



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

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Mr. Robert Nelb
Project Officer
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-02-26
Baltimore, MD 21244-1850

Ms. Angela Garner
Deputy Director
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Ms. Gloria Nagle, PhD, M.P.A
Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services, Region IX
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

**CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (No. 11-W-00193/9)
AMENDMENT COORDINATED CARE INITIATIVE**

Dear Mr. Nelb, Ms. Garner, and Ms. Nagle:

The State of California proposes to amend the Special Terms and Conditions (STC) and Expenditure Authority of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration (Waiver), pursuant to STC paragraph 7.

The amendments would allow the Department of Health Care Services (DHCS) to carry out the State of California's Coordinated Care Initiative (CCI) in eight select counties to integrate Medicare and Medicaid benefits for dual eligibles, mandatorily enroll dual eligibles, and integrate long term services and supports (LTSS) as managed care benefits.

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The State is requesting that this waiver amendment have an effective date of: January 1, 2014, and is prepared to work diligently to respond to any questions, or provide any information the Centers for Medicare and Medicaid Services (CMS) may need in order to secure prompt approval of this amendment.

Background

In January 2012, Governor Brown announced his Coordinated Care Initiative (CCI) to enhance health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities (SPDs) by shifting service delivery away from institutional care, and into the home and community. Governor Brown enacted the CCI by signing Senate Bill (SB) 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012). The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than January 1, 2014.

There are three major components of the CCI:

1. **Cal MediConnect:** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries that will coordinate medical, behavioral health, long-term institutional and home- and community-based services through a single health plan.

The framework for the Cal MediConnect program was approved by CMS and documented in a Memorandum of Understanding (MOU) between CMS and DHCS. This waiver amendment requests approval of all provisions of the MOU as necessary to implement and operate the Cal Medi-Connect program. The MOU was signed on March 27, 2013, and is available at the following link:
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>

2. **Mandatory Enrollment of Dual Eligibles into Medi-Cal Managed Care:** All dual eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care organization to receive their Medi-Cal benefits. This includes beneficiaries who opt out or are excluded from enrollment in a Cal MediConnect plan.

- 3. Inclusion of Long Term Services and Supports in Managed Care (MLTSS):** Beneficiaries enrolled in a Medi-Cal managed care health plan or a participating Cal MediConnect plan will receive their long-term services and supports through the plan. LTSS includes the following:
- In-Home Supportive Services (IHSS) – personal care for people who need help to live safely at home.
 - Community Based Adult Services (CBAS) – adult day health care provided at special centers. This service is currently available through the health plans.
 - Multipurpose Senior Services Program (MSSP) – provides social and health care coordination services for people 65 and older. Health plans will work with MSSP providers to provide this service.
 - Nursing home care – long-term care provided in a facility.

Description of Waiver and Effective Date

To enable the state to comply with state law establishing the CCI, DHCS proposes changes to California's existing Waiver in order to waive the requirements of the federal Medicaid program regarding payment to providers, freedom of choice, statewide, amount, duration and scope of services, and comparability. These changes to the Waiver will do the following:

- Allow the state to implement a Medi-Cal and Medicare combined product, capitated reimbursement rate, and passively enroll (if beneficiaries do not make a choice) duals in a participating Cal MediConnect plan for their Medicare and Medi-Cal benefits.
- Allow the state to expand mandatory Medi-Cal managed care enrollment to Duals in the eight CCI counties.
- Allow the state to require Duals and Medi-Cal only beneficiaries receiving long term services and supports to receive those benefits through Medi-Cal managed care health plans.

The above changes would be in effect in the eight participating counties in 2014. Specified categories of beneficiaries would be exempt from these requirements.

Waiver Authority

DHCS believes the existing waivers of freedom of choice, statewide, and comparability encompasses this proposed amendment. To the extent necessary, DHCS requests that the authority to operate under these waivers extend to the amendments contained in this request.

Special Terms and Conditions and Expenditure Authority

This proposed waiver amendment will impact the existing Waiver expenditure authority. Applicable changes to the Waiver STCs and the expenditure authority documents will be developed in conjunction with CMS during the consultative period of the amendment.

Public Notice and Tribal Notice

As required by STC Paragraph 7 and STC Paragraph 14, DHCS conducted public notice of this amendment to the Waiver through:

1. Public Notice and Processing:

- Public budget hearings in 2012 and 2013, as well as inclusion in the state budget in these years.
- Numerous stakeholder meetings regarding the policy development of CCI with beneficiaries, advocates, health plans, providers and their representatives, and county representatives. DHCS sponsored stakeholder meetings included:
 - Beneficiary Enrollment, Notification, Appeals, and Protections (met April 12, April 25, May 10, May 24, June 7, June 21 and August 7, 2012).
 - Provider Outreach and Engagement (met April 19 and June 13, 2012).
 - IHSS Coordination (met May 11, May 17, November 30, 2012 and April 2, 2013.)
 - LTSS Integration (met May 3, June 28 and August 8, 2012).
 - Behavioral Health Integration (met April 18, May 16, June 20, August 15, October 3 and December 19, 2012).
 - Fiscal and Rate Setting (met June 5, 2012).
 - Signed MOU review (conference calls held on March 27 and 28, 2013)
 - Stakeholder meeting events, agendas and summaries are maintained on the DHCS's website at:
<http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx>.
- The development of a stakeholder distribution list:
 - DHCS has developed and is maintaining a stakeholder list that includes beneficiaries, advocates, health plan representatives and other interested parties. This list currently has over 3,500 participants and is ongoing.
 - DHCS will continue to augment the stakeholder list as it receives new contact information and will continue to send notices to these stakeholders as needed (ongoing).

