Healthy Families Program Transition to Medi-Cal

DRAFT for Stakeholder Comments

PHASE 4 Implementation Plan

June 1, 2013

Submitted by the
California Department of Health Care Services
in Fulfillment of the Requirements of
Assembly Bill 1494 (Chapter 28, Statutes of 2012), as amended by AB 1468 (Chapter 438, Statutes of 2012), Welfare and Institutions Code section 14005.27(e)(2) and (9)

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PHASE 4 IMPLEMENTATION PLAN

OVERVIEW

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of approximately 860,000 Healthy Families Program (Healthy Families) subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. The Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Department of Managed Health Care's (DMHC) focus is to work collaboratively to facilitate a smooth transition, minimize disruption in access to services, maintain existing eligibility gateways, and maintain access to and continuity of care.

This submission fulfills the Legislative requirement to submit the Phase 4 implementation plan and network adequacy assessment to the Legislature at least 90 days prior to the start of Phase 4, pursuant to Welfare and Institutions Code Section 14005.27 (e)(2) and (9). It provides specific details about the State's efforts to prepare for and implement Phase 4 beginning September 1, 2013.

PHASE 4 TRANSITION DETAILS

Health Care Services

In Phase 4, approximately 37,383 children will transition from Healthy Families to Medi-Cal. Children in these counties will transition on September 1, 2013. Please see *Appendix 1*. The Phase 4 transition was originally specific to children who are currently enrolled in a Healthy Families plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan. However, DHCS plans to transition the Phase 4 counties to Medi-Cal managed care on September 1, 2013.

Depending on the county that the member lives in, California Health and Wellness Plan (CHWP), Anthem Blue Cross (Anthem), and Partnership Health Plan (Partnership) are the managed care health Plans that will be available. In Del Norte, Humboldt, Trinity, Siskiyou, Shasta, Modoc, Lassen and Lake Counties, Partnership is the only Plan available because it operates under the County Organized Health System model. Members that live in these eight counties will not be sent an enrollment choice packet, but will receive the 90 day letter and a Reminder Notice. Members in San Benito County will be enrolled into Anthem and members living in Imperial County will be enrolled into CHWP; those plans will be the only ones available in those counties. Members living in both San Benito and Imperial Counties will also receive a 90 day letter and a Reminder Notice.

The remaining 18 rural counties (see *Appendix 1*) will operate under a Regional County Model and children and their families will have a plan choice between Anthem and CHWP. Anthem currently operates Healthy Families plan operating in these counties,

and CHWP is a new health plan to California and does not have a Healthy Families line of business today. Children in those 18 counties that are already enrolled with Anthem as Healthy Families enrollees will remain with Anthem as they transition to Medi-Cal. In Amador, El Dorado and Placer counties, children enrolled in Kaiser will remain with Kaiser. Additionally, Health Net enrollees in Placer County will be sent a Choice Enrollment packet and will be required to select a health plan—either Anthem or CHWP. In Placer County, Health Net members will get a 90 day notice, an enrollment packet approximately two months prior to the transition date, and a Reminder Notice. Please see *Appendix 1* for a list of the counties and the health plans that will be available in those counties beginning September 1, 2013.

In Medi-Cal, members have the right to change health plans monthly, to the extent there is more than one Medi-Cal health plan in the county. Additionally, members may change their Primary Care Physician (PCP) anytime with their health plan or health plan's subcontractor. In the Regional County Model, members are provided contact information for Health Care Options in the Reminder Notice. A Health Care Options representative can assist a member with changing their health plan as well as assist them with using the Provider Information Network (PIN) online. Through the PIN they can choose a new doctor, dentist, hospital, medical clinic or dental clinic. In a County Organized Health System county, members can work with their Plan to choose a new doctor upon enrollment.

Before the transition, families will receive information about Medi-Cal, including the specific date on which the child will transition, how their dental services will be provided, an overview of covered services under Medi-Cal, their Rights and Responsibilities under Medi-Cal and contact information for questions they may have.

Once the child transitions, the Medi-Cal managed care plan will mail informing materials which include a Member Handbook/Evidence of Coverage (EOC), Provider Directory, and a health plan card. The Provider Directory explains the process to the member on how they can choose a PCP. The information provided to the family will be specific to their services under Medi-Cal.

Vision Benefits

In terms of vision coverage, today in Healthy Families children receive vision services through a separate vision plan. In Medi-Cal, while the benefits are nearly identical, vision services will be available as part of the medical coverage that is provided through the managed care health plan and will be provided based on medical necessity criteria, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, as applicable.

Dental Coverage

Dental services will transition at the same time as the medical coverage transitions. The mode of dental coverage delivery will be determined by the child's county of residence. All children, except those residing in Los Angeles and Sacramento Counties, will be provided dental services under Denti-Cal, Medi-Cal's fee-for-service dental program.

Dental Managed Care

Dental managed care services are only available in Los Angeles and Sacramento Counties; therefore, no children in Phase 4 will transition to a Medi-Cal Dental Managed Care plan.

Denti-Cal

For children in this phase who need to secure a new dental provider, the following steps can be taken:

- Contacting Denti-Cal's Beneficiary Customer Service line; or
- Accessing the Denti-Cal website to locate providers that are accepting new patients.

A dental insert included in the Welcome to Medi-Cal packet that children and their families receive will include instruction to contact Denti-Cal's Beneficiary Customer Service line (1-800-322-6384) to locate a provider. The Denti-Cal website address (www.denti-cal.ca.gov) is also included in the insert.

DHCS has recently improved both of these resources in order to ensure ease of accessing providers and care. These changes include:

- Improved referral processes with the Beneficiary Customer Service line. Callers will now experience a "warm transfer" to a dental provider who has actively indicated to the representative they are accepting new patients.
- Improved ease of adding providers to the online list who are accepting new patients. This will provide beneficiaries with a wider selection of providers in their area.
- Accessing the "insurekidsnow.gov" website on the Denti-Cal website which includes Denti-Cal provider network information. This website allows beneficiaries to search for providers by State, name of provider, location of beneficiary, specialty, accepting new patients, and other factors.

Denti-Cal Transition Activities

Enrollment Workshops

Denti-Cal has scheduled and will continue to schedule enrollment workshops for each phase of the Healthy Families transition to Medi-Cal. The workshops will have enrollment representatives available for providers to meet with to obtain assistance with enrollment documents. Denti-Cal is using the beneficiary data from MRMIB to identify Healthy Families providers that are not enrolled in Denti-Cal. Denti-Cal is mailing enrollment workshop invitations to these providers. Providers are able to register for the workshops by mailing back the invitation, registering online though the Denti-Cal website, or by calling the Provider Customer Service line. Denti-Cal is placing calls to providers who have not responded to the invitations to confirm they received it and to encourage registration in one of the workshops. Denti-Cal is also following up after the workshops with providers if they have not submitted their applications yet or if they did not come to the workshop they registered for. Denti-Cal is also emailing dental societies to inform them of the enrollment workshops and to request their assistance in informing

their providers of the workshops. Denti-Cal is also reaching out to the California Dental Association to seek their assistance in publicizing the enrollment workshops.

