ENCLOSURE

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

08-001*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page (s)
Section 3: page 31e (TN 07-005), pages 31f thru 31l (TN 03-009) page 31m (TN 07-005) pages 31n- 31p (TN 03-009)	**None**
None/New Amendment	**Attachment 3.1-F, pages 1-25 (New Attachment)**
Attachment 3.7A, pages 2-11 (TN 07-005)	**None**
Attachment 3.7B, pages 1-10 (TN 06-005)	**None**

*Attachment 3.1-F, pages 1-25 replaced Section 3, pages 31e-31p of the State Plan and removed Attachment 3.7A and Attachment 3.7B altogether

Citation		Condition or Requirement
1932(a)(1)(A)	A.	Section 1932(a)(1)(A) of the Social Security Act.

The State of **California** enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

The various models have been in operation as follows: Sacramento Geographic Managed Care (GMC) as of April 1, 1994, Two-Plan Model as of January 22, 1996, and Healthy San Diego Geographic Managed Care as of October 16, 1998.

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

__**X**__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

This program is called Medi-Cal Managed Care (MMC). The program is being implemented in select counties and ZIP Codes throughout California. All Medicaid beneficiaries, depending on the beneficiaries' geographic location, and Medi-Cal eligibility-related aid code, as described in Section D, are required to enroll in a managed care organization (MCO). Those Medicaid beneficiaries as described in Section G, are not subject to mandatory enrollment, but are permitted to voluntarily enroll in a MCO. Regardless of model, all MCOs are risk-comprehensive contracts.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;
__**X**__ ii. capitation;
____ iii. a case management fee;

Citation	Condition or Requirement
	____iv. a bonus/incentive payment; ____ v. a supplemental payment, or __X_vi. other. (Please provide a description below). **Former Agnews Residents:** **The managed care health plans that the Department contracts with to provide services to Former Agnews Residents will paid under a non-risk arrangement as described in 42 CFR 438.2 and 42 CFR 447.362. The Department's payments to the health plans will not exceed what the Department would have paid on a fee-for-service basis for services furnished to health plan enrollees plus the net savings of administrative costs the Department achieves by contracting with the health plans instead of purchasing the services on a fee-for-service basis.**
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. __X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **On an ongoing basis, DHCS employs many methods to ensure public involvement:**

Citation	Condition or Requirement

- **The Medi-Cal Managed Care Advisory Group: DHCS Medi-Cal Managed Care Division (MMCD) Advisory Group was formed in December 1998, as a vehicle to facilitate active communication between the Medi-Cal managed care program and all interested parties and stakeholders. The MMCD Advisory Group membership consists of advocacy groups, health plan representatives, medical associations, and the State's enrollment broker. The Advisory Group meetings are held in Sacramento and are chaired by the MMCD Division Chief. This group is routinely advised about issues relevant to Medi-Cal managed care, and is often solicited for feedback on issues such as informing materials and the State Quality Strategy.**

- **Tribal input is/will be solicited by direct inquiry to tribal councils and the California Rural Indian Health Board (CRIHB) regarding any future changes to the managed care program.**

- **Public input is/will be solicited in the future through published news articles produced by DHCS Public Information Office.**

1932(a)(1)(A)

5. The state plan program will___/will not_**X**_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_**X**_/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory)

Medi-Cal Managed Care/ Two-Plan Model:

- **Los Angeles, except (*see list of excluded ZIP Codes)**
- **Kern, except (**see list of excluded ZIP Codes)**
- **San Bernardino, except (***see list of excluded ZIP Codes)**
- **Riverside, except (***see list of excluded ZIP Codes)**
- **Tulare**
- **Fresno**
- **Santa Clara**
- **Stanislaus**
- **San Joaquin**
- **San Francisco**
- **Alameda**
- **Contra Costa**

Excluded ZIP Codes

***The Los Angeles Region includes Los Angeles County with the exclusion of the following ZIP Code, which covers Santa Catalina: -- 90704.**

****Kern County---93555 and 93556 Ridgecrest.**

Citation | Condition or Requirement

*****The San Bernardino/Riverside Region includes San Bernardino County and Riverside County with the exclusion of the following rural ZIP Codes in these counties:**

