Cal DMC plan. If the child's HFP plan is not a Medi-Cal DMC plan, the child will be automatically enrolled into Denti-Cal Fee-For-Service. All transitioning children will have the choice to change dental plans, to enroll into a Medi-Cal DMC plan, or to enroll into Denti-Cal.

Vision Coverage

Vision coverage transition also coincides with the medical coverage transition. As children transition from HFP to Medi-Cal based on the phases outlined above, they will move out of their HFP vision plan and will receive their vision services under the managed health care plan or in Medi-Cal fee-for-service, as applicable. The Medi-Cal managed care plans will coordinate with the Prison Industry Authority for the fabrication of optical lenses.

B. Overview of Operational Steps, Timelines, and Key Milestones

There are many milestones that must be met to ensure a smooth transition across all phases. *Attachment I, Healthy Families Program Transition High-Level Timeline, provides* a high level timeline of critical milestones that must be met across the three departments. Key efforts include the following:

- Strategic Plan Submission to Legislature
- Implementation Plan Submission to the Legislature
- Reports to the Legislature
- State Plan Amendment Submission and Approval
- Waiver Submission and Approval
- Provider Transitions
- MAXIMUS Contract Transition
- Stakeholder Meetings

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C. Methods and Processes for Stakeholder Engagement

Effective, ongoing communication is critical to the success of this transition. Such communication must involve the engagement of key partners including the federal Centers for Medicare & Medicaid Services (CMS), other state agencies/ departments, the Legislature, health and dental managed care plans, and advocates. Key state agencies/departments engaged with DHCS are MRMIB, the California Health and Human Services Agency (CHHS), DMHC, and the Department of Finance (DOF).

California Health and Human Services Agency (CHHS)

CHHS has responsibility for convening legislative staff and key stakeholders in the development of the Strategic Plan for the transition. The Strategic Plan will serve as the Phase 1 Implementation Plan and the basis for the subsequent implementation plans for each phase. CHHS is also working closely with DHCS, MRMIB, and DMHC in its planning efforts to ensure a successful transition and has formed a small planning group of legislative staff and advocates familiar with policy and implementation issues who will meet regularly. These meetings are in addition to larger meetings with the broader array of interested stakeholders. The planning group includes children's advocates, health care advocates, physician, pediatric, dental and plan associations, and county representation. The planning group will meet in person and/or via teleconference every few weeks and the larger stakeholder meetings will meet in person and/or via Webinar every four to six weeks during the transition period.

Managed Risk Medical Insurance Board (MRMIB)

MRMIB conducts a public board meeting monthly, with a standing agenda item to discuss the transition of the Healthy Families children to the Medi-Cal Program. The information presented at the meetings includes all updates on coordinated efforts between the DHCS, DMHC, and CHHS, Department of Finance, and CMS. MRMIB staff are also engaged with Maximus to identify the activities and processes necessary to complete the transition and assist DHCS staff in development of its contract with Maximus for on-going activities.

MRMIB will continue participation in technical assistance calls with CMS to assure compliance with federal Title XXI requirements. In addition, MRMIB will continue to conduct quarterly advocate meetings and quarterly HFP Advisory Panel meetings in which DHCS will also participate. MRMIB will also hold monthly meetings with HFP contracted health, dental, and vision plans. MRMIB staff will participate in stakeholder engagement meetings with DHCS, DMHC, and CHHS. MRMIB has created a special section on their website to post relevant information and documents.

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DHCS will work collaboratively with MRMIB to develop a plan for transitioning the HFP Advisory Panel to DHCS. Such efforts will include identification of current members, need for replacement of members, roles, and responsibilities for advisory board members, and establishing a timeline for transition. This transition plan will be informed by input from the advisory panel and will be shared publicly.

Additionally, MRMIB has a network of over 4,000 Enrollment Entities (EE) and 24,000 Certified Application Assistants (CAAs) who help families fill out the HFP/Medi-Cal application. Information about the transition will be communicated to the EEs and CAAs through bi-monthly newsletters, e-mail notifications, and postings to the EE and CAA section of the HFP website.

Department of Health Care Services (DHCS)

DHCS has multiple efforts underway in order to reach a variety of stakeholders. These include weekly planning meetings with CHHS, DOF, MRMIB, and DMHC and twice monthly meetings with CMS. The CMS meetings are designed to provide technical assistance on key components of the transition strategy including needed federal approvals via State Plan and waiver amendments, health and dental plan contract approvals, eligibility provisions and cost sharing requirements.

Additionally, DHCS' Divisions of Medi-Cal Managed Care, Eligibility, and Dental Services conduct meetings with key partners who have operational roles in the transition.