Outreach by Geographical Areas

Denti-Cal is using program data to identify geographical areas (regions, zip codes) with low or no Denti-Cal providers and along with the beneficiary data from MRMIB to identify un-enrolled Healthy Families providers in these areas. Denti-Cal will perform extensive outreach to the un-enrolled providers, including call campaigns and field office visits.

Denti-Cal has recruited a dental consultant specifically to assist with provider outreach, including priority outreach in areas identified as needing concentrated efforts. The consultant is assisting with provider trainings, training to Federally Qualified Health Centers (FQHC), and provider recruitment. The dental consultant is also attending health fairs in rural areas. The consultant's effort is helping garner support and participation from providers serving in areas with low or no Denti-Cal providers.

Webinars (Phone Bank)

Denti-Cal is offering one day a month where providers can call a toll-free line to contact enrollment representatives directly. Information on these sessions will be advertised on the Denti-Cal website and also allow providers to register to call in during the session. Providers are able to leave a voicemail the day of the session if they choose to, if they do not speak to a representative immediately when calling. Denti-Cal will follow up with all provider messages to assist them in enrolling and answer any questions. Denti-Cal will also call providers that registered for the session but did not call in or leave a message.

Streamlined Provider Enrollment

Throughout each transition Phase, DHCS is prioritizing and accelerating the processing of all Healthy Families provider applications to enroll in Denti-Cal. If additional information is needed to process the applications, Denti-Cal staff is contacting the provider by phone to retrieve information and expedite the processing of the application.

Denti-Cal has established a new process to allow dental providers to request Preferred Provisional Provider Status. This allows any un-enrolled provider, including Healthy Families providers, interested in enrolling into Denti-Cal, that meet requirements set forth in W&I 14043.26(d)(3), the opportunity to begin providing care for their patients even though their applications may not be fully credentialed by September 1, 2013.

Provider Enrollment Call Campaign

Denti-Cal is placing calls to follow-up with providers who have not responded to enrollment workshop invitations, have stated that they will not enroll in the program, are newly licensed dental providers, and Healthy Families providers who are identified in Phase 4 counties as not being enrolled. These calls are serving as an additional effort to encourage the providers to enroll in Denti-Cal and, consequently, improve network adequacy and assist in access to and continuity of care.

Provider Referral List Call Campaign
Denti-Cal is conducting a call campaign to enrolled Denti-Cal billing providers, who are not on the provider referral list, in counties that have low to no providers on the referral list. The call campaign is being used to encourage these providers to add to the provider referral list if they are able to service new patients. Denti-Cal is reaching out to enrolled providers that are currently billing the Denti-Cal program and to recently enrolled providers who may have not added to the referral list at time of enrollment. The table in *Appendix 4 – Number of Denti-Cal Providers on Referral List – By County* shows the number of provider service office locations in counties that transition in Phase 4.

Beneficiary Data
Denti-Cal is analyzing subscriber data received from MRMIB by county to identify service offices that are not enrolling into Denti-Cal that service a large number of Healthy Families children. Additional call campaigns are taking place to again encourage enrollment into the Denti-Cal program and to also assess how to transition children, if needed, to already enrolled Denti-Cal providers.

Online Training
Denti-Cal's website has online trainings to assist providers in enrolling in the Denti-Cal program, how to bill for services, and to answer other frequently asked questions.

Provider Postcard Mailing
Denti-Cal will be mailing postcards to billing providers to inform them of updates to the Denti-Cal website, new provider bulletins, and update to program policies. An introductory postcard was mailed in mid-February and postcards informing providers of program updates are being sent out on a monthly basis.

Provider Bulletins
Denti-Cal is publishing bulletins monthly to educate providers on program changes and/or reminders on trainings and other events.

Provider Survey
DHCS initially sent a survey to providers to determine provider capacity, their ability to accept new Medi-Cal beneficiaries, and to identify barriers to enrollment. Surveys were sent to three provider groups: Denti-Cal only billing providers, Healthy Families-only providers, and Healthy Families /Denti-Cal providers. Survey results allowed program staff to assess the number of providers that plan to enroll in Denti-Cal or contract with Medi-Cal dental managed care plans and continue providing services to their Healthy Families children.

Staff have collected the results of the surveys received thus far and have begun reaching out to providers who indicated interest in the program, adding providers to the provider referral list online, and analyzing for possible program improvements. 11,852 surveys were mailed to providers and a little over 7,000 phone calls to providers were made using this survey, DHCS received a total of 9,328 surveys, of which 4,683 were

completed. Of those that submitted a completed survey, 2,784 Denti-Cal providers indicated that they will continue to treat children who have transitioned from Healthy Families to Medi-Cal. Denti-Cal enrolled providers in Phase 4 counties have indicated through the survey that they can accept over 68,000 new patients. 102 un-enrolled providers also completed the survey. The survey is also online for providers to continue to submit their responses. DHCS will continue to use this survey until the transition is complete and will look to continue collecting provider feedback in a similar fashion.

Beneficiary Customer Service Line

Denti-Cal reviewed processes of the Beneficiary Customer Service line to determine how to streamline and improve services to beneficiaries. Denti-Cal improved the process for beneficiaries to receive a provider referral to ensure that beneficiaries are able to find a provider when they call. DHCS has implemented a new, "warm transfer" process where the customer service representatives will locate and speak to a provider who can treat the beneficiaries, while the beneficiaries are still on the line. This allows the customer service representative to confirm that providers are accepting new patients and allows beneficiaries to make an appointment immediately. Allowing for the representative to locate an active provider willing to accept a new patient is increasing the success of the appointments and the ability to access care. As reported in the Healthy Families Program Transition to Medi-Cal Monitoring Report and Summary Denti-Cal has had a 99% success rate for February and 98% for March in finding providers for beneficiaries. DHCS is looking into strategies to begin follow-up with these beneficiaries to track appointments kept and missed and services provided. In cases where there is not an appointment scheduled at the conclusion of the call, beneficiaries generally chose to call back after checking their schedule or a provider needed to call the beneficiary back because they had other calls waiting.

Continuation of Services

Denti-Cal is continuing to honor all prior authorizations for treatment for Healthy Families children that have transitioned to Denti-Cal if the service is a Denti-Cal benefit and performed within the time period for which the service is authorized. Providers enrolled in Denti-Cal will submit proof of the prior authorization they received from a Healthy Families dental plan with claim for payment to Denti-Cal on services performed. Claims for payment will be made as stipulated in the Denti-Cal Schedule of Maximum Allowances found in the Medi-Cal Dental Program Provider Handbook.