EXCLUDED RURAL CA ZIP CODES [illegible] SAN BERNARDINO COUNTIES		
ZIP CODE	**PREFERRED CITY NAME**	**COUNTY**
92225	Blythe	Riverside
92226	Blythe	Riverside
92239	Desert Center	Riverside
92275	Salton City	Riverside
92280	Vidal	Riverside & San Bernardino
92242	Earp	San Bernardino
92252	Joshua Tree	San Bernardino
92256	Morongo Valley	San Bernardino
92267	Parker Dam	San Bernardino
92268	Pioneer Town	San Bernardino
92277	Twenty-Nine Palms	San Bernardino
92278	Marine Base Corp	San Bernardino
92284	Yucca Valley	San Bernardino
92285	Landers	San Bernardino
92286	Yucca Valley	San Bernardino
92304	Amboy/Cadiz	San Bernardino
92305	Angelus Oaks	San Bernardino
92309	Baker	San Bernardino
92310	Fort Irwin	San Bernardino
92311	Lenwood/Barstow	San Bernardino
92312	Barstow	San Bernardino
92314	Big Bear City	San Bernardino
92315	Big Bear lake	San Bernardino
92317	Blue Jay	San Bernardino
92319	Cadiz	San Bernardino
92321	Cedar Glen	San Bernardino
92322	Cedarpines Park	San Bernardino
92323	Cima	San Bernardino
92325	Crestline	San Bernardino
92326	Crest Park	San Bernardino
92327	Daggett	San Bernardino
92332	Essex	San Bernardino
92333	Fawnskin	San Bernardino
92338	Ludlow (Newberry Springs)	San Bernardino
92339	Forrest Falls	San Bernardino
92341	Green Valley Lake	San Bernardino

Citation | Condition or Requirement

92342	**Helendale**	**San Bernardino**
92347	**Hinkley**	**San Bernardino**
92352	**Lake Arrowhead**	**San Bernardino**
92356	**Lucerne Valley**	**San Bernardino**
92363	**Needles**	**San Bernardino**
92364	**Nipton**	**San Bernardino**
92365	**Newberry Springs**	**San Bernardino**
92366	**Mountain Pass**	**San Bernardino**
92368	**Oro Grande**	**San Bernardino**
92372	**Pinon Hills**	**San Bernardino**
92378	**Rimforest**	**San Bernardino**
92397	**Wrightwood**	**San Bernardino**
92382	**Running Springs**	**San Bernardino**
92385	**Skyforest**	**San Bernardino**
92386	**Sugarloaf**	**San Bernardino**
92391	**Twin Peaks**	**San Bernardino**
92398	**Yermo**	**San Bernardino**
93528	**Johannsburg**	**San Bernardino**
93554	**Johannsburg**	**San Bernardino**
93558	**Red Mountain**	**San Bernardino**
93562	**Trona**	**San Bernardino**
93592	**Trona**	**San Bernardino**

Medi-Cal Managed Care/Geographic Managed Care (GMC):

- **Sacramento**
- **San Diego**

ii. county/counties (voluntary) **see Section B item 5 i above**
iii. area/areas (mandatory) **see Section B item 5 i above**
iv. area/areas (voluntary) **see Section B item 5 i above**

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. _X_The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)

2. ___The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

Not Applicable

Citation	Condition or Requirement
42 CFR 438.50(c)(2) 1902(a)(23)(A) 1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362	7. _X_The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. **Former Agnews Residents:** **The managed care health plans that the Department contracts with to provide services to Former Agnews Residents will paid under a non-risk arrangement as described in 42 CFR 438.2 and 42 CFR 447.362. The Department's payments to the health plans will not exceed what the Department would have paid on a fee-for-service basis for services furnished to health plan enrollees plus the net savings of administrative costs the Department achieves by contracting with the health plans instead of purchasing the services on a fee-for-service basis.**
42 CFR 438.50(c)(6) 45 CFR 74.40	8. _X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. **Title XIX of the Social Security Act applicable sections:** **A. 1925** **B. 1905 (u)(2)** **C. 1931** **D. 1902(a)(10)(A)(i)(III)**

Citation	Condition or Requirement

E. 1902(a)(10)(A)(i)(IV)
F. 1902(a)(10)(A)(i)(VI)
G. 1902(a)(10)(A)(i)(VII)

Enrollment will be mandatory for beneficiaries who meet the criteria for A-G above, and are not ineligible to participate because they fail to meet any of the following additional criteria listed in a-c below:

a. Are eligible to receive Medi-Cal services that are not limited in scope. If services are limited in scope, the beneficiary is not eligible to enroll. Limited scope means a subset of the scope of benefits as described in the state plan with or without a share-of-cost.
b. Have been determined to have a share-of-cost equal to zero. If the share of cost is greater than zero, the beneficiary is not eligible to enroll.
c. Have been found by their county welfare department to be eligible under one of the following programs (Section D 2i-2vii) and do not qualify for an exemption to mandatory enrollment.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. _X_Recipients who are also eligible for Medicare.