Medi-Cal Managed Care Division

- Weekly phone calls with Medi-Cal managed care plans (Every Tuesday)
- Quarterly Meetings with the Medi-Cal managed care plan Advisory Group
- Bi-weekly meetings with DMHC
- Joint review of Medi-Cal managed care provider network with DMHC

Dental Services Division

- Monthly stakeholder meetings with plans and advocates in Los Angeles and Sacramento County
- Monthly all plan meetings
- Monthly stakeholder meetings specific to the transition

Medi-Cal Eligibility Division

- Weekly/bi-weekly meetings with DHCS Information Technology Division staff, counties, county consortia, MAXIMUS, and MRMIB on issues specific to policy and system changes
- Monthly meetings with counties on eligibility policy changes specific to the transition
- Quarterly meetings and more frequent meetings, as necessary, with advocates on eligibility policy changes specific to the transition

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Department of Managed Health Care (DMHC)

DMHC conducts quarterly meetings with advocates and quarterly meetings with health plans.¹ While DMHC discusses various topics at these meetings, the Healthy Families Program transition has been an ongoing discussion topic and it is anticipated that the Healthy Families Program transition to Medi-Cal will remain an agenda item throughout all phases of the transition. The next Health Plan Oversight Roundtable meeting is scheduled on November 14, 2012, and the next consumer advocate meeting is scheduled on October 11, 2012.

D. State, County, and Local Administrative Components to Facilitate Successful Subscriber Transition

1. Eligibility Processing and Enrollment

DHCS has responsibility for establishing policies and procedures for eligibility determination processes, premium collection and cost sharing provisions and performance metrics for application processing and will work closely with counties, MAXIMUS, the HFP Administrative Vendor, and stakeholders on these efforts. Clear and consistent communication to children and their families will be critical to this transition. MRMIB and DHCS will coordinate subscriber notices that will be provided in advance of each transition phase based on the statutory timeframes of at least 60 days prior to the Phase 1 effective date and at least 90 days prior to Phases 2, 3, and 4 effective dates, as applicable. DHCS and MRMIB will work collaboratively on general outreach strategies such as posting communication notices on their respective websites so that counties, health plans, providers, and CAAs will have prior access to the notices that the families will receive in order to inform families and provide outreach during the transition period.

a. Enrollment Communication and Outreach

Outreach to Subscribers and Families

MRMIB is developing notices using the “*What We Need to Tell Families*” grid as a guide. This grid was developed by MRMIB with input from stakeholders, DHCS, and DMHC. The grid will be updated periodically to reflect the information in the actual notices. In preparation for the Phase 1 transition, and as required by AB 1494, Healthy Families subscribers will receive notice, at a minimum, at least 60 days prior to their transition date. Stakeholders and CMS will have opportunities to also provide input into the notices and DMHC and DHCS will be reviewing these notices to ensure accurate information is included.

¹ The Health Plan Oversight roundtable is a forum for the DMHC to communicate and discuss issues with the health plans it regulates.

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While CMS approval is not a requirement to release the notices, MRMIB and DHCS solicit and welcome the technical assistance and feedback from its federal partners. The final drafts of each notice will be submitted to the Center for Health Literacy to ensure they are written at an appropriate reading level. All notices will be translated into the twelve Medi-Cal threshold languages, will be posted online at the respective DHCS and HFP Transition websites of both organizations, and will be shared broadly with stakeholders, plans, and providers.

In addition to the notices sent by MRMIB, DHCS will release a welcome packet to all transitioning families which will include general Medi-Cal informing materials (such as general eligibility, covered services, fair hearings, rights and responsibilities and continuity of care rights, and what to do if a family has a problem accessing care). The welcome packet will be released in the identified preferred language of the subscriber with an insert regarding additional language options for all written materials. In a separate mailing, DHCS will also send transitioned children a Benefit Identification Card (BIC) to ensure access to Medi-Cal benefits with a mailing stuffer explaining the purpose, effective date of Medi-Cal coverage, and importance of the card. The BIC mailing and stuffer will take place in a phased approach beginning no earlier than December 2012 to ensure there is no lapse in coverage for these children once they transition. Children who are transitioned in the later phases will receive a BIC no later than 30 days prior to their transition to Medi-Cal. Equally important is the issuance of the health plan cards which will occur once a given transition phase is operational.

Enrollment Communication

DHCS will also develop notices specific for enrollment into a Medi-Cal managed care health plan. These notices will confirm with the HFP family the child's plan enrollment and inform them of who they can contact for assistance, including a toll free number. HFP children transitioning in Phases 3 and 4 will receive an enrollment packet to choose a Medi-Cal managed care plan prior to their transition.²

For purposes of dental coverage, as the children transition, their county of residence will determine how dental services will be delivered. Their county of residence will also dictate the information that will be provided specific to either Denti-Cal or DMC. Children transitioning into Denti-Cal will be given information on how to choose a provider and how to access services. For children who live in Los Angeles and Sacramento County, upon transition, informational packets describing plan choice will be sent, allowing members to choose their providers and to assist with continuity of care.