Reporting

Denti-Cal will be required to report on eleven performance measures including: Annual Dental Visits, Continuity of Care, Use of Preventative Services, Use of Sealants, Sealant to Restoration Ratio (Surfaces), Treatment/Prevention of Caries, Exams/Oral Health Evaluations, Overall Utilization of Dental Services, Usual Source of Care, Use of Dental Treatment Services, and Preventative Services to Filling. These performance measure reporting is a part of the ongoing, improved dental monitoring and oversight for the entire dental program. These reports will look at annual utilization rates for each performance measure. Healthy Families Program beneficiaries will be reported

separately. Please refer to *Appendix 2* for a more detailed list of the Dental Performance Measures.

Mental Health Services

Pursuant to AB 1494, Phase 4 of the Healthy Families transition moves individuals residing in counties that do not have Medi-Cal managed care plans from their Healthy Families health plan into the Medi-Cal fee-for-service delivery system. Children in Phase 4 receiving Medi-Cal specialty mental health services from a county mental health plan (MHP) prior to September 1, 2013, will continue to receive those services through the MHP following the Phase 4 transition unless the MHP reassesses the child and determines that the child does not meet medical necessity criteria for Medi-Cal specialty mental health services. If an MHP provider reassesses a child and determines that they no longer meet specified criteria, the MHP will refer the child to the child's new Medi-Cal managed care plan for mental health treatment. DHCS expects that most, if not all, of the Healthy Families children that were served by the MHPs under the Healthy Families seriously emotionally disturbed (SED) benefit will continue to be served by the MHPs under the Medi-Cal specialty mental health program following their transition to Medi-Cal. Medi-Cal managed care plans provide mental health services to the extent the services can be provided by a primary care physician. If a child needs additional mental health services, but does not meet the Medi-Cal specialty mental health services medical necessity criteria to be served by the MHP, the child may access these services through the Medi-Cal fee-for-service delivery system.

DHCS hosts weekly calls with the California Mental Health Directors Association (CMHDA) and MHPs. Currently, MHPs from Phase 1, 2, and 3 counties participate on the calls. DHCS will add the Phase 4 counties to the call in May 2013, two months prior to the Phase 4 transition. These calls provide an opportunity for MHPs to communicate with one another, share resources, and ask questions of each other and of the State.

As Phase 4 approaches, DHCS will continue current efforts to assist MHPs with proactive communication with plans to ensure a smooth transition of children receiving or in need of mental health services from Healthy Families to Medi-Cal. These efforts include providing updated information about the transition in general and specifically as it relates to mental health, providing key contact information, and assisting with specific issues that arise on a case-by-case basis.

DHCS is in the process of cross-referencing Healthy Families provider data with the fee-for-service Medi-Cal provider database to determine the overlap of providers and to allow DHCS to contact providers that are not currently fee-for-service Medi-Cal providers and invite them to become fee-for-service Medi-Cal providers. Preliminary findings indicate low provider overlap between Healthy Families providers and fee-for-service Medi-Cal providers. DHCS will continue exploring possibilities for streamlining enrollment of existing Healthy Families providers into fee-for-service Medi-Cal. Additionally, DHCS will also share the Healthy Families provider data with county mental health plans so that they may offer to contract with current Healthy Families mental health providers and expand their individual provider networks. Many MHPs

report that they are aware of the Healthy Families providers in their area and have already invited them to becoming MHP providers, and continue to pursue that effort.

Alcohol and Drug Treatment Services

California's alcohol and drug treatment services are administered at a county level and include services funded through the Drug Medi-Cal program (DMC), and other treatment and prevention services funded outside of DMC. Each county has an Alcohol and Other Drug (AOD) Program Administrator which will be the principal contact between the Healthy Families plans, and the county AOD programs. These AOD Program Administrators were participants in Healthy Families transition meetings and discussions throughout the previous phases and are aware of the issues.

- County alcohol and drug programs will obtain information about the child or youth, ascertain the type of services needed, and either serve them directly or refer them to a provider under the Drug Medi-Cal program. In some cases, the provider may be a direct provider that contracts with DHCS.
- If the Healthy Families plan chooses to refer the child or youth to the county alcohol and drug program, they will continue to serve the child/youth until they are connected to services. In addition to plan referrals, there may be some self-referrals to county alcohol and drug programs.

Use of Data for Planning

Data will be important to counties as they develop plans to ensure continuity and access to care for the transitioning children. DHCS will continue to share the Healthy Families plans contact data with county alcohol and drug programs to help them prepare for the intake of the transitioning Healthy Families children and youth.

- County AOD Program Administrators will collect data that provides an unduplicated count of the children and youth who are accessing alcohol and drug treatment services, the type of alcohol and drug treatment services they are receiving, and the providers that serve them.
- DHCS will share the provider information with county alcohol and drug programs to encourage the counties to contract with these Healthy Families providers. If the counties wish to contract with these providers, DHCS will fast track the certification for the providers to participate in the Drug Medi-Cal program and facilitate continuity of care.

Communications

DHCS has brought the Healthy Families transition to the forefront of the County AOD Program Administrators, by incorporating the transition as a topic into the weekly County Alcohol and Drug Program Administrators' Association of California (CADPAAC) call that is attended by all 58 county Administrators. CADPAAC has formed a special Youth Treatment Committee to address issues specific to this population, and has included the Healthy Families transition on their agenda. DHCS is working with this committee by coordinating communications, and participating in the meetings.

DHCS will facilitate introductions between county alcohol and drug programs and Healthy Families plans where a strong relationship does not currently exist. To assist with the transition, the DHCS Drug Medi-Cal Division will provide technical assistance, information, and guidance to the county alcohol and drug programs on any issues that arise and are related to the Healthy Families transition and ensuring continuity of care.

DHCS has taken several steps to help the transitioning Healthy Families subscribers and their families understand the services available to them in the Medi-Cal program. This information empowers the families to ask for assistance where they need it. The Welcome Packet that is sent to all transitioning Healthy Families subscribers and their families includes Frequently Asked Questions with information on how to access alcohol and other drug (AOD) treatment services.

Services for Children with Developmental Disabilities

As the Healthy Families transition progresses, stakeholders, including advocates, parents, health plans, and mental health plans, have raised questions and concerns about the provision of behavioral health services used to treat individuals diagnosed with autism.

Pursuant to AB 88, Chapter 534, Statutes of 1999, California's mental health parity law, Healthy Families health plans and other commercial health plans and insurers are required to cover behavioral services as distinct services. Additionally, SB 946, Chapter 650, Statutes of 2011, requires commercial health plans and insurers to provide coverage for behavioral health treatment to individuals diagnosed with pervasive developmental disorder or autism. Health plans contracted with Medi-Cal are exempt from both AB 88 and SB 946 and plans contracted with Healthy Families and the California Public Employees Retirement System (CalPERS) are exempt from SB 946. On September 6, 2012, the Office of Administrative Law approved emergency regulations that clarified that Healthy Families and CalPERS plans are required to pay for behavioral services under AB 88, even though they were exempt from SB 946. Prior to the transition, some Healthy Families children received ABA services through their Healthy Families health plans. Others may have received them through a regional center under the authority of the Department of Developmental Services (DDS). Currently, Medi-Cal pays for behavioral services for children eligible under the DDS Home and Community Based Services waiver provided through the regional centers.