2. Tribal Notice:

- On April 13, 2012, DHCS issued a Tribal Notice regarding the first major component of the CCI.
- On August 24, 2012, DHCS issued a second notice discussing the second and third components of CCI, which are the mandatory enrollment of Duals into Medi-Cal managed care, and the inclusion of MLTSS as a Medi-Cal managed care benefit.
- On February 22, 2013, DHCS issued a third notice with updates on the status the CCI Waiver resulting from the development of MOU with CMS.

Budget Neutrality

The CCI will be occurring in the eight selected counties and impacts the "With Waiver" and "Without Waiver" for all managed care enrollees in these eight counties beginning the effective date of the CCI program. Due to additional MLTSS benefits that will be offered to beneficiaries in these eight counties, beneficiaries currently counted under certain existing MEGs of the Budget Neutrality worksheet will need to be separated out from the existing MEGs from the effective date of the CCI, as they will have different PMPMs than non-demonstration COHS and TPM/GMC counties. DHCS proposes the addition of eight new Medicaid Eligibility Groups (MEGs) in order to include the CCI population and benefits.

There will be four distinct population categories within the CCI, with two new MEGs for each category for the COHS and the TPM/GMC CCI counties, respectively. This results in the need for eight additional MEGs to the budget neutrality. The additional CCI MEGs are further described below:

- Create two distinct rows for full-benefit duals that are eligible for the Demonstration in COHS and TPM/GMC counties. Services include Medicare and Medi-Cal benefits. These individuals/expenditures will neither add to, nor subtract from, the Budget Neutrality margin and will be treated similarly to the Adults Newly Eligible, CBAS/ECM populations where the "With Waiver" and the "Without Waiver" costs will be equal.
- Create two distinct rows for full-benefit duals that Opt-out of Cal MediConnect or are excluded from Cal MediConnect, and are mandatorily enrolled in managed care for their Medi-Cal only and LTSS benefits.
- Create two distinct rows for SPDs¹ in the eight CCI counties as they will now be receiving LTSS benefits through managed care. This population includes

¹ SPDs include Medi-Cal only and partial Duals (member has Medicare Part A or B, but not both)

Medi-only SPDs that were not previously mandatorily enrolled and partial duals (beneficiary has Medicare Part A or B, but not both). Prior to the effective date of the CCI, the populations in these MEGs would be included in the "Existing SPDs" and the "Special Population – SPDs" MEGs.

- Create two distinct rows for the population in the "Family" MEGs in the eight CCI counties, which would receive LTSS benefits through Medi-Cal Managed Care. Prior to the effective date of the CCI, this population would be included under the existing "Family COHS" and "Family TPM/GMC" MEGs

Concurrent with the approval of this amendment, DHCS requests the addition of two MEGs for dual eligibles back to the beginning of the Waiver, as a correction to the original Waiver budget neutrality worksheet. The two MEGs would account for:

- All dual eligibles that are mandatorily enrolled in all COHS counties
- Dual eligibles who voluntarily enrolled in TPM/GMC counties

It should be noted that the addition of these two rows is outside of the CCI and rather, is a necessary correction to the Budget Neutrality worksheet. Starting on the effective date of the CCI, beneficiaries in these two groups who are in the eight CCI counties will be placed in the appropriate CCI MEGs described above.

DHCS is in the process of developing capitation rates for the populations in the proposed new eligibility groups and anticipates discussions with CMS on the proposed changes to Budget Neutrality and potential impacts in the coming weeks.

Evaluation Design

DHCS will develop processes and protocols for evaluating the overall impact of the CCI program. The evaluation will include monitoring changes in person-level health outcomes, experience of care, costs by sub-population(s), and changes in patterns of primary, acute, and long-term care and social support services use and expenditures, using principles of rapid-cycle evaluation and feedback. For the Cal MediConnect program, California will collaborate with CMS throughout all monitoring and evaluation activities phases. Participating Plans will be required to submit all data required for the monitoring and evaluation of this initiative according to the data and timeframe requirements identified in the contracts with Participating Plans.

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Thank you for your assistance and consideration. DHCS is happy to assist you and your staff in any way as you review the proposed amendment. If you have any questions, please contact Margaret Tatar, Chief, Medi-Cal Managed Care Division at (916) 449-5000.