² DHCS is in the process of working on establishing managed care in the remaining 28 counties which are currently Medi-Cal FFS, effective June 1, 2013; to the extent managed care is operational, children in Phase 4 will move into managed care delivery systems versus Medi-Cal FFS.

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DHCS will also conduct outreach to transitioned families via a survey to specifically assess utilization of dental services in both Denti-Cal and DMC. The survey will include communication to families on how to access dental services available to them and provide frequently asked questions and answers to common issues or barriers they may face. As an outreach venue to families with information about the transition from HFP to Medi-Cal, DHCS is looking into engaging with community-based organizations statewide.

DHCS will work collaboratively with MRMIB to provide ongoing information to EEs and CAAs about the transition of children from HFP to Medi-Cal. During the four transition phases, it will be critical that CAAs have current information to assist families to enroll and retain coverage. After HFP no longer enrolls children, CAAs will continue to submit applications via Health-e-App and paper applications to the Single Point of Entry (SPE) for a Medi-Cal determination. After the transition, DHCS will continue to utilize the electronic communications available through MAXIMUS such as the CAA/EE help desk, CAA newsletter, and CAA news blast to be sure that CAAs have current information to help families. DHCS will work with MAXIMUS to update training tools and refresher courses to reflect the transition.

The departments anticipate increased use of available call centers due to the significant amount of outreach to HFP children and their families, as described above. To ensure accurate and consistent responses to questions about the transition, MRMIB, DHCS, and DMHC are working together to create shared call center scripts to be used by their respective call centers, the DHCS Ombudsman's Office and will be shared with county offices and providers. The call center scripts will be periodically updated as necessary.

b. County Coordination

Eligibility Determinations

County coordination is a key component for ensuring a smooth transition given the primary role that counties have in conducting Medi-Cal eligibility determinations. The Department is convening a series of meetings with the counties, consortia, MAXIMUS, and MRMIB to plan for a smooth transition of children with a focus on policy decisions and data sharing capabilities. The meetings occur no less than monthly and subgroups will meet on a weekly basis. DHCS is also working with stakeholders through quarterly meetings and additional sub-groups, as needed, to discuss specific eligibility policies such as redeterminations, premiums, the use of presumptive eligibility at the SPE, and due process.

DHCS will release several All County Welfare Director's Letters (ACWDLs) regarding the transition. Draft letters will be shared with counties, stakeholders, and CMS to obtain feedback prior to being finalized and released by DHCS.

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While CMS approval is not a requirement to release the ACWDLs, DHCS requests and welcomes the technical assistance and feedback from its federal partners. The first letter is about the HFP Transition to Medi-Cal which focuses on the policy for transitioning children currently receiving HFP. The second letter is about the new coverage group, Targeted Low-Income Children's Program, which focuses on the policy for increasing the federal poverty level income limits for children ages zero to 19 and the use of aid codes for these children. The third letter will be a technical letter to the counties about how the county eligibility systems will interact and interface with MAXIMUS and the Medi-Cal Eligibility Data System (MEDS). It is anticipated that these letters will be finalized in October 2012. To the extent necessary, additional ACWDLs will be issued.

To the extent applicable and needed, based on CMS guidance, DHCS will employ the use of Express Lane Eligibility (ELE) for transitioning cases from HFP to Medi-Cal and will continue to use Accelerated Enrollment (AE) for new cases that present at SPE in accordance with existing Medi-Cal policy. DHCS is considering stakeholder recommendations to provide accelerated eligibility to all applicants at SPE. ELE, also known as "automatic enrollment," is a strategy designed to ensure that eligible children enroll in publicly supported health insurance programs based upon data used for another publicly subsidized program. For purposes of the transitioned cases, DHCS will accept the most current eligibility determination made by MRMIB/MAXIMUS to transition the HFP child to the applicable new Medi-Cal transition aid code. The child's annual redetermination date will remain the same as it was under HFP.

Eligibility Data Reports and Performance Standards

DHCS has convened two conference calls with the counties, the County Welfare Director's Association, the consortia, and other interested stakeholders to discuss the required data reports and performance standards. Follow-up conference calls, as needed, will be conducted in October 2012 to finalize the requirements for the data reports and performance standards.

The data reports will include information on the number of applications processed on a monthly basis, a breakout of the applications based on income using the federal percentage of poverty levels, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from SPE. These data reports will be reported monthly and will be made public each month by posting on the DHCS website. The required performance standards will be in accordance with Welfare and Institutions Code, sections 14005.27 (n)(2) and 14154 (d) and processing ninety percent of applications received from SPE, which are complete and without client errors, within 10 working days of receipt. The performance standards will be reported on a semi-annual basis and will be publicly reported and posted on the DHCS website.

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2. Linkage with Health Plan Providers

DHCS will amend health plan contracts to ensure protections that require transitioning children to stay with their primary care physician to the extent the family does not choose otherwise.