Based on the literature, covered services for autism include, but are not limited to, behavioral health services, psychiatry and psychology services, speech and language therapy, physical therapy, and/or occupational therapy. Services provided to children under Medi-Cal with a diagnosis of autism generally include occupational, physical, and speech therapy. Additionally, the DDS provides other behavioral services to Medi-Cal beneficiaries who meet specified eligibility criteria through the home and community-based services waiver program and DDS's 1915(i) state plan amendment. An individual may also receive behavioral services through the local county mental health plan if the child meets medical necessity criteria for specialty mental health services.

The California Health and Human Services Agency, in collaboration with DHCS, DDS, and the Department of Managed Health Care is working to connect children transitioning from Healthy Families to Medi-Cal to needed services with minimal disruption. DHCS is in the process of developing a written response to stakeholder questions about these issues that will be posted on the DHCS Healthy Families transition webpage.

The California Health and Human Services Agency in collaboration with DHCS, DDS, and the Department of Managed Health Care are working to connect children transitioning from Healthy Families to Medi-Cal to needed services with minimal disruption. DHCS is in the process of developing a written response to stakeholder questions about these issues that will be posted on the DHCS Healthy Families transition webpage.

California Children's Services

If a Healthy Families subscriber gets health care though the CCS Program to treat a CCS medical condition, that child's care for the CCS condition will not change. The child's primary and preventive care will now be provided through a Medi-Cal Health Plan or fee-for service Medi-Cal instead of a Healthy Families Health Plan. The most important point to consider is that coverage for CCS children does not change with the transition from Healthy Families to Medi-Cal.

Communication with Children and their Families

Notifying children and their families of the transition is critical to facilitating a smooth transition. Per the enabling legislation for the transition, the State is to provide written notice to the transitioning children at least 90 days prior to the start of Phase 4. The 90-day notice has been reviewed by stakeholders and CMS, and will be sent to the families of the Phase 4 transitioning children on June 1, 2013. Stakeholders and the State's federal partners at the Centers for Medicare and Medicaid Services (CMS) have had and will continue to have, the opportunity to comment on all notices to children and their families and the State will consider their comments prior to the finalization of the notices. (Notice is still in development- Phase 4 90-day notice will be available in the final version.)

Similar to previous phases transitioning children will receive subsequent notices throughout the 90 days leading up to the transition in order to adequately inform the families about the transition and steps they can take for questions. The notices will be modeled upon those previously sent to Phases 1, 2, and 3 children.

Like the notification process for Phase 3, children who are not in a County Organized Health System (COHS) county will also receive a plan enrollment packet 60 days prior to September 1 if they live in Placer County and are currently assigned to Health Net. The Plan enrollment packet will include a cover letter that tells the family that if they do not make a health plan choice, they will be assigned to a health plan in their county with an effective date of September 1. Within a COHS county, there is only one Medi-Cal

health plan allowed in that county so all Medi-Cal beneficiaries automatically become members of the COHS Medi-Cal health plan. Children in COHS counties will not need to actively enroll in their county's COHS plan and will simply move into the COHS plan in their county. Children transitioning in non-COHS counties will be given the opportunity to choose from the available Medi-Cal managed care plans within their county.

A Reminder Notice will be sent approximately 30 days prior to September 1 reminding families about the upcoming transition, and the need to choose a Medi-Cal managed care health plan in their county if they have not done so already. If a health plan choice has been made and processed or if the beneficiary has been assigned a plan based on linkage; that health plan will be listed.

Phase 4 children and their families will receive a Welcome to Medi-Cal packet shortly after their final Reminder Notice. The Welcome Packet will contain the same information as provided in previous phases, and will include general Medi-Cal informing materials on such topics as general eligibility, covered services, fair hearings, member rights and responsibilities, continuity-of-care rights, and what to do if a family has a problem accessing care.

In addition to the Welcome to Medi-Cal packet, a Beneficiary Identification Card (BIC) will be mailed separately to beneficiaries along with instructions on how to use the card. Beneficiaries will also receive a new plan card and welcome packet from their health plan immediately after they are transitioned into Medi-Cal.

Similar to all previous phases, Phase 4 mailings will be translated into the Medi-Cal threshold languages and provide contact information for resources to answer questions and provide additional assistance.

In addition to the notices being sent out to Healthy Families beneficiaries, DHCS has also engaged in an Outbound Call Survey of recently transitioned beneficiaries. The survey was developed in accordance with the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph, 109. The intent of the survey is to get a general idea of the overall transition and to gauge the beneficiary's family's perceptions of continuity of care with providers as well as their overall satisfaction with their move to Medi-Cal. The survey was intended to be no more than 3-5 minutes.

The Phase 4 Outbound Call Survey will be conducted in the same format that the previous surveys were conducted. Based on lessons learned from the Phase 1A survey, DHCS adjusted the timeframe that the outbound call survey was conducted to accommodate work schedules of members parents or guardians that the calls were being made to. Instead of making calls throughout day, calls were made in the evening after 5:00pm. This resulted in an increase in response rate. The survey is scheduled to begin in mid-October. Survey results will be made available after completion of the survey and after their submission to CMS. The DHCS website also offers a section dedicated to the Healthy Families Transition. Families can find a multitude of

information about the Healthy Families transition online, such as FAQs, notices, premium information and general transition information.

Consumer Assistance

The State anticipates increased use of available call centers as the transition of children from the Healthy Families Program to Medi-Cal continues. As appropriate, State and Administrative Vendor resources have been put in place to manage the increased call volumes. The Phase 4 90-day notice directs Healthy Families children and their families to call Healthy Families with questions because they are still Healthy Families enrollees. Once these children transition to Medi-Cal, beginning September 1, 2013, DHCS expects increased call volume to the DHCS Medi-Cal Managed Care and Mental Health Ombudsman's and to the Denti-Cal and Health Care Options call centers with questions about how a child can access their Medi-Cal benefits and how a child can change their health and dental plans. MRMIB, DHCS, and DMHC have coordinated call center material to provide accurate and consistent responses to questions.

The State is also actively engaged with a variety of stakeholders that represent on-the-ground, community-based assistance groups. These include certified application assisters to legal aid resources to county health and human services offices. The State holds regular planning group meetings and Webinars to provide information to stakeholders and to dialogue about the transition and what families and advocates are experiencing. The State will continue to convene these forums throughout the transition in order to facilitate discussions about how to communicate with families, plans, providers, and community-based assistance organizations.