Sincerely,



Toby Douglas
Director

Enclosures

cc: Jane Ogle, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Health Care Delivery Systems, MS 4050
P.O. Box 997413
Sacramento, CA 95899-7413

Margaret Tatar, Chief
Medi-Cal Managed Care Division
Department of Health Care Services
1501 Capitol Avenue, MS 4400
P.O. Box 997413
Sacramento, CA 95899-7413

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
Amended Effective January 1, 2014

NUMBER: 11-W-00193/9

TITLE: California Bridge to Reform Demonstration

AWARDEE: California Health and Human Services Agency

I. PREFACE

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

As part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) was adopted to better coordinate Medicare and Medicaid benefits for dual eligibles, mandatorily enroll dual eligibles into managed care plans and to include long term services and supports (LTSS) as managed care benefits [Chapter 33, Statutes of 2012, Senate Bill (SB) 1008 and Chapter 45, Statutes of 2012, SB 1036, Committee on Budget and Fiscal Review]. The primary goals and objectives of the CCI are to improve health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), while achieving savings from rebalancing service delivery away from institutional care and into the home and community.

The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than January 1, 2014.

The three major components of the CCI are:

1. ***Cal MediConnect:*** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries that will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan.

The framework for the Cal MediConnect program was approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in a Memorandum of Understanding (MOU) between CMS and the California Department of Health Care Services (DHCS). This waiver amendment requests approval of all provisions of the MOU as necessary to implement and operate the Cal Medi-Connect program. The MOU was signed on March 27, 2013 and is available at the following link: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>

2. ***Mandatory Enrollment of Dual Eligibles into Medi-Cal Managed Care:*** All dual eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care organization to receive their Medi-Cal benefits. This includes beneficiaries who opt out or are excluded from enrollment in a Cal MediConnect plan.

3. ***Inclusion of Long Term Services and Supports (MLTSS) in Managed Care (MLTSS):*** Beneficiaries enrolled in a Medi-Cal managed care organization or a participating Cal MediConnect plan will receive their long-term services and supports (LTSS) through the plans.

Long-term services and supports includes home- and community-based services such as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), 1915(c) waiver

programs, Multipurpose Senior Services Program (MSSP), in addition to nursing facility care services.

The sunset date for the three-year Demonstration is anticipated to be December 31, 2016. The 1115 waiver is approved through October 31, 2015, and will need to be assessed for a time extension as part of this amendment.

III. GENERAL PROGRAM REQUIREMENTS

No changes necessary for this amendment.

IV. GENERAL REPORTING REQUIREMENTS

21. Monthly Calls. CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to;

- a. The health care delivery system;
- b. The Medicaid Coverage Expansion (MCE) program;
- c. The Health Care Coverage Initiative (HCCI) program;
- d. The Seniors and Persons with Disabilities (SPD) Program
- e. The Community Based Adult Services (CBAS) Program, including Enhanced Case Management (ECM) Services;
- f. California Children's Services (CCS) Program;
- g. Healthy Families Children Transition to the Demonstration;
- h. Designated State Health Programs (DSHP) receiving federal financial participation. – as defined within these STCs;
- i. Enrollment, quality of care, access to care;
- j. The benefit package, cost-sharing;
- k. Audits, lawsuits;
- l. Financial reporting and budget neutrality issues;
- m. Progress on evaluations;
- n. State legislative developments;
- o. Any Demonstration amendments, concept papers or State plan amendments the State is considering submitting;
- p. The Cal MediConnect Program; and
- q. The Managed Long-Term Services and Supports (MLTSS) Program.

24. Demonstration Annual Report. The state will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state will submit the draft annual report no later than 120 days after the end of each demonstration year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the demonstration year to CMS. The annual report will also contain:

- a. The previous State fiscal year appropriation detail for those state programs referenced in paragraph 38.b.ii, which are permissible expenditures under the Safety Net Care Pool.
- b. The progress and outcome of program activities related to the:
 - a. MCE;

- b. HCCI;
- c. SPD program;
- d. CBAS program;
- e. CCS Program;
- f. Healthy Families Children Transitioning to the Demonstration;
- g. Cal MediConnect program; and
- h. Managed Long Term Services and Supports (MLTSS) program.

V. GENERAL FINANCIAL REQUIREMENTS PAYMENTS FOR MEDICAID-ELIGIBLE PATIENTS

No changes necessary for this amendment.