DHCS will also work with the California Department of Public Health, Immunizations Branch regarding the Vaccines for Children Program to ensure HFP providers, who are new to Medi-Cal are aware of what they need to do for enrollment into this program.

3. Payments of Applicable Premiums and Overall Systems Operation Functions: Administrative Vendor Coordination

MAXIMUS is another key partner to ensuring a smooth transition of children from the HFP to Medi-Cal. DHCS will contract with MAXIMUS, the HFP Administrative Vendor, for transition and ongoing work associated with this initiative. The anticipated scope of work activities include maintaining the SPE, managing premium payments, maintaining call center operations, developing needed systems changes for interfaces with the county eligibility systems and MEDS, and developing changes to the Health-e-App web portal. In using the SPE, MAXIMUS will continue to provide Accelerated Enrollment for children. The purpose of Accelerated Enrollment is to assign temporary, fee-for-service, full-scope, no-cost Medi-Cal enrollment for children under the age of 19 who are new to Medi-Cal, applied for Medi-Cal through SPE, and are likely eligible for a Medi-Cal percent of poverty program³ based on the screening done at SPE.

Premium Management

DHCS plans to maintain the same premium payment collection processes and standards as HFP, adjusting as needed to conform to Medicaid requirements. Families with incomes above 150 percent of the federal poverty level (FPL) and up and including 250 percent of the FPL will be subject to premiums - \$13 monthly for each child, with a maximum of \$39 monthly per family.

DHCS intends to contract with MAXIMUS for premium collection management services including providing informational services that instruct families on how and where to pay premiums. Families will be able to use the same payment methods available to subscribers in HFP - use of checks, money orders, cash to any Western Union Convenience Pay location, by credit card over the phone or on the website, or by electronic fund transfers with the 25 percent monthly discount, or by paying 3 months in advance and getting the 4th month free.

³ DHCS is working through the policy of determining the applicable FPL income level that can be used for accelerated enrollment and will obtain guidance from CMS on this matter.

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MAXIMUS will be responsible for sending monthly premium billing notices (to be paid by the 20th of each month), premium collections, notices for lack of payment, notification to counties for when there is a lack of payment for two consecutive months to initiate a redetermination of Medi-Cal eligibility. Counties will conduct a redetermination of Medi-Cal eligibility consistent with the process set forth in Senate Bill (SB) 87 (Escutia, Statutes of 2000, Chapter 1088) during which time the child will continue to receive benefits. Under SB 87, the county must follow three specific steps to try to support a finding of eligibility: 1) a thorough ex parte review; 2) phone contact if necessary, and, finally, 3) sending a special form for information if necessary. The county must evaluate the case for continuing eligibility under another Medi-Cal program. If the child is not eligible for any other program, the county would discontinue the case for no premium payment and would provide a timely Notice of Action which would provide hearing rights and information on how to request a fair hearing. The counties will notify MAXIMUS if upon completion of the reevaluation the child is found to be eligible for another program, ineligible for any Medi-Cal program, or if the family requests to disenroll the child. Upon notification from counties of the child's disenrollment from the program, MAXIMUS will be responsible for discontinuing premium collection services.

Cost Sharing (Premiums and Co-Payments)

Currently, Medi-Cal has nominal co-payment requirements pursuant to Welfare and Institutions Code Section 14134, ranging from \$1 to \$5, for medical/dental services, prescription drugs and non-emergent use of the emergency room of a hospital. These co-payment provisions are not enforceable—providers cannot deny the service if the person cannot pay the applicable co-payment. Also, children under the age of 18 are exempt from these co-payments. Because current state policy does not impose these co-payments on children under age 18, DHCS is working with CMS and internally on thinking through current policy on co-payments for children between the ages of 18 and 19.

Additionally, DHCS is in the process of seeking federal approval of enforceable co-payments for prescription drugs and non-emergent use of the emergency room of a hospital. For purposes of this new policy, enforceable co-payments means that the provider can deny the service to the extent the individual does not pay the co-payment. To the extent federal approval is obtained for the use of enforceable co-payments, children covered under Medi-Cal, including the children in this transition, will be subject to them.

Federal Medicaid rules require that total premiums and cost-sharing may not exceed five percent of the family income for a time period specified by the State. DHCS will work to ensure that transitioning families with incomes above 150 FPL, who will be subject to premiums, will not have cost-sharing provisions that exceed the 5 percent threshold.

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In planning ahead for the federal approval of co-payments, DHCS will seek stakeholder input to develop a methodology for tracking the 5 percent monthly cap. A premium/co-payment tracking process could be developed in coordination with MAXIMUS and DHCS' fiscal intermediary to ensure the 5 percent threshold is not exceeded.

The chart on the following page demonstrates the premium amounts based on FPL by family size and the 5 percent cap on cost-sharing on a monthly basis. The 5 percent cap is the total amount that would have to be expended on both premiums and any applicable co-payments by a family, on a monthly basis.