As call center information and Frequently Asked Questions are developed, these materials will continue to be shared with stakeholders representing on-the-ground community-based assistance groups, advocate organizations, health, mental health and dental plans, county social service departments and community-based assistance organizations to help assist with information sharing to families to ensure a consistent message for purposes of information sharing. Additionally, as transition efforts continue, such information will be posted to the DHCS and MRMIB Healthy Families Program Transition to Medi-Cal websites.

The DHCS website has a section dedicated to the Healthy Families transition. This section offers consumers a multitude of information such as FAQs, notices, premium information and general transition information. A dedicated email address was established for inquiries regarding the Healthy Families Program transition efforts: dhcshealthyfamiliestransition@dhcs.ca.gov.

NETWORK ADEQUACY ASSESSMENT

The Department of Managed Health Care (DMHC) licenses and regulates health and dental plans pursuant to the Knox-Keene Health Care Services Plan Act of 1975, as

amended ("Knox-Keene Act"). MRMIB contracts with health plans licensed by the DMHC to provide coverage for Healthy Families subscribers.

Prior to each phase, DHCS, in consultation with DMHC (the departments), will assess each Medi-Cal plan's provider network and ensure that plans meet the network adequacy requirements necessary for a smooth transition.

For Phase 4, the departments submitted a request to all Healthy Families managed care plans operating in a Phase 4 county to provide data related to their networks. A request for information regarding network development and continuity of care was also sent to the Medi-Cal managed care plans slated to operate in the Phase 4 counties.

Also, DHCS will contact health plans when concerns about network adequacy are presented either by the data submitted by the plans or by stakeholder and provider feedback. The plan will be notified of the concern and will be asked to submit to the departments its plan of action for rectifying the situation. Ongoing monitoring and follow up with the plans will continue to facilitate a smooth transition and continuity of care both during and after the transition.

TRANSITION PREPARATION ACTIVITIES

Webinars/Online Training

In collaboration with advocacy groups and following two webinars held for Enrollment Entities (EE) and Certified Application Assistants (CAA) on February 19, 2013 and March 18, 2013, training modules in conjunction with an online training manual are being update and will be posted on DHCS' website for the on-the-ground community-based assistance groups to provide eligibility information on the Optional Targeted Low Income Children's Program and Medi-Cal premium payments. The webinar slideshows, which include a toolkit of resources and other resource documentation, are posted on DHCS' website. The recorded presentations are available following any webinar for a limited time period. DHCS will also send periodic e-blast and newsletters to CAA and EE as a means to provide programmatic updates. Webinars will continue to be offered as needed to supplement the provided training resources.

Stakeholder Engagement

Effective, ongoing communication is critical to the success of this transition. Such communication must involve the engagement of key partners including the federal CMS, other state agencies/ departments, the Legislature, health and dental managed care plans, county representatives and advocates. Key state agencies/departments engaged with DHCS are MRMIB, Agency, DMHC, and the Department of Finance. To this end, Agency, DHCS, DMHC, and MRMIB convene monthly stakeholder meetings that regularly include behavioral health discussions and monthly webinars.

DHCS engages in weekly calls with their managed care health plans specific to the Healthy Families transition and holds quarterly Advisory Group meetings to discuss such topics as the Healthy Families transition.

DHCS offered two CAA training webinars on February 19 and March 18. The purpose of the sessions were to familiarize the CAA with the Healthy Family to Medi-Cal transition and to provide guidance as it relates to Eligibility and Forms and documentation, necessary to assist children with applying for Medi-Cal. In the first session DHCS also provided an overview on dental services, mental health services, alcohol and substance use services and provider selection. In addition DHCS invited staff from the Department of Public Health Women, Infants and Children Supplemental Nutrition Program (WIC) to both sessions to provide an overview of the WIC program eligibility for children transitioning from Healthy Families to Medi-Cal and information on local WIC resources for CAAs to contact to assist families to enroll in WIC. A stakeholder meeting took place on April 18th, titled "Healthy Families Program Transition to Medi-Cal Webinar". This webinar included an update of the various phases, network adequacy addendum for Phases 1 and 2, and a review of the most recent Monitoring Report that is submitted monthly to the Legislature and the Center for Medicaid and Medicare Services. In each webinar, DHCS provides a segment for questions and answers as well as email addresses to submit questions after the session. The next webinar is scheduled for July 10, 2013. These meetings are in addition to DHCS-specific workgroup and technical assistance efforts focusing on eligibility, dental services, managed care, and mental health and substance use disorder services.

Currently, DHCS meets three times a week with counties, consortia, County Welfare Director's Association (CWDA) and Maximus to provide guidance and technical assistance on eligibility processes. DHCS has also begun making weekly calls to transitioned counties to provide assistance with eligibility related issues and to request feedback from counties regarding the Healthy Families transition to Medi-Cal.

Administrative Activities

Since January 2013, DHCS has contracted with MAXIMUS, the Healthy Families Administrative Vendor, for ongoing work and work associated with the transition and the administration of the Optional Targeted Low Income Children's Program. The scope of work activities includes maintaining the Single Point of Entry (SPE), managing premium payments, maintaining call center operations, developing needed systems changes for interfaces with the county eligibility systems and the Medi-Cal Eligibility Data System (MEDS) update and maintain the on-the-ground, community-based assistance groups' resources and web portals and developing changes to the Health-e-App web portal. By DHCS overseeing the SPE, MAXIMUS will continue to provide Accelerated Enrollment for children that meet the criteria. The purpose of Accelerated Enrollment is to assign temporary, fee-for-service, full-scope, no-cost Medi-Cal enrollment for children under the age of 19 who are new to Medi-Cal, applied for Medi-Cal through SPE, and are likely eligible for a Medi-Cal children's percent of poverty program based on the screening done at SPE. DHCS will continue to respond to any SPE applicant concerns directly by phone, email, or letters. DHCS will use the information received from

applicants to monitor if there are deficiencies or needs for business flow improvements, to provide favorable customer service experiences.

As of January 1, 2013, DHCS implemented similar premium payment collection processes and standards as Healthy Families, making adjustments as needed to conform to Medicaid requirements, and using MAXIMUS, via the contractual arrangement, for premium collection management.

In preparation for the start of Phase 4, DHCS continues to lead the technical stakeholder meetings that began in preparation of previous phases. The stakeholder meetings with counties, including CWDA, discuss in detail the operational changes needed to transition the children. As it is currently, DHCS will continue to update and/or revise policies and procedures from the efforts of prior phases to ensure a unified transition and consistency in Phase 4.