VI. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

51. **Eligibility:** Certain State plan eligibles and Demonstration populations authorized under the expenditure authorities are affected by the Demonstration. The Medicaid Coverage Expansion (MCE) population, described below in 51.a.i., and CCS with special health care needs population, described below in 51.b., are subject to all applicable Medicaid laws and regulations except as expressly waived or described herein. The Health Care Coverage Initiative (HCCI) population, described below in 51.a.ii., are subject to Medicaid laws or regulations except as specified in the expenditure authorities or described herein for these Demonstration populations.

g. Cal MediConnect eligible populations: are individuals age 21 and older with full-scope Medicare and Medi-Cal coverage and reside in one of the CCI authorized counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Populations excluded from enrollment in CalMediConnect include the following:

- Beneficiaries with other private or public health insurance.
- Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services (DDS) 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD).
- Beneficiaries enrolled in the following 1915(c) waivers: Nursing facility/acute hospital waiver service, HIV/AIDS waiver services, assisted living waiver services, and In-Home Operations waiver services.
- Beneficiaries residing in designated rural zip codes.
- Beneficiaries residing in a veterans' home of California.
- Beneficiaries with end stage renal disease (ESRD) in all counties except for San Mateo and Orange. (If a beneficiary develops ESRD after enrolling in a Cal MediConnect plan, he or she may stay enrolled in that plan.)
- Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE).
- Beneficiaries enrolled in the AIDS Healthcare Foundation.

h. Managed Long-Term Services and Supports (MLTSS) Populations: are individuals age 21 and older and includes dual eligible beneficiaries who opt out or are excluded from the Cal MediConnect program and Medi-Cal only SPDs who were previously excluded from the mandatory managed care SPD transition program, and reside in one of the following counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San

Mateo, and Santa Clara. Populations excluded from mandatory managed care enrollment include:

- Beneficiaries with developmental disabilities residing in an intermediate care facility for the developmentally disabled (ICF/DD) in except for San Mateo and Orange counties.
- Beneficiaries residing in a veterans' home of California.
- Beneficiaries with other health insurance, except in San Mateo and Orange counties.
- Beneficiaries enrolled in PACE.
- Beneficiaries enrolled in the AIDS Healthcare Foundation.
- Beneficiaries in designated rural zip codes.
- Medi-Cal-only beneficiaries excluded due to an approved Medical Exemption Request.

VII. DEMONSTRATION DELIVERY SYSTEMS

61. **Transition of the Multipurpose Senior Services Program (MSSP) 1915 (c) Home and Community Based Services (HCBS) program into the Demonstration.** Payment for the MSSP 1915 (c) waiver services will be included in the MCO capitation payments from the State. Eligible beneficiaries in the eight CCI counties who are participating in the MSSP waiver will be allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in an MCO. The Cal MediConnect plans and Medi-Cal only managed care plans will be required to contract with MSSP providers to ensure on-going access to MSSP waiver services for enrolled beneficiaries. MSSP waiver providers will continue to provide the same services to MSSP Waiver participants/clients; however, they will receive payment for Medi-Cal managed care members from the MCOs. These requirements shall be outlined in the MCO and MSSP Waiver provider contracts.

VIII OPERATION OF DEMONSTRATION PROGRAMS

F. Managed Care Delivery Systems for the Coordinated Care Initiative (CCI)

119. CCI Enrollment Processes

- b. **Cal MediConnect Enrollment** – Effective no sooner than January 1, 2014, the State may begin enrollment of beneficiaries eligible for the Cal Medi-Connect program. Enrollment will be phased in over a 12-month period with enrollment periods specific to each county depending on the demographics and size of the eligible population. Beneficiaries will be passively enrolled into a participating Cal MediConnect plan if they do not make an active choice to opt out of the program. Beneficiaries who opt out of Cal MediConnect, will remain in their existing Medicare program and be enrolled in a Medi-Cal managed care plan for coverage their Medi-Cal benefits, including LTSS. Beneficiaries may opt out of the Cal MediConnect program at any time.
- b. **MLTSS mandatory enrollment** – Dual eligibles who opt out or are excluded from the Cal MediConnect program, and Medi-Cal only SPDs who were previously excluded from the SPD mandatory enrollment program will be mandatorily enrolled into a Medi-Cal managed care plan effective no sooner than January 1, 2014. The mandatory enrollment of the eligible

individuals will apply to new or existing Medi-Cal beneficiaries when the plan or plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access to care, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The enrollment may be tailored for each county as appropriate to address the specific demographics and population of each county.

Notwithstanding the provisions under paragraph 80, dual eligibles enrolled in a Medicare Advantage plan may be mandatorily enrolled in a Medi-Cal managed care plan that is not operated by the same parent organization for their Medi-Cal and Medicare wrap around benefits. This is applicable only in the eight authorized CCI counties.

- c. **Choice** - For counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of enrollment, the individuals will have an opportunity to choose from the managed care health plans and providers available to the specific population groups. If the beneficiary does not choose a health plan, they will receive a default plan assignment as described below. For counties that operate a COHS, the State will ensure individuals have a choice of providers.
- d. **Approaches to Default**
 - i. For individuals who do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data to make a default selection into a plan based on usual and known sources of care, including previous providers, and utilization history, including use of particular specialty and LTSS providers data. Default enrollees will have the opportunity to see their existing Medi-Cal providers for a period of 12 months after enrollment. The default shall not occur until education and outreach efforts are conducted as noted above. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.
 - ii. At least 60 days prior to the effective implementation date, the State will provide documentation and assurances for CMS review, that the infrastructure is in place at the State level, and across the plans, to effectively manage the default selection process.
 - iii. DHCS shall submit to CMS for review the enrollment broker protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to plan default assignment. Such protocol should, in circumstances where available data and utilization is insufficient to provide a clear, reasonable default selection, provide for pre-default assessment to determine individual needs.
 - iv. DHCS shall inform individuals of their opportunity to change plans at any time.