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5 Percent Monthly Cost Sharing Cap, Based on Family Size (by child) and Income

Children	150% FPL	Premiums	5% Cap	Amount Available for Co-Pay
1	\$1,398	\$13	\$70	\$57
2	\$1,893	\$26	\$95	\$69
3	\$2,388	\$39	\$119	\$80
4	\$2,883	\$39	\$144	\$105
5	\$3,378	\$39	\$169	\$130

Children	185% FPL	Premiums	5% Cap	Amount Available for Co-pay
1	\$1,723	\$13	\$86	\$73
2	\$2,333	\$26	\$117	\$91
3	\$2,944	\$39	\$147	\$108
4	\$3,554	\$39	\$178	\$139
5	\$4,165	\$39	\$208	\$169

Children	200% FPL	Premiums	5% Cap	Amount Available for Co-pay
1	\$1,862	\$13	\$93	\$80
2	\$2,522	\$26	\$126	\$100
3	\$3,182	\$39	\$159	\$120
4	\$3,842	\$39	\$192	\$153
5	\$4,502	\$39	\$225	\$186

Children	250% FPL	Premiums	5% Cap	Amount Available for Co-pay
1	\$2,328	\$13	\$116	\$103
2	\$3,153	\$26	\$158	\$132
3	\$3,978	\$39	\$199	\$160
4	\$4,803	\$39	\$240	\$201
5	\$5,628	\$39	\$281	\$242

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E. Health Care and Dental Delivery System Components

1. Network Adequacy

a. Medical and Dental Managed Care

DHCS and DMHC (the departments) are tasked with assessing health and dental plan provider network adequacy and continuity of care efforts. DHCS will have the lead responsibility on ensuring that Medi-Cal health and dental plans meet DHCS/Medicaid contractual network adequacy requirements and DMHC will have the lead responsibility for ensuring that plans meet Knox-Keene licensure network adequacy requirements.

The departments will evaluate health plan networks against established Knox Keene Act network and access standards and standards set forth in the DHCS health plan contracts. These reviews include, at a minimum:

- Assessing steps the health plan (Plan) will take to preserve continuity of care to ensure a smooth transition. The Plan's transition process relating to continuity of care, including communications to members and providers.
- How the Plan will ensure access to specialist(s) and prescription medication so that there is no disruption in services for children with special health care needs and those receiving specialty services, such as autism treatment services or mental health services.
- The Plan's outreach and communication process that explains the Primary Care Provider (PCP) reassignment process to enrollees.
- Efforts the Plan made to contract with HFP providers who are not currently in the Plan's Medi-Cal network.
- The Plan steps taken to review its out-of-network authorization process to ensure that, under circumstances where a patient cannot be transitioned to a new provider, the Plan is able to preserve continuity of care for transitioning HFP members whose treating providers are not in the Plan's network.
- Steps the Plan has taken to ensure that individuals moving to new providers as a result of the HFP transition will have timely access to their new provider and will not have a disruption in services.
- Any changes in the Plan's network to ensure there are no disruptions in services as a result of the transition.
- Any administrative changes the Plan has made to ensure there are no disruptions in services as a result of the transition (e.g. care management staff, expedited utilization management services, etc.).
- Steps the Plan has taken to evaluate whether its current Medi-Cal contracted providers will continue to contract and treat the Medi-Cal enrollees after the transition of HFP enrollees.

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- Steps the Plan has taken to evaluate whether its current Medi-Cal contracted provider groups will remain financially solvent with the addition of HFP lives into the Medi-Cal product.

The two departments jointly submitted a request to all medical and dental Medi-Cal managed care plans participating in Phase 1 to provide data related to their provider networks. This request was also submitted to all participating dental managed care plans participating in Medi-Cal. Similar requests will be made of all medical plans participating in the remaining phases of the transition. A copy of the data request that was sent to all plans is included in this report (*Attachment III*). MRMIB has also provided to DHCS network data on enrolled health and dental providers as well as submitted a request to their respective health and dental plans for subscriber level information. The following describes the types of data the departments have requested and how the departments intend to use the data to evaluate the impact of the HFP transition on Medi-Cal managed health care provider networks:

- *Qualitative Continuity of Care and Provider Network Data*
The departments provided plans with a list of questions requiring plans to explain the efforts the plan has taken to preserve continuity of care, evaluate the capacity of the existing provider network to treat additional Medi-Cal patients, build additional network capacity when necessary, develop administrative capacity to serve this new population, and ensure all members will have timely access to quality health and dental care. The departments have also asked the plans to specifically address what efforts they have made to bring HFP-only providers into their Medi-Cal network. The departments will utilize this information to evaluate whether the plans have taken appropriate steps to prepare their networks for the transition, estimate how children/families may be affected by the transition, and assess how the plans have arranged to provide continuity of care to their patients.
- *Summary Provider Network Data*
The departments have asked plans to provide a high-level overview of the total available primary care providers, specialist providers, and physician extenders (when appropriate) in each plan's network, the total number of patients expected to transition into the plan, an overall percentage of transitioning patients who will be able to keep their primary care provider post-transition, and an estimate of the future utilization of services based on past Medi-Cal and HFP utilization. This data will be specific to each county in which the plan operates a Medi-Cal managed care product. The departments will use this data to estimate the increase in demand for provider services after the transition and to evaluate whether each plan's provider network will be sufficient to accommodate that demand.