Eligibility Processes

DHCS has responsibility for establishing policies and procedures for eligibility determination processes, premium collection, cost sharing provisions, and performance metrics for application processing. New applications received at the Single Point of Entry (SPE) undergo a completeness determination and missing information is requested before the application is forwarded to the counties for an eligibility determination. Eligible children continue to be provided with accelerated enrollment (AE) during the eligibility determination process, which allows children to receive services without delay. A flowchart describing the SPE application process has been developed and provided to counties and is available for review on the DHCS website. Additionally, MRMIB, DHCS, Counties, Consortia, and MAXIMUS, DHCS' Administrative Vendor, worked together to develop an e-IAT (electronic – inter agency transfer) process for transmitting data. With the use of the e-IAT, application data will be electronically transmitted directly from MAXIMUS to the consortia for use by counties to manage Medi-Cal cases and determine initial Medi-Cal eligibility. DHCS will continue to work closely on these efforts with counties, stakeholders, and MRMIB, as well as MAXIMUS in its role as both the DHCS' Administrative Vendor and Healthy Families Administrative Vendor.

County Administration

For purposes of the transitioned cases, DHCS accepts the most current eligibility determination made by MRMIB to transition the Healthy Families child to the applicable new Medi-Cal transition aid code. The child's annual redetermination date will remain the same as it was under the Healthy Families Program. At the transitioned child's annual redetermination date, the county reassesses the child for Medi-Cal eligibility and moves the child to a permanent Medi-Cal aid code. Applications submitted directly to the county continue to be processed according to existing processes, including evaluating for eligibility to the new Optional Targeted Low Income Children's Program.

In the case of non-payment of premiums, counties will conduct a redetermination of Medi-Cal eligibility consistent with the process set forth in Senate Bill (SB) 87 (Escutia,

Statutes of 2000, Chapter 1088) during which time the child continues to receive benefits. Under SB 87, the county follows three specific steps to determine eligibility: 1) a thorough ex parte review; 2) phone contact if necessary, and, finally, 3) sending a special form for information, if necessary. The county remains committed to evaluating the case for continuing eligibility under another Medi-Cal program. If the child is not eligible for any other program, the county may discontinue the case for non-payment of premium and the county shall provide a timely Notice of Action, which includes information on fair hearing rights and how to obtain a fair hearing. A county will notify MAXIMUS if, upon reevaluation of the case, the child is found to be eligible for another program, the child is ineligible for any Medi-Cal program, or if the family requests to disenroll the child. Upon notification from counties of the child's disenrollment from Medi-Cal, MAXIMUS will be responsible for discontinuing premium collection services as directed by DHCS.

Currently, DHCS meets three times a week with counties, consortia, CWDA, and MAXIMUS to discuss eligibility processes. Issues that arise during these calls are responded to in meetings, in issue logs that are updated and provided to the counties multiple times a week, and on the DHCS website in the dedicated Healthy Families Program Transition section. As new counties are transitioning, they are able to review the issue logs and website to resolve questions that arise that have already had a resolution. DHCS has also begun making weekly calls to representatives of transitioned counties to provide assistance with eligibility related issues and to request feedback from counties regarding specific concerns raised during the conference calls. As a result of feedback during the weekly calls, DHCS along with a MAXIMUS representative previously conducted an onsite visit with a county that requested assistance understanding the forms sent to them from SPE. DHCS and MAXIMUS gained insight into the counties concerns from the counties perspective and became better informed to provide guidance to other counties on the issue. Due to the favorable outcome of the visit, DHCS and MAXIMUS are willing to make additional county visits as needed should other concerns arise.

Eligibility Data Reports and Performance Standards

DHCS facilitated discussions with the counties, the CWDA, the consortia, and other interested stakeholders to discuss the required data reports and performance standards. The requirements for the data reports and performance standards were finalized and released in ACWDL 12-29, Data Reporting and Performance Standards for the Healthy Families Program to Medi-Cal Transition, which was released in November 2012.

The data reports include information on the number of applications processed on a monthly basis, a breakout of the applications based on income using the FPLs, the final disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from SPE. Several counties submitted the first report to DHCS on March 15, 2013 for the month of January 2013 and data collection continues in its early stages.

In an effort to receive Healthy Families Program Data in an efficient manner, DHCS has established dedicated inboxes to receive the information. Counties have been instructed to send their monthly data report (Attachment I of ACWDL 12-29) to HFData@dhcs.ca.gov. The counties are following the instructions and the monthly reporting activity is being monitored the Program Review Branch (PRB).
Also, MAXIMUS submits monthly reports to DHCS for Single Point of Entry (SPE) activities. MAXIMUS sends their monthly report to the dedicated inbox HFMaximus@dhcs.ca.gov. This activity is also monitored by PRB. Every county has a designated staff member assigned for submitting their reports to DHCS or to be contacted if necessary by DHCS for clarification, etc. DHCS has obtained the name, telephone number, and E-Mail address of each contact person. In addition, PRB has developed charts to store the data received by the counties to insure their compliance with ACWDL 12-29.

Premium Management

DHCS is maintaining similar premium payment collection processes and standards as Healthy Families, adjusting as needed to conform to Medicaid requirements. Families with incomes above 150 percent of the FPL and up to and including 250 percent of the FPL are subject to premiums at $13 monthly for each child, with a maximum of $39 monthly per family.

DHCS has contracted with MAXIMUS for premium collection management services including providing informational services that instruct families on how and where to pay premiums. Families are able to use the same payment methods available to subscribers in the Healthy Families Program - use of checks, money orders, cash to any Western Union Convenience Pay location, by credit card over the phone or through a portal on the DHCS website, or by electronic fund transfers (EFT). As with the Healthy Families Program, families with recurring EFTs will receive a 25 percent monthly discount and families that pay three months in advance will get the 4th month free. MAXIMUS is responsible for sending monthly premium billing notices (to be paid by the 20th of each month), premium collections, notices for lack of payment, and notification to counties when there is a lapse of payment for two consecutive months to initiate a redetermination of Medi-Cal eligibility. In addition, Maximus has implemented a premium repayment policy for transitioned children who have credits in their Healthy Families account for premiums. For children that have Healthy Families credits for premium payments at the time of transition, a refund will be provided after they have transitioned to Medi-Cal.

Cost Sharing Limits (Premiums and Co-Payments)

Currently Medi-Cal does not implement enforceable co-payments for any service a beneficiary receives, though nominal co-payments are permitted pursuant to Welfare and Institutions Code Section14134, ranging from $1 to $5. These include medical/dental services, prescription drugs and non-emergency use of the emergency room of a hospital. These co-payment provisions are not enforceable, meaning providers cannot deny the service if the person cannot pay the applicable co-payment. The co-payment amounts are expressly inapplicable to individuals under the age of 19.

Cost sharing provisions are not imposed for individuals who are American Indians/ Alaskan Natives and receive or are eligible to receive services from an Indian Health Service Provider.

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

Federal Medicaid rules require that total premiums and cost-sharing may not exceed five percent of the family income for a time period specified by the State, which can be monthly or quarterly. This time period is monthly for California. DHCS will ensure that transitioning families with incomes above 150 percent FPL, who are subject to premiums, will not exceed the five percent monthly limit for cost-sharing.