In the case of a beneficiary who is in a mandatory aid code whose eligibility is subsequently changed to a voluntary aid code, the individual would be allowed to exercise their right to disenroll from a managed care plan. Individuals are informed of their rights by the enrollment broker at the time they become eligible for Medicare.

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. _X_Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Members of Federally recognized tribes, Native American Indians, Alaskan Native, or qualified non-Indian (means the immediate family member), or a non-Indian who has been verified by the

Citation	Condition or Requirement
	Indian Health Service Center as receiving services there, may choose to disenroll and receive health care services from an Indian Health Service Center. Alternatively, American Indians and Alaskan Natives may choose to enroll on a voluntary basis.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _**X**_Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. ___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. _**X**_Children under the age of 19 years who are in foster care or other out-of-the-home placement. **For children who cannot be immediately identified as foster care by Medi-Cal's unique identifier, upon obtaining concurrence of the child's caretaker, a county director of social services, his/her designee in one of the designated counties, or the Probation Officer in the case of a foster child who is a ward of the court, a foster child may be enrolled voluntarily into an available managed care plan. Similarly, an adoptive parent may voluntarily enroll an Adoption Assistance Program (AAP) child into an available managed care plan.**
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _**X**_Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. **See comment in Section D item v. above**
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ___Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. **Children receiving services through the California Children's Services (CCS) program in geographic areas served by either the Two-Plan, San Diego GMC, or Sacramento GMC models of managed care will be mandatorily enrolled into a Two-Plan or GMC model MCO under a separate Section 1915(b) waiver.**
	E. <u>Identification of Mandatory Exempt Groups</u>
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services*

Citation		Condition or Requirement
		at a specific clinic or enrolled in a particular program.) **The State's definition includes all children receiving services through the CCS program.** **Children receiving services through the CCS program in geographic areas serviced by the Two-Plan , San Diego GMC, or Sacramento GMC models of managed care will be mandatorily enrolled into a Two-Plan or GMC model MCO under a separate Section 1915(b) waiver. Identification of this population is possible by:** • **A Medi-Cal unique identifier on the eligibility file.** • **CMS Net-an automated case management system that includes the CCS programs' demographic data, or** • **For those counties not on CMS Net, a manual report is prepared by the county and distributed to each managed care plan the recipient is enrolled in.**
1932(a)(2) 42 CFR 438.50(d)	2.	Place a check mark to affirm if the state's definition of title V children is determined by: _**X**__ i. program participation, ____ ii. special health care needs, or ____ iii. Both
1932(a)(2) 42 CFR 438.50(d)	3.	Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _**X**__ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; **By Medi-Cal or other unique identifier or by self identification** ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **Not applicable**

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; **By Medi-Cal or other unique identifier or by self identification** iv. Children under 19 years of age who are receiving foster care or adoption assistance. **By Medi-Cal or other unique identifier or by self identification**
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Children not otherwise identified by unique identifiers are allowed to self-identify to the State and be exempt from mandatory enrollment.**
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. **There is a unique other health coverage code on the Medi-Cal Eligibility Data System (MEDS) record.** ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. **By self identification**
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment **1. The following populations may be excluded from mandatory enrollment upon filing an exemption with the State's enrollment broker, and receiving services through traditional Fee-For-Service (FFS).**

Citation	Condition or Requirement

A. Non-Medical:
Enrolled in a waiver for skilled nursing services in their home.

B. Medical:
Beneficiaries being treated for a complex condition from a physician, who is participating in the Medi-Cal program but is not a contract provider of themanaged care plans in the service area, may request exclusion from mandatory enrollment upon filing an exemption with the State's enrollment broker and receive services through traditional FFS. Complex conditions include:

1. **Pregnancy;**
2. **Cancer;**
3. **Organ transplant (except Kidney) – or are scheduled for one;**
4. **Renal disease and have dialysis at least two times a week;**
5. **A disease that affects more than one organ system (such as diabetes);**
6. **HIV positive;**
7. **A neurological disorder (such as multiple sclerosis); and**
8. **Other conditions as determined by the State.**