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- *Detailed Provider Network Lists*

The departments asked plans to provide a detailed list of all primary and specialist providers, as well as physician extender providers when applicable. These provider lists will indicate the location of each provider and whether the provider currently serves Medi-Cal and/or HFP patients. For primary care providers, the plans must also indicate each provider's total Medi-Cal capacity, the total Medi-Cal and HFP patients currently assigned to the provider, whether the provider is accepting new patients, and whether the provider will continue to treat HFP children after they transition to Medi-Cal. For specialists, the plans must also indicate each provider's specialty type and whether that provider operates a pediatric practice. This data will allow the departments to take a more detailed look at the geographic availability of providers, the total number of patients each provider is serving, the capacity of individual providers to take on additional patients, and whether this provider will be available to treat HFP subscribers post-transition. The departments will also evaluate how many primary and specialty providers in the HFP network will also be available in the Medi-Cal network so that the departments can assess continuity of primary and specialty care.

b. Fee-for-Service Denti-Cal

The following describes the types of data DHCS has requested and will use to evaluate the impact of the HFP transition on Medi-Cal Fee-for-Service dental services and provider networks and the types of provider outreach that will occur to provide network adequacy:

- *Denti-Cal Provider Network Adequacy*

Denti-Cal Provider Network Adequacy will be assessed by analyzing the number of currently enrolled Denti-Cal providers and the proposed number of HFP children who will be transitioned into Denti-Cal. This will be used to determine areas that the beneficiary to provider ratio is high and what counties are in need of concentrated provider outreach. Outreach will be performed to encourage providers to enroll in Denti-Cal, if not already enrolled, to continue treatment of their HFP children and accept additional Denti-Cal children to provide services to.

- *Denti-Cal to Healthy Families Network Adequacy*

DHCS will assess Denti-Cal to HFP Network Adequacy by comparing the current Denti-Cal network and the HFP dental network. Data was requested from the HFP dental plans by MRMIB and provided to DHCS on the HFP provider network and provider assignment to HFP children. DHCS will use this data to determine the extent to which services may be disrupted for transitioning HFP members by assessing the number of providers available in each county for each program, understanding the utilization of services by

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provider by program, and evaluating available provider capacity by counting the number of members assigned to each provider.

- *Provider Survey*
DHCS will send a survey to providers to determine provider capacity, their ability to accept new Medi-Cal beneficiaries, and to identify barriers to enrollment. Survey results will allow program staff to assess the providers that are willing to enroll in the program and/or continue providing services to their HFP children. Surveys⁴ will be sent to three provider groups: Denti-Cal only billing providers, HFP-only providers, and HFP/Denti-Cal rendering providers. A billing provider typically owns the dental practice and has the authority to bill or request authorization for services in the Denti-Cal program. A rendering provider provides services and those services are billed under a billing provider name and billing number; the rendering provider is also referred to as the “treating provider.”
- *Provider Call Campaign*
Denti-Cal will place calls to follow-up with providers who have not responded to surveys or have stated that they will not enroll in the program and to newly licensed dental providers. These calls will serve as an additional effort to encourage the providers to enroll in Denti-Cal and, consequently, improve network adequacy and assist in access to and continuity of care.
- *Streamlined Provider Enrollment*
DHCS will prioritize and accelerate the processing of all HFP provider applications to enroll in Denti-Cal. If additional information is needed to process the applications, Denti-Cal staff will contact the provider by phone to retrieve information and expedite the processing of the application.
- *Webinars/Online Training*
Denti-Cal will hold a series of webinars to educate providers on how to enroll in the Denti-Cal program, how to bill for services, and to answer other frequently asked questions. Online training videos will be available to educate providers on the Denti-Cal enrollment process.
- *Provider Bulletins*
Denti-Cal will publish bulletins monthly to educate providers on program changes and/or reminders on events (i.e. trainings).
- *Beneficiary Customer Service Line*
Denti-Cal is reviewing current processes of the Beneficiary Customer Service line to determine how to streamline and improve services to beneficiaries.