120. Benefit Package

- a. Beneficiaries enrolled in a Cal MediConnect plan or a Medi-Cal managed care plan will be eligible for Medi-Cal benefits as identified in Attachment N – Capitated Services List/Managed Care Benefit Package. Attachment N has been updated to include the additional long term services and supports authorized under the CCI. The State will assure that enrolled individuals have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package.

- b. Effective in the authorized CCI counties, managed care benefits for the eligible Cal MediConnect and MLTSS populations will be expanded to include the following long term services and supports (LTSS) as specified in Attachment N:
- In-home supportive services (IHSS);
 - Multipurpose Senior Services Program (MSSP) services as defined in the 1915(c) waiver; and
 - Skilled Nursing Facility services and Intermediate Care Facility services.

All services will be provided in a manner that is fully compliant with requirements of the Americans with Disabilities Act (ADA), as specified by the *Olmstead* decision. DHCS will ensure, through ongoing surveys and readiness and implementation monitoring, that Participating Plans provide for enrollees long-term services and supports in care settings appropriate to their needs.

121. Consumer Assistance

- a. **Initial and On-going Outreach and Communication Strategy** – The State shall develop an outreach and education strategy to explain the changes to individuals who are impacted by the Coordinated Care Initiative. The strategy shall describe the State’s planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific populations. The strategy will further articulate the State’s efforts to ensure that the individuals have access to information and human assistance to understand the new systems and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for initial implementation and on-going operation of the CCI. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review.
- d. **Informing/Education Materials** - The State shall develop and submit for CMS review informational and educational materials that meet the requirements of 42 CFR 438 to explain the changes in service delivery. Such materials must comport with 42 CFR 438, and be developed in collaboration with stakeholders.

The State shall submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain all facets of mandatory and passive enrollment in the authorized CCI counties, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process.

Beneficiaries will be notified at least 90-days of the effective date of enrollment of upcoming changes in delivery systems; mailed choice packets and enrollment guidebooks at least 60-days prior to enrollment; reminder notices 30 days prior to enrollment, and final enrollment confirmation notices prior to the enrollment effective date.

- e. **Readability and Accessibility-** All informing and educational materials should be clear and easy to read at no more than a sixth-grade reading level, provide information to beneficiaries need to help them navigate the transition, and be made available in the twelve Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

122. Efforts to Ensure Seamless Transitions

- a. The State will provide CMS its methodology for providing plans with a maximum of available data on service utilization and provider utilization for CCI eligible enrollees. This includes Medi-Cal administered services that are administered through sister agencies. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.
- b. The State shall provide documentation that information technology systems and infrastructure-are in place and can effectively manage the data exchange expectations set forth in this section to support smooth transition.
- c. The State shall provide data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees upon assignment or enrollment.

123. Plan Readiness and Contracts

- a. **Plan Readiness – Initial and Ongoing**
 - i. The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the mandatorily enrolled MLTSS population that ensures compliance with 42 CFR 438 and the Knox Keene Act.
 - ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation.
 - iii. The State will complete network certifications for each county. Each county network certification will be done across the geographic area covered by the county.
 - iv. The State will submit any updates to the network adequacy procedures upon changes.
- b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply.
- c. The State will submit to CMS for review a list of deliverables/submissions for readiness that is being requested from plans (presently and on regular intervals), and a description of State approach to analysis and verification.
- d. The State shall submit to CMS its plan for ongoing monitoring of plans. Beginning in year one of mandatory enrollment, monitoring must occur quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter.
- e. The State will submit to CMS for review the State's contingency plan for addressing insufficient network issues.

f. Items Necessary for plan readiness:

i. **Care Coordination** - The State shall submit to CMS their procedures for ensuring that each plan has sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the CCI population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

ii. **Standardized Assessments** - The State shall provide detailed information regarding the process to conduct health risk assessments for individuals at risk based on FFS data.

The State shall direct the plans to engage in a preliminary assessment process that assesses each new enrollee's risk level and needs; assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings; and uses a mechanism or algorithm to determine the health risk level of members. Based on the results of the health risk assessment, the plans shall be directed to develop individual care plans for higher risk beneficiaries.

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments.

iii. **Care Continuity** – Initial and Ongoing - The State shall ensure that the plans have mechanisms to provide continuity of care to enrolled individuals in order to furnish seamless care with existing providers for a period of 12 months after enrollment and established procedures to bring providers into network.