Based on Medi-Cal's current cost-sharing structure, DHCS does not expect that a typical Healthy Family transitioned family's cost-sharing, consisting of premium payments, not to exceed $39 per month per family, would exceed the federal five percent threshold based on the income projections of children that will be assessed a premium. The chart below provides a sample of the projected incomes and potential cost sharing limit.

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

Children	150% FPL	Premiums	5% Cap	Amount Available for Co-Pays
1	$1,437	$13	$72	$59
2	$1,939	$26	$97	$71
3	$2,442	$39	$122	$83
4	$2,944	$39	$147	$108
5	$3,447	$39	$172	$133

Children	185% FPL	Premiums	5% Cap	Amount Available for Co-pays
1	$1,772	$13	$89	$76
2	$2,392	$26	$120	$94
3	$3,011	$39	$151	$112
4	$3,631	$39	$182	$143
5	$4,251	$39	$213	$174

Children	200% FPL	Premiums	5% Cap	Amount Available for Co-pays
1	$1,915	$13	$96	$83
2	$2,585	$26	$129	$103
3	$3,255	$39	$163	$124
4	$3,925	$39	$196	$157
5	$4,595	$39	$230	$191

Children	250% FPL	Premiums	5% Cap	Amount Available for Co-pays
1	$2,394	$13	$120	$107
2	$3,232	$26	$162	$136
3	$4,069	$39	$203	$164
4	$4,907	$39	$245	$206
5	$5,744	$39	$287	$248

In planning ahead for the federal approval of co-payments, DHCS will seek stakeholder input to develop a methodology for tracking the five percent monthly cap without requiring beneficiary involvement. A potential premium/co-payment tracking process could be developed in coordination with MAXIMUS to ensure the five percent limit is not exceeded.

MONITORING AND OVERSIGHT

Monitoring Plan

Beginning February 15, 2013, and monthly thereafter, for the duration of the transition, DHCS will be reporting to the Legislature information on health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks, including provider enrollment and disenrollment changes, and eligibility performance standards which will be encompassed in the Department's Monitoring Plan. Data on changes to the provider network and grievances/complaints are collected quarterly. The data from the Quarterly Reports received from Plans will be incorporated into the June 15th Monitoring Plan. The goal of the reports is to inform DHCS, the Legislature, partners, and stakeholders of the impact the transition has on the children over the course of the transition period.

For a detailed description of the State's monitoring policies and metrics and reporting frequencies, see the Master CA 1115 Demo Final document (starting on pages 276 and 284, respectively) at
http://www.dhcs.ca.gov/services/hf/Pages/HFPFederalApprovals.aspx.

On the matter of eligibility, DHCS is particularly interested in continuous enrollment of children once transitioned to Medi-Cal or newly enrolled. Early reporting suggest that children transitioned to Medi-Cal are maintaining their coverage and children previously identified as Healthy Families children are accessing Medi-Cal at the county level as new enrollments. In addition, it has been reported at the county level that children previously eligible for share of cost programs in Medi-Cal prior to the transition are having their eligibility redetermined for the new Optional Targeted Low Income Children's Program in Medi-Cal.

Continuity of Care

Continuity of care is another critical element in ensuring a smooth transition of children from the Healthy Families Program to Medi-Cal. This is particularly important for children needing dental, mental health, and alcohol and drug treatment services. All transitioning subscribers will be eligible for continuity of care in accordance with the completion of covered services protections set forth in Health & Safety Code § 1373.96. That provision requires plans to continue to cover treatment by a non-network treating physician when that treatment is a covered benefit under the plan and the patient is being treated for specific conditions defined in that section.

In addition to the protections in the Health and Safety Code, DHCS' contracts with the health plans requires the plans to provide ongoing care, for contracted Medi-Cal covered services, with a non-network treating PCP for 12 months following the transition, if the PCP accepts the Medi-Cal rate and there are no quality of care concerns with regard to that provider. Therefore, subscribers whose PCP does not contract with the Plan may still continue to see their PCP for 12 months post-transition under those circumstances.

If a service is not covered under Medi-Cal, or not to the same extent that it was in Healthy Families, continuity of care may not apply.

Please refer to *Appendix 3* for the Dental Continuity of Care provisions.

FEDERAL APPROVAL

AB 1494 requires that the State obtain federal approval prior to the start of the transition. On Monday, December 31, 2012, CMS approved the amendment to California's section 1115 waiver, the "California Bridge to Reform Demonstration (11-W-00193/9)", and Phase 1A of the transition, effective January 1, 2013. For details on the federal approval letter, see http://www.dhcs.ca.gov/services/hf/Pages/HFPFederalApprovals.aspx. For details on the Standard Terms and Conditions on the Healthy Families Program Children Transitioning to Medicaid Expansion Demonstration (HFPCTD), see the Master CA 1115 Demo Final, Section 8, Title E (starting on page 62) at http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx. . As part of the STC, DHCS is required to seek federal approval prior to each phase transitioning over. DHCS has received approvals from CMS to proceed with Phase 1B, Phase 1C, and Phase 2 implementations. DHCS will continue follow its existing process and seek federal approval prior to commencing Phase 4 on September 1, 2013.

Beginning January 2013, DHCS has regular monthly and weekly meetings with CMS staff for guidance on various aspects of the State Plan Amendment (SPA) to ensure the final version meets with federal approval.

The effective date of the Title XIX State Plan Amendment (SPA) is September 1, 2013, the date Phase 4 children transition to Medi-Cal. DHCS, in collaboration with CMS and input from stakeholders, continues to work on the details of this SPA. The draft SPA documents are currently posted on the HFP Transition website http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx. Subsequent versions of the SPA will also be posted on the HFP Transition website upon submission to CMS for review.

Additionally, MRMIB must submit a Title XXI State Plan Amendment, which occurs once the transition completes. The MRMIB amendment is a conformance amendment which will affirm the changes resulting from the transition.

DHCS reviews each transition phase with CMS to study ways to improve upon the current course taken and how the transition affected the beneficiary and/or their families. The monitoring report, webinar sessions, and website news serve as tools to inform CMS government, interested stakeholders, the Legislature, and the general public of our transition goals and how well we meet those goals.