2. The following populations are excluded from enrollment in an MCO under this state plan:

A. If another health coverage code indicates Medicare coverage, the beneficiary will be excluded from enrollment unless they are enrolled in Medicare in the same plan or their plan partners approved Medicare Advantage Special Needs Plan.
B. Individuals eligible for Medicaid after paying a share of cost.
C. Individuals already residing in a Long Term Care (LTC) (includes: nursing facility, sub-acute, pediatric, and intermediate care facilities) facility at the time Medicaid is approved.
D. Individuals who have an eligibility period that is less than 3 months.
E. Individuals who have an eligibility period that is only retroactive.
F. Individuals eligible for Limited Services (See page 7).
G. Members of a commercial health plan through private insurance that are identified as having specific "other health coverage" at the time of initial enrollment eligibility. If an individual acquires other health coverage after enrollment in a plan, the State will allow the member to remain enrolled on a voluntary basis in the plan.

Citation	Condition or Requirement

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

1. Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria as described in section 2 of the California State Plan, including related attachments and supplements:

A. Are eligible to receive services that are not limited in scope.
B. Have been determined to have a share of cost equal to zero.
C. Have been determined by their county welfare department to be eligible for one of the following programs:

Title XIX of the Social Security Act applicable sections:

1. **1902(a)(10)(A)(ii)(XVIII)**
2. **1902(a)(10)(A)(i)(I)**
3. **1902(a)(10)(C)**
4. **1902(a)(10) (A)(ii)(X)**
5. **1902(a)(10)(A)(i)(II)**
6. **1902(a)(10)(A)(ii)(XVII)**
7. **1634**

D. Beneficiaries enrolled in one of the following forms of other health coverage, obtained after enrollment in a Medi-Cal managed care plan, shall be allowed to remain enrolled:

1. **Medicare HMO (subject to restrictions on Page 12, Section F 2-A).**
2. **Tricare HMO.**
3. **Kaiser HMO.**
4. **Any other HMO, or prepaid health plan in which the enrollee is limited to a prescribed panel of providers for comprehensive services.**

H. Enrollment process.

Use of an enrollment broker:

Process:

The enrollment broker will conduct in-person enrollment sessions in each county with all Medicaid eligible beneficiaries that voluntarily choose to attend.

Citation	Condition or Requirement

Beneficiaries are informed of these sites through the presentation schedule included in the enrollment packets. Referrals are also made by eligibility workers and the enrollment broker's call center staff.

The State assures the information will be presented to non-English speaking participants in a culturally competent manner. Accommodations for the visually and hearing impaired, and the physically disabled are made available.

***GMC exception: In San Diego County, county employees will conduct in-person enrollment sessions with all Medicaid eligibles that voluntarily choose to attend.**

Content:

The content of the enrollment sessions includes information as follows:

- **A. Description of what is a Medi-Cal MCO;**
- **B. Who must vs. who may join a MCO;**
- **C. Those who are not eligible to join a MCO;**
- **D. Those who may be exempt from mandatory participation in a MCO;**
- **E. Service and items covered by the MCO;**
- **F. Benefits outside the managed care contract, and how participants may access these services;**
- **G. How to change Primary Care Providers (PCPs) or MCOs; and**
- **H. Grievance and appeal rights provided by the MCOs and the State Hearing process, and the procedures for using them.**

Enrollment Packets:

The population subject to the initial process includes those Medi-Cal beneficiaries in mandatory aid codes who are eligible for enrollment in a managed care plan.

Beneficiaries who are newly eligible for enrollment in a mandatory aid code managed care plan are mailed an Intent to Assign (IA) Packet. The IA process is as follows:

- **A. The enrollment broker receives the newly eligible list and an IA record is generated;**
- **B. The IA records are sent and received by the enrollment broker mail house, which has three days to process them;**
- **C. The enrollment broker prepares the IA packet and mails it to the newly eligible. Five days are allowed for mail time;**

Citation	Condition or Requirement

D. The newly eligible has 30 days to decide on a plan and respond with his/her decision; and

E. When the newly eligible's response is received, a transaction is processed and he/she is enrolled in the plan. The enrollment packet contains the directive that eligible beneficiaries may change plans at any time after this selection.

Annual Renotification Process:

Managed Care enrollees are again informed of their right to change health plans at any time during the Annual Renotification process. This process includes sending a notice to each enrollee that has been in the same plan for ten consecutive months. The notice includes a "tear off" postcard that can be mailed back requesting materials for changing health plans.