⁴ The dental survey is online at: <http://www.denti-cal.ca.gov/WSI/Default.jsp?fname=Default>

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- *Reporting*
Dental plans will be required to report on performance measures including, but not limited to, utilization, enrollment/disenrollment of providers, network adequacy, and continuity of care.
- *Beneficiary Surveys*
Surveys will be sent to determine reasons for utilization of dental services, how to educate beneficiaries on accessing dental services, and what common issues or barriers beneficiaries may face when accessing dental services. These surveys will be made available publicly.

c. Network Adequacy Assessments

Initial Network Adequacy Assessment

The data requests described above for the medical, DMC, and Denti-Cal programs will be submitted to plans prior to each phase. Upon receipt of the requested data, the departments will assess the adequacy of health and dental plan provider networks to treat and preserve continuity of care for the patients transitioning into Medi-Cal from Healthy Families. To accomplish this, DMHC and DHCS will jointly review all data provided by plans, as described above, pursuant to legislatively-defined timeframes: 60 days in advance of Phase 1 and 90 days in advance of Phases 2, 3, and 4. The departments will evaluate the health plan data against existing Knox Keene Act and DHCS contract network requirements. If any of the medical or dental plan networks are found to not meet network adequacy standards, the departments will alert the plans to those areas where the network needs improvement and work with the plans to correct network inadequacies. The departments will work with the health and dental plans to correct any deficiencies and will re-assess health and dental plan networks before HFP subscribers' transition into the plan.

Because the data provided prior to each phase is point-in-time, the departments, in coordination with the Plans, intend to continue monitoring networks after all phases of the transition have been completed.

DMHC Ongoing Network Adequacy Assessments

DMHC will use existing methods of network review to continually monitor Medi-Cal Managed Care and Dental Managed Care provider networks after the transition. Separate from the network assessments, specific to the HFP transition that is described above, the DMHC currently has the following other mechanisms in place to assess network adequacy:

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- *Quarterly Network Assessments*
DMHC and DHCS currently review all Medi-Cal managed care plan networks on a quarterly basis to evaluate whether the plans have accessible and available providers. This assessment involves reviewing Medi-Cal managed care networks in their entirety and, therefore, would identify potential provider network inadequacies that could affect the HFP children who have transitioned into the Medi-Cal network. Through these quarterly reviews, the departments monitor change in provider networks, call center reports, grievance reports, and State-sponsored call center data to ensure access to care.
- *Medical Surveys*
DMHC conducts medical surveys of all licensed health plans, including Medi-Cal managed care plans, once every three years. That audit typically includes a review of access and availability of services provided by the health plan and compliance with language assistance regulations. Medical surveys may include a review of health plan provider networks for compliance with Knox Keene timely access and geographic access standards.
- *DMHC Help Center*
DMHC operates and maintains a call center to address patient complaints against their health plan. The Help Center accepts calls from Medi-Cal Managed Care and Dental Managed Care patients and tracks all calls in a central database that is regularly utilized to identify trends related to access to care and provider availability. To the extent possible, the Help Center also assists callers in resolving their complaints against their health plans, as described in the Knox Keene Act and its supporting regulations.
- *Block Transfer Review*
Under certain circumstances, health plans licensed under the Knox Keene Act are required to inform the DMHC whenever it will be transferring enrollees to a new provider group or hospital due to a contract termination. Under certain conditions, the DMHC must approve transfers of enrollees to new provider groups and hospitals. Prior to approving a request, the DMHC regularly evaluates the effect of the plan's proposed termination of a hospital or provider group on the availability of services for patients.

2. Financial Solvency

Contracts between DHCS and Dental Managed Care and the Dental Fiscal Intermediary (FI) require that the plans and FI maintain and provide reports to demonstrate financial solvency. Financial reports are submitted to the Department on a monthly, quarterly, and yearly basis and can be made available upon request.

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DMHC regularly reviews and audits each health plan's financial condition to assure fiscal solvency. This includes making sure that each health plan has the required amount of Tangible Net Equity (TNE) to meet the requirements of the Knox-Keene Act. Health plans submit quarterly financial statements that are reviewed by DMHC staff. If there are concerns, DMHC staff will submit inquiries as appropriate and will require monthly monitoring if needed. DMHC review includes on-site audits. If the case is extreme, the DMHC has enforcement options that include the insertion of a monitor or even taking over a plan.

The DMHC regularly reviews the financial solvency of Risk Bearing Organizations (RBOs) to assure compliance with the solvency grading criteria, including TNE, working capital and maintaining cash to claims ratio of 0.75. The ongoing oversight includes quarterly self-reported submissions along with annual audited financial statements. The DMHC may also audit an RBO as needed. If an RBO is not compliant with the solvency grading criteria, the RBO is required to submit a corrective action plan to the DMHC for approval.