The State shall submit to CMS the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended period of care continuity for individuals with significant, complex or chronic medical conditions.

iv. **Person-Centered Planning and Service Design** - The State ensures that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee. While definitions and models of person-centered planning vary, the protocols shall, at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

v. **Physical Accessibility** - The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

- vi. **Interpreter Services - Information Technology** - The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.
 - vii. **Transportation – Specialized** - The State will ensure that each plan offers a limited number of non-emergency medical transportation so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.
 - viii. **Fiscal Solvency** - The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis.
 - ix. The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c).
 - x. **Transparency** - The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to the CCI eligible population.
The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.
 - xi. **Timing** - The State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.
- 124. Contract Requirements** - Each of the elements noted above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains:
- a. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:
 - i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and
 - ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution.
 - b. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using FFS claims data as a source of clinical data on CCI enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.
 - c. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.
 - d. Each plan shall be required to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion within 90 days after initial plan enrollment, or as specified by the State.

- e. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.
- f. The State must ensure that a uniform Grievance System is in place and monitored by the State for enrolled individuals in each plan that includes a grievance process, an appeal process and access to the State's Fair hearing process as defined in the Medicaid statutory and regulatory requirements per 42 CFR 438 subpart F. This includes, but is not limited to the following:
 - i. Protocols for receiving, tracking and resolving grievances (complaints)
 - ii. Protocols for what to include in a Notice of Action when a service request is denied or reduced
 - iii. Protocols for receiving tracking and responding to Member Appeals including Notice of Decision including State Fair Hearing Request instructions
- g. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable.
- h. Eligible beneficiaries in the authorized CCI counties will be substantially involved in plan advisory groups and committees.
- i. Provisions outlining when out-of-network care be provided.
- j. Comprehensive health assessments for eligible CCI populations.
- k. Coordination of carved out services based on FFS data.

125. Participant Rights and Safeguards

- a. **Information** - All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

126. Quality Oversight and Monitoring - In addition to all quality requirements set forth in 42 CFR 438, the State will ensure the following:

- a. **Encounter Data** - The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by impacted beneficiaries in the authorized CCI counties, in a manner that enables the State to assess performance by plan, by county, and Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data from each plan in the authorized CCI counties is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the CCI Cal MediConnect and MLTSS program. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

- b. **Measurement Activities** - The State will collect data information on the following measures to ensure ongoing monitoring of individual well being and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

The State will submit a plan for developing and implementing additional HEDIS and QIP measures specific to the CCI population. The plan must be submitted to CMS and must include the timelines for developing and implementing such measures.

- c. **Stratification and Analysis by County and Plan** - For all data collected from the MCOs, and COHS the State will be able to stratify information by population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the counties and the plans.
127. **Notice of Change in Implementation Timeline** - The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified above.
128. **Withholding Approval** - At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

IX. OTHER ADMINISTRATIVE REQUIREMENTS

No changes necessary for this amendment.

X GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

119. Reporting Expenditures under the Demonstration. In order to track expenditures under this Demonstration, California will report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM).

- a. For each Demonstration year, ~~twenty-five~~ **forty-three (2743)** separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration expenditures. The specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets below:
- i. Safety Net Care Pool – Hospital Services [SNCP-Hosp.];
 - ii. Safety Net Care Pool – Non-Hospital Services [SNCP – Non-Hosp.];
 - iii. Family & Children – COHS counties– [Families COHS];
 - iv. Family & Children – TPM/GMC [Families TPM/GMC];
 - v. Existing Seniors & People with Disabilities – COHS counties [Existing SPD COHS];
 - vi. Existing SPD TPM/GMC [Exist SPD TPM/GMC]
 - vii. Special Populations – SPDs [Special Pops – SPDs]
 - viii. Special Populations Special Needs Child [Special Pops – Child]