Should a beneficiary request disenrollment from their current plan during the renotification process or at any other time, the request will be processed no later than the end of the month following the month in which the request to disenroll is received by the enrollment broker.

(H. Enrollment Process Continued)

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollment will be based upon maintaining a prior family-plan relationship, or where not possible, a default algorithm will be used. Assignments made for continuity of care are not considered to be default assignments.

Citation	Condition or Requirement
	The State will use an enrollment broker, and the criteria for assigned enrollment are described below. **When a beneficiary is assigned to a plan, a weighted assignment method shall be used to determine the plan to be assigned. Considerations that apply include, but are not limited to, the following:** **A. A beneficiary shall only be assigned to a managed care plan with a primary care service site in the same ZIP Code as the beneficiary's residence;** **B. A beneficiary shall be assigned to the same managed care plan as:** **1. that in which he/she was previously enrolled;** **2. that in which a head of household (case head) is enrolled** **3. if the case head is not enrolled in a plan, then that in which another family member is enrolled.** **However, provided at least one family member has maintained managed care assignment history, and in order to preserve continuity of care, the following considerations shall be taken into account for each assignment:** **A. Continuity of care is maintained at a case/household level;** **B. At least one member of the household must remain continuously eligible within the county for continuity of care to be assigned to someone within that case;** **C. If a member of the case loses eligibility for more than 120 days, the case history is archived; however, should the member re-establish eligibility, continuity of care will be restored based on the case;** **D. If all members of the case lose eligibility for more than 120 days, the case is archived, and continuity of care is lost; and** **E. If the entire case moves out of the county of eligibility, continuity of care is lost.**
	ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). **Two-Plan and GMC plans are required to contract with traditional and safety net providers and they must make a reasonable effort to maintain the ongoing participation of these**

Citation	Condition or Requirement
	types of providers. Plans are required to ensure that these providers are proportionately included in the assignment process for members who do not voluntarily select a primary care physician.
	iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	A formula, based on eight performance measures, six of which come from Health Effectiveness Data and Information Set (HEDIS) and two safety net measures, determines the equitable distribution of Medi-Cal beneficiaries. The State's default process is based on health plan performance with a greater number of beneficiaries being assigned to higher performing Two-Plan and GMC health plans. A cap is placed on auto assignments preventing one plan from capturing a hundred percent of the defaults should one plan perform exceptionally well and another perform poorly.
	The two safety net measures ensure that plans are given credit for using traditional and safety net providers in their network. All distributions of beneficiaries to plans are checked by the State each month to determine that all auto-assignments are done correctly according to the formula. If a health plan is at capacity or cannot take enrollments for a particular period, the beneficiaries are distributed to the other health plans.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will____/will not_**X**_ use a lock-in for managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be within:
	30 days of receiving the enrollment packet.

Citation	Condition or Requirement

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Medicaid recipients who are subject to mandatory enrollment, but fail to make a choice within 30 days of receiving an enrollment packet, shall be automatically enrolled (defaulted) into a MCO as follows:

A. If no response is received within 20 days of the mailing of the enrollment packet, an Intent to Default (ID) letter is mailed.
- **The ID letter will address:**
  1. **A reminder that unless the eligible responds to the IA packet, he/she will be assigned to a MCO by default, and the effective date of assignment, and;**
  2. **Reiterates the date in which he/she must respond by in order to preclude assignment.**

B. If still no response is received, a default transaction is created and sent to Medi-Cal Eligibility Data System (MEDS).

C. Then a confirmation letter is generated and mailed to the beneficiary informing them of the name of the plan assigned and the effective date of the assignment.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.) How are they notified of this right to change plans?*

If no response is received within 20 days of the mailing of the enrollment packet, an ID letter is mailed to the beneficiary. This letter informs the beneficiary that should they not be satisfied with the plan assigned to them, they are able to change plans by completing a choice form.

The beneficiary may choose to change plans at any time after receiving the official default notification from the enrollment broker. If the beneficiary decides to change plans, the beneficiary may call the enrollment broker's toll-free telephone number for additional assistance.

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The enrollment broker shall adhere to the State's algorithm for a performance-based auto-assignment of beneficiaries to the various managed care plans in Two-Plan and GMC Model counties, pursuant to State regulations (California Code of Regulations, Title 22, Section 53820), and written directives.