3. Related Factors That Ensure Timely Access to Care

Ensuring timely access to care for HFP members transitioning into Medi-Cal is a primary focus of the departments involved in this transition. Timely access to care will be reviewed utilizing the following mechanisms:

- *Network Adequacy Assessments.* The network adequacy review being conducted by the departments will focus on access to physicians and continuity of care. By evaluating whether plans and their providers have the steps in place to ensure member assigned physicians continue services during the transition.
- *Express Lane Eligibility (ELE) and Accelerated Enrollment (AE).* As described above, DHCS will employ ELE, as appropriate/applicable, based on CMS guidance, for transitioned cases and AE, for new cases in accordance with current Medi-Cal policy, to ensure that children do not experience a delay in care due to difficulties obtaining or verifying benefit eligibility.
- *Timely Access Reporting.* On an annual basis, DMHC reviews timely access reports from health plans related to plan compliance with appointment time-elapsed standards as set forth in the Knox Keene Act and supporting regulations. Medi-Cal Managed Care plans are required to participate in this reporting and are subject to DMHC review for compliance with timely access standards.

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F. Federal Approvals

DHCS has begun engagement with CMS regarding needed federal approvals for the transitions. In order for the transition to occur, the federal approvals necessary are the Title XIX and Title XXI State Plan Amendments and an amendment to the federal Section 1115 Bridge to Reform Waiver. Federal approvals are needed prior to any transitions taking place. In accordance with federal requirements, Tribal notification of the HFP Transition to Medi-Cal was released on August 24, 2012. Tribal entities have 30 days from receipt of the notice to provide input on the proposed SPA and Waiver changes. Also on August 30, 2012, DHCS discussed the effects of the transition on Native Americans in a webinar.

Proposed SPA Approvals (Title XIX or XXI, as determined appropriate by CMS)

- Provide full-scope Medi-Cal to children who are optional targeted low-income children with family incomes up to and including 200 percent of the FPL.
- Use of less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent of the FPL up to and including 250 percent of the FPL.
- Use of premiums for families with incomes above 150 percent of the FPL and up to and including 250 percent of the FPL (after applying the applicable income disregards).
- Use of ELE, to the extent necessary, for transitioned children and for DHCS to rely on findings determined by MRMIB regarding one or more components of eligibility determined prior to the transition.
- Ability to transition the children from HFP to Medi-Cal in accordance with the four transition phases.
- Changing the delivery system of Children's Health Insurance Program (CHIP) for those children with family incomes at and below 250 percent of the FPL (HFP in California) from that described in the CHIP Title XXI State Plan to the Medi-Cal delivery system described in the Medicaid Title XIX State Plan.

Proposed Section 1115 Bridge to Reform Waiver Approvals

- Addition of the new Targeted Low Income Population as a covered group under the waiver.
- Use of the Medi-Cal managed care and dental managed care delivery systems for the transitioned children in counties where managed care exists.

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- Revised Cost Neutrality.

G. State Monitoring of Managed Care Health Plans' Performance and Accountability for Provision of Services

In order to monitor managed care health plans' performance and accountability for provision of services ongoing, DMHC and DHCS will engage in the following efforts:

DMHC Plan Surveys. Pursuant to Health and Safety Code section 1380, DMHC surveys health plan operations once every three years to evaluate compliance with Knox Keene provisions related to health plan operations. These surveys utilize methods such as policy and procedure review, file review, and interviews with key health plan staff to evaluate health plan compliance.

DHCS Plan Surveys and Audits. Pursuant to each health plan's contract, DHCS monitors all aspects of the contractor's operation for compliance with the provisions of the contract and applicable Federal and State laws and regulations. Such monitoring activities include, but are not limited to, inspection and auditing of the contractor, subcontractor, and provider facilities, and management systems. Most surveys are conducted every 2 years and audits every 3 years.

Performance Measures and Metrics

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 Medi-Cal managed care 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.

Dental plan metrics will include, but will not be limited to, provider network adequacy, overall utilization of dental services, annual dental visits, use of preventive dental services, use of dental treatment services, use of examinations and oral health evaluations, sealant to restoration ratio, filling to preventive services ratio, treatment to caries prevention ratio, use of dental sealants, use of diagnostic services, and a survey of member satisfaction with plans and providers. All performance measures will be monitored for Dental Managed Care plans as well as Fee-for-Service, Denti-Cal. An annual report will be produced to represent the findings, similar to the current Healthy Families Quality Report. This report will be publicly reported and posted on the DHCS Denti-Cal website.

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H. Conclusion and Next Steps

Throughout the transition, DHCS, MRMIB, and DMHC's goal will be to work cooperatively to facilitate a smooth transition, ensure minimum disruption in services, maintain existing eligibility gateways, and ensure access to and continuity of care. We look forward to engaging with you—consumers, stakeholders, and legislative staff—in the development of each phase's implementation plan and encourage you to send your comments, questions, and other feedback to us throughout this period of transition.

DHCS Information/Questions

DHCSHealthyFamiliesTransition@dhcs.ca.gov

<http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx>

MRMIB Information/Questions

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