- ix. Low Income Health Program/ Medicaid Expansion [MCE]
- x. Low Income Health Program / Health Care Coverage Initiative [SNCP - HCCI];
- xi. California Children Services [CCS – State Plan]
- xii. California Children Services - Designated State Health Program [CCS - DSHP]
- xiii. Genetically Handicapped Persons Program - Designated State Health Program [GHPP – DSHP]
- xiv. Medically Indigent Adult Long Term Care - Designated State Health Program [MIALTC – DSHP]
- xv. Breast & Cervical Cancer Treatment Program - Designated State Health Program [BCCTP – DSHP]
- xvi. AIDS Drug Assistance Program - Designated State Health Program [ADAP-DSHP]
- xvii. Expanded Access to Primary Care - Designated State Health Program [EAPC-DSHP]
- xviii. Department of Developmental Services - Designated State Health Program [DDS – DSHP]
- xix. Workforce Development Programs - Designated State Health Program [Work – DSHP]
- xx. Private and Non-Designated Government-Operated Hospital Payments [P/ND Govt. Hosp];
- xxi. Designated Government-Operated Hospital Payments [D. Govt. Hosp];
- xxii. Delivery System Reform Incentive Pool - Infrastructure Development [DSRIP - Cat 1];
- xxiii. Delivery System Reform Incentive Pool - Innovation & Redesign [DSRIP – Cat 2];
- xxiv. Delivery System Reform Incentive Pool – Population –focused Improvement [DSRIP – Cat 3];
- xxv. Delivery System Reform Incentive Pool – Urgent Improvement in Care [DSRIP – Cat 4];
- xxvi. Delivery System Reform Incentive Pool – HIV Transition, Improvements in Infrastructure and Program Design [DSRIP – Cat 5A];
- xxvii. Delivery System Reform Incentive Pool – HIV Transition, Improvements in Clinical and Operational Outcomes [DSRIP – Cat 5B];
- xxviii. County Mental Health Services [CMHS – DSHP];
- xxix. Every Woman Counts [EWC – DSHP];
- xxx. IMProving, Counseling & Treatment [IMP – DSHP];
- xxxi. Community Based Adult Services [CBAS];
- xxxii. Enhanced Case Management [ECM]; and
- xxxiii. Uncompensated care payments to IHS and 638 Facilities [IHS].
- xxxiv. Duals—COHS Counties [Duals COHS]
- xxxv. Duals—TPM/GMC [Duals TPM/GMC]
- xxxvi. CCI—Duals COHS counties [CCI Duals COHS]
- xxxvii. CCI—Duals TPM/GMC [CCI Duals TPM/GMC]
- xxxviii. CCI—Duals COHS counties opt-out [CCI Duals COHS opt Out]
- xxxix. CCI—Duals TPM/GMC opt-out [CCI Duals TPM/GMC Opt Out]
- xl. CCI—SPDs COHS counties [CCI SPDs COHS]
- xli. CCI—SPDs TPM/GMC [CCI SPDs TPM/GMC]

- xlii. CCI—Families COHS counties [CCI Family COHS]
- xliii. CCI—Families TPM/GMC [CCI Family TPM/GMC]

X. Monitoring Budget Neutrality for the Demonstration

135. Limit on Title XIX Funding. California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California. Spending under the budget neutrality limit is authorized for managed care population expenditures for the following groups – family and children, SPD, and CCS, **dual eligible**, public hospital expenditures and for spending under the SNCP, and for the CBAS/ECM services to SPDs and dual eligibles. Spending under the SNCP is for uncompensated care, DSHP, HCCI and DSRIP. Attachment C lists the designated public hospitals. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for Monitoring Budget Neutrality. The data supplied by the State to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

136. Risk. California will be at risk for the per capita cost for Demonstration enrollees (Medicaid State plan or hypothetical populations) under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

137. Budget Neutrality Annual Expenditure Limit. For each DY, two annual limits are calculated.

- a) **Limit A.** For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each eligibility group (EG) described as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section entitled General Reporting Requirements for each EG, including the hypothetical population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
 - ii. Starting in SFY 2011, actual expenditures for the MCE EG will be included in the expenditure limit for California. The amount of actual expenditures to be included will be the actual MCE per member per month cost experience for DY 6-10;
 - iii. Starting in the fourth quarter of SFY 2012 (March-June), and continuing through August 31, 2014, actual expenditures for the CBAS and ECM benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be

included will be the actual cost of providing the CBAS and ECM services (whether provided through managed care or fee-for-service) to the SPD Medicaid-only population and to dual eligibles;

- iv. Starting in January 2014 and continuing through December 2016, actual expenditures for the CCI Dual Demonstration COHS and TPM/GMC EGs will be included in the expenditure limit for California. The amount of actual expenditures to be included will be the actual per member per month cost experience for this time period.
- v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)	Trend Rate	DY 6 PMPM *	DY 7 PMPM *	DY 8 PMPM*	DY 9 PMPM*	DY 10 PMPM*
Mandatory State Plan Groups						
Families - COHS	5.30%	\$171.68	\$180.78	\$190.36	\$200.45	\$211.07
Families – TPM/GMC	5.3%	\$150.40	\$158.37	\$166.76	\$175.60	\$184.91
Existing SPD – COHS	7.4%	\$1,069.73	\$1,148.89	\$1,233.91	\$1,325.22	\$1,423.29
Existing SPDs – TPM/GMC and Special Populations SPDs	7.4%	\$730.43	\$784.48	\$842.53	\$904.88	\$971.84
CCS – State Plan Special Needs Child	3.28%	\$1,390.66	\$1,436.27	\$1,483.38	\$1,532.04	\$1,582.29
Duals -COHS						
Duals –TPM/GMC						
CCI—Duals COHS						
CCI—Duals TPM/GMC						
CCI—Duals COHS counties opt-out						
CCI—Duals TPM/GMC opt-out						
CCI—SPDs COHS						
CCI—SPDs TPM/GMC						
CCI—Families COHS						
CCI—Families TPM/GMC						
Hypothetical Populations*						
MCE	5.00%	\$300.00	\$315.00	\$330.75	\$347.29	\$0
CBAS	3.16%		\$916.60	\$945.57	\$975.45	\$1,006.27
ECM			\$10.00	\$10.00	\$10.00	\$10.00

Key: TPM = Two Plan Model counties, GMC = Geographic Managed Care counties

*These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit.