A description of the most significant parameters is as follows:

- **A. The distribution of auto-assignments will be determined based on an assessment of comparative plan performance on eight measures.**
- **B. Six of the measures come from HEDIS: Childhood Immunizations: Combination 2, Well-Child Visits: 3rd – 6th Years of Life, Adolescent Well-Visits, Timeliness of Prenatal Care, Appropriate Medications for People with Asthma, and Cervical Cancer Screening. The DHCS used the first five measures for the first two years, and for Year three added one additional HEDIS measure, Cervical Cancer Screening. There are also two safety net provider support measures that were created through collaboration among MCOs and DHCS: Members Assigned to Safety Net Provider PCPs and Discharges at Disproportionate Share Hospital (DSH) Facilities.**
- **C. For the HEDIS measures, a health plan will be awarded two points for a score that is statistically and significantly better than those of its competitor. If there is no statistical difference in rates, each plan will get one point.**
- **D. For each of the safety net provider support measures, a plan will be awarded one point if its rate is 5 percent higher than that of its competitor, with an additional 0.25 (1/4) points awarded for each additional 5 percent difference, up to a maximum of two points being awarded for a difference of 25 percent or more.**
- **E. For each of the first three years (Year three began on Dec 1, 2007 and ends November 30, 2008), the percentage of auto-assignments received by a plan will not change more than 10 percent from the prior year.**

Citation	Condition or Requirement

F. Beginning in the second year, plans were awarded one point for demonstrating statistically significant improvement for each measure relative to prior year performance, with the possible loss of one point for a statistically significant decline in performance as well. Those plans determined by DHCS to have exceptionally strong performance automatically earn a point and are not required to demonstrate statistically significant improvement.

G. Eliminates the minimum enrollment level for LI.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The default rates are monitored through a reporting process. Health Care Options (HCO) receives daily, weekly, and monthly reports from the enrollment broker that are required for monitoring the default process. Monitoring is done as follows:

A. Review the Daily Status Report- provides a breakdown of enrollment into the Two-Plan and GMC plans in each managed care county and the default ratios for each county.

B. Review the Monthly Managed Care Maximum Enrollment Report – provides information on the maximum and minimum beneficiary enrollment capitations of all Two-Plan and GMC managed care plans.

C. Review the Monthly Enrollment Default Percentages Report –provides county specific default percentages for all managed care counties.

D. Review the MSC-B-M02 Monthly Enrollment summary – provides formula determined default percentage rates for the Two-Plan and GMC.

E. Review the Monthly Progress Report – provides a summary of the MSM-B-M22 Monthly Cumulative Medical Beneficiaries Assigned to Two-Plan and GMC plans.

F. Random sampling of the processed enrollment forms.

The default rates are monitored daily and determined on a monthly basis for plan accuracy.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _**X**_The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _**X**__The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _**X**_This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _**X**_ This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   _**X**_This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_**X**_ use lock-in for managed care.
   Not Applicable

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

   _**X**__The state assures that beneficiary requests for disenrollment (with

Citation	Condition or Requirement
	and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe any additional circumstances of "cause" for disenrollment (if any).
	The State does not limit disenrollment. The enrollee may request to switch plans at any time. However, actual disenrollment does not take effect until the first day of the following month.
	K. Information requirements for beneficiaries
	Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	_**X**__ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)
	All services included in the approved California Medicaid State Plan are provided by the MCOs under this State Plan Amendment, with the following exceptions:
	• **Services for major organ transplant procedures that are Medi-Cal benefits (except for kidney transplant).**
	• **Long Term care (LTC) services in a facility for longer than the month of admission plus one month.** ○ **For former Agnews residents, LTC is defined as care in a facility for longer than the month of admission plus three months.**
	• **Home and Community Based Services (HCBS) waiver program services authorized under section 1915 (c) of the Social Security Act, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver.**
	• **Services authorized by the California Children Services (CCS) program.**
	• **Mental health services which are outside the scope of PCPs. (Except in the cases of Western Health Advantage and Kaiser in Sacramento County. Kaiser is responsible for all mental health services (including inpatient and outpatient specialty mental health services) and Western Health Advantage is responsible for all outpatient mental health services).**

Citation	Condition or Requirement

- **Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health providers, with the exceptions listed above for Western Health Advantage and Kaiser in Sacramento County.**