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X ¹	X ¹	X ¹
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X ⁵	X ⁵	X
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X
California Children Services (CCS)	Service is not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			X ⁶
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provides services within the scope of their practice.	X	X	X
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X
Child Health and Disability Prevention (CHDP) Program		A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X ⁴
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)		A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.			
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X ¹	X ¹	X ¹

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph Error! Reference source not found.	X	X	X
Comprehensive Perinatal Services	Extended Services for Pregnant Women- Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X
Dental Services		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.			
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.			
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Enhanced Case Management (ECM), as defined in paragraph Error! Reference source not found.		A service consisting of those “Complex Case Management” and “Person-Centered Planning” services including the coordination of beneficiaries’ individual needs for needed long-term care services and supports.	X	X	X
Erectile Dysfunction Drugs		FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.			
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.			
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X ^{1,3}	X ^{1,3}	X ^{1,3}
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(1)(2)(B)).	X	X	X
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X
Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.			
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			X ²
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.			X
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	X	X	X

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services		In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X [§]	X [§]	X
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X [§]	X [§]	X
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N) are covered subject to prior authorization by the Department for the ICF/DD-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/DD-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X [§]	X [§]	X

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X ⁵	X ⁵	X
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.			

Attachment N – Capitated Benefits Provided in Transitioned 1915(b) Waivers
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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Long Term Care (LTC), except in CCI authorized counties: Alameda, Los Angeles, San Bernadino, San Diego, Santa Clara, Riverside		Care in a facility for longer than the month of admission plus one month.	X ⁵	X ⁵	X
Long Term Care (LTC) in CCI Counties		Medically necessary care in a facility covered under managed care health plan contracts	X ⁹ San Diego	X ⁹ Alameda, Los Angeles, San Bernardino, Santa Clara, Riverside	Already covered
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	X	X	X
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.	X	X	X
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.	X ⁹ San Diego	X ⁹ Alameda, Los Angeles, San Bernardino, Santa Clara, Riverside	X ⁹ Orange San Mateo
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.			
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.			
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X⁵	X⁵	X
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.	X² San Diego	X⁴ Alameda, Los Angeles, San Bernardino, Santa Clara, Riverside	X³ Orange San Mateo
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	X	X	X
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited psychiatry services when rendered by a physician, and limited allergy treatments.	X	X	X

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Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X ¹	X ¹	X ¹
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X
Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X ^{1,2*}	X ^{1,2}	X ^{1,2*}
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X

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Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.			
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.			
Skilled Nursing Facility Services, except in CCI authorized counties: Alameda, Los Angeles, San Bernadino, San Diego, Santa Clara, Riverside	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X ⁵	X ⁵	X
Skilled Nursing Facility Services in CCI Authorized counties	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital. (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X ⁹ San Diego	X ⁹ Alameda, Los Angeles, San Bernadino, . Santa Clara, Riverside	Already covered
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X
Specialty Mental health services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.			
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X ⁵	X ⁵	X
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X

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Subacute Care Services except in CCI authorized counties: Alameda, Los Angeles, San Bernadino, San Diego, Santa Clara, Riverside	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X ⁵	X ⁵	X
Subacute Care Services in CCI Authorized Counties	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X ⁹ San Diego	X ⁹ Alameda, Los Angeles, San Bernardino, Santa Clara, Riverside	Already covered
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.			
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.			
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	X	X
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.			

¹ Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A

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and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Psychologist, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.

² Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider are not covered, except that Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

³ Fabrication of optical lenses only covered by CenCal Health.

⁴ Not covered by CenCal

⁵ Only covered for the month of admission and the following month

⁶ Not Covered by CalOptima, Central California Alliance for Health, Partnership HealthPlan of California (Sonoma County Only) and CenCal (San Luis Obispo County Only)

⁷ Only covered in Health Plan of San Mateo and CalOptima

⁸ Only Only covered in Health Plan of San Mateo

⁹ Services covered under managed care in CCI Authorized Counties: Alameda, Los Angeles, Orange, San Bernadino, San Diego, San Mateo, Santa Clara, Riverside.

Authorized counties for the Coordinated Care Initiative – Cal MediConnect and MLTSS

County Name	Plan Model			Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	
Alameda	X			X
Contra Costa				
Fresno				
Kern				
Kings*				
Los Angeles	X			X
Madera*				
Marin**				
Mendocino**				
Merced				
Monterey				
Napa				
Orange			X	X
Riverside	X			X
Sacramento				
San Bernardino	X			X
San Diego		X		X
San Francisco				
San Joaquin				
San Luis Obispo				
San Mateo			X	X
Santa Clara	X			X
Santa Barbara				
Santa Cruz				
Solano				
Sonoma				
Stanislaus				
Tulare				
Ventura*				
Yolo				