- **Alcohol and substance abuse treatment services available under the Drug Medi-Cal program as defined in CCR, Title 22, Section 51341.1 and outpatient heroin detoxification services defined in CCR, Title 22, Section 51328.**

- **Fabrication of optical lenses provided through Prison Industry Authority optical laboratories.**

- **Directly observed therapy for treatment of tuberculosis provided by local health departments.**

- **Dental services as specified in CCR, Title 22, Section 51307 and Early Periodic Screening Diagnosis and Treatment (EPSDT) supplemental dental services as described in CCR, Title 22, Section 51340.1(a). However, Contractor is responsible for all Covered Services that are within the scope of the PCP regarding dental services.**

- **Acupuncture services as specified in CCR, Title 22, Section 51308.5 (Two-Plan model only).**

- **Chiropractic services as specified in CCR, Title 22, Section 51308 (Two-Plan model only).**

- **Prayer or spiritual healing as specified in CCR, Title 22, Section 51312 (Two-Plan model only).**

- **Local Education Agency (LEA) assessment services as specified in CCR, Title 22, Section 51360(b)(1) provided to a member who qualifies for LEA services based on CCR, Title 22, Section 51190.1(a).**

- **Any LEA services as specified in CCR, Title 22, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq., or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in CCR, Title 22, Section 51360.**

Citation	Condition or Requirement

- **Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHCS.**
- **Adult Day Health Care.**
- **Pediatric Day Health Care.**
- **Personal Care Services.**
- **State supported Services.**
- **Targeted case management services as specified in CCR, Title 22, Sections 51185(h) and 51351. Except that the MCO shall be responsible for: 1) coordinating health care with the Targeted Case Management (TCM) provider and for determining medical necessity of diagnostic and treatment services recommended by the TCM provider, and 2) ensuring access to services comparable to EPSDT TCM services for those members under age 21 who are not accepted for TCM services.**
- **Childhood lead poisoning case management provided by county health departments.**
- **Specific psychotherapeutic drugs and psychotherapeutic drugs classified as Anti-Psychotics and approved by the Federal Food and Drug Administration (FDA) after July 1, 1997.**
- **Specific Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) drugs and HIV/AIDS drugs classified as Protease Inhibitors, Nucleoside Reverse Transcriptase Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors, and Nucleoside Analog Reverse Transcriptase Inhibitor Combination approved by the FDA after July 1, 1997 and any future category of drugs for the treatment of HIV and AIDS, not previously classified and those classified as Fusion (Entry) Inhibitors, approved by the FDA after March 1, 2003.**

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will **X** /will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation	Condition or Requirement

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

Two-Plan Model:

The State will contract with two MCOs in each county to provide services, and beneficiaries will have a choice between these two plans* (See exceptions below for Stanislaus, Tulare, and Fresno Counties).

In general, the State will contract with one MCO, referred to as the Local Initiative health plan and one MCO, referred to as the Commercial Plan. The Local Initiative is a locally developed comprehensive managed care system, developed under the leadership of the County Board of Supervisors. It is essentially a public-private partnership that will have a contractual obligation to include traditional and safety net providers in its network. If there is no Local Initiative in a particular county, the State may seek to contract with two Commercial Plans.

***In Stanislaus and Tulare, the County has designated a Commercial Plan to act as the Local Initiative. In Fresno County, there are two Commercial Plans.**

The Commercial Plan contractors in the Two-Plan Model are awarded through the competitive bid process in accordance with Title 22, CCR (California Code of Regulations), Section 53800(b)(1). The Request for Proposal (RFP) bidding method is used due to the highly complex nature of the services to be provided. The resulting contracts are generally entered into for a period of up to eight years, having an original term of five years with three one-year extensions. The average RFP process takes approximately 18 months to complete. Therefore, it should begin at least 18 months prior to end of the eight-year period. Since contracts for the Two-Plan contractors were executed at various dates, the RFP process is staggered so that various geographic areas are solicited during each proposal cycle.

For former Agnews residents: Services will be provided by the Medi-Cal managed care health plans that are operating as Local Initiatives in Santa Clara and Alameda counties, based on their networks' readiness to serve the health care needs of this population, if consumers, where applicable, choose to enroll.

Citation	Condition or Requirement
	GMC:
	The State will contract with multiple MCOs to provide services and beneficiaries will have a choice of no less than two plans.
	The selective contracting provision is not applicable to the GMC model
	4. __ The selective contracting provision is not applicable to this state plan.