APPENDIX 1 – Counties Transitioning in Phase 4 on September 1, 2013

Healthy Families Program Transition to Medi-Cal Phase 4 Enrollment Breakdown					
Upon implementation of the transition, all new applicants will be evaluated for coverage under the Medi-Cal program. Members will maintain linkage to the sub plan, through the primary Medi-Cal health plan.					
Counties Transitioning on September 1, 2013					
County	**Medi-Cal Plan Model**	**Healthy Families Health Plan**	**Approximate Enrollment**	**Medi-Cal Managed Care Plan Choices**	**Medi-Cal Dental Enrollment**
Alpine	Regional County	Anthem Blue Cross	6	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Amador	Regional County	Anthem Blue Cross	345	Anthem Blue Cross or California Health and Wellness Plan or Kaiser*	Denti-Cal
		Kaiser	17		
Butte	Regional County	Anthem Blue Cross	2,755	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Calaveras	Regional County	Anthem Blue Cross	546	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Colusa	Regional County	Anthem Blue Cross	1,562	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Del Norte	COHS	Anthem Blue Cross	458	Partnership Health Plan	Denti-Cal
El Dorado	Regional County	Anthem Blue Cross	1,976	Anthem Blue Cross or California Health and Wellness Plan or Kaiser*	Denti-Cal
		Kaiser	500		
Glenn	Regional County	Anthem Blue Cross	1,124	Anthem Blue Cross or California Health	Denti-Cal

Healthy Families Program Transition to Medi-Cal Phase 4 Enrollment Breakdown					
Upon implementation of the transition, all new applicants will be evaluated for coverage under the Medi-Cal program. Members will maintain linkage to the sub plan, through the primary Medi-Cal health plan.					
Counties Transitioning on September 1, 2013					
County	**Medi-Cal Plan Model**	**Healthy Families Health Plan**	**Approximate Enrollment**	**Medi-Cal Managed Care Plan Choices**	**Medi-Cal Dental Enrollment**
				and Wellness Plan	
Humboldt	COHS	Anthem Blue Cross	2,630	Partnership Health Plan	Denti-Cal
Imperial	Imperial Model	Anthem Blue Cross	3,784	California Health and Wellness Plan	Denti-Cal
Inyo	Regional County Model	Anthem Blue Cross	257	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Lake	COHS	Anthem Blue Cross	1,301	Partnership Health Plan	Denti-Cal
Lassen	COHS	Anthem Blue Cross	190	Partnership Health Plan	Denti-Cal
Mariposa	Regional County Model	Anthem Blue Cross	146	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Modoc	COHS	Anthem Blue Cross	103	Partnership Health Plan	Denti-Cal
Mono	Regional County Model	Anthem Blue Cross	374	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Nevada	Regional County Model	Anthem Blue Cross	2,180	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Placer	Regional County Model	Anthem Blue Cross	2,331	Anthem Blue Cross or California Health and Wellness Plan or Kaiser*	Denti-Cal
		Health Net	765		
		Kaiser	1,755		
Plumas	Regional County Model	Anthem Blue Cross	215	Anthem Blue Cross or	Denti-Cal

Healthy Families Program Transition to Medi-Cal Phase 4 Enrollment Breakdown					
Upon implementation of the transition, all new applicants will be evaluated for coverage under the Medi-Cal program. Members will maintain linkage to the sub plan, through the primary Medi-Cal health plan.					
Counties Transitioning on September 1, 2013					
County	**Medi-Cal Plan Model**	**Healthy Families Health Plan**	**Approximate Enrollment**	**Medi-Cal Managed Care Plan Choices**	**Medi-Cal Dental Enrollment**
				California Health and Wellness Plan	
San Benito	Regional County Model	Anthem Blue Cross	1,606	Anthem Blue Cross	Denti-Cal
Shasta	COHS	Anthem Blue Cross	3,092	Partnership Health Plan	Denti-Cal
Sierra	Regional County Model	Anthem Blue Cross	26	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Siskiyou	COHS	Anthem Blue Cross	541	Partnership Health Plan	Denti-Cal
Sutter	Regional County Model	Anthem Blue Cross	3,026	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Tehama	Regional County Model	Anthem Blue Cross	1,194	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Trinity	COHS	Anthem Blue Cross	187	Partnership Health Plan	Denti-Cal
Tuolumne	Regional County Model	Anthem Blue Cross	823	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
Yuba	Regional County Model	Anthem Blue Cross	1,568	Anthem Blue Cross or California Health and Wellness Plan	Denti-Cal
		Total	**37,383**		

* Includes only current Kaiser Healthy Family members

Source: HFP Monthly Enrollment Reports – March 2013

APPENDIX 2 – Performance Measures

1. Annual Dental Visits
Percentage of Medi-Cal eligible beneficiaries who had at least one (1) dental visit during the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received one or more of the following dental procedures:
D0120-D0999
D1110-D2999
D3110-D3999
D4210-D4999
D5110-D5899
D6010-D6205
D7111-D7999
D8010-D8999
D9110-D9999

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:

0-3	7-10	19-20
2-3	9-11	2-18
4-5	11-14	
4-6	12-14	
6-8	15-18	

2. Continuity of Care
Percentage of Medi-Cal eligible beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation or a prophylaxis in both the year prior to the measurement year and in the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries in the denominator who also received a comprehensive or periodic oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled for two (2) years with no gap in coverage who received a comprehensive oral evaluation (D0120, D0150) or a prophylaxis (D1110, D1120) in the year prior to the measurement year.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

3. Use of Preventive Services
Percentage of Medi-Cal eligible beneficiaries who received any preventive dental service during the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received any preventive dental service (D1000-D1999) in the same measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

4. Use of Sealants
Percentage of Medi-Cal eligible beneficiaries ages 6-9 and 10-14 continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received a dental sealant on at least one permanent molar tooth during the measurement year.

Calculation
Numerator: 1) Number of Medi-Cal eligible beneficiaries ages 6-9 continuously enrolled during the measurement year with no more than a one-month gap in eligibility, who received a dental sealant (D1351) on a permanent first molar (Tooth Number = 3,14,19,30).
2) Number of Medi-Cal eligible beneficiaries ages 10-14 continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received a dental sealant (D1351) on a permanent second molar (Tooth Number = 2,15,18,31).

Denominator: Number of Medi-Cal eligible beneficiaries ages 6-9 and 10-14, respectively, continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:
6-9
10-14

5. Sealant to Restoration Ratio (Surfaces)
The ratio of occlusal surfaces of permanent first and second molars receiving dental sealant to those receiving restoration among Medi-Cal eligible beneficiaries ages 6-9 and 10-14 continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Calculation
Numerator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3,14,19,30) in 6-9 and 10-14 year olds and of permanent second molars (Tooth Number = 2,15,18,31) in 10-14 year olds receiving dental sealant (D1351) among Medi-Cal eligible beneficiaries in those age groups continuously enrolled during the measurement year with no more than a one-month gap in eligiblity .

Denominator: Number of occlusal surfaces of permanent first molars (Tooth Number = 3,14,19,30) in 6-9 and 10-14 year olds and of permanent second molars (Tooth Number = 2,15,18,31) in 10-14 year olds receiving a restoration (D2000-D2999) among Medi-Cal eligible beneficiaries in those age groups continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:
6-9
10-14

6. Treatment/Prevention of Caries
Percentage of Medi-Cal eligible beneficiaries who received either treatment for caries or a caries-preventive procedure during the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received a treatment for caries (D2000-D2999) or a caries-preventive procedure (D1203-D1206, D1310, D1330, D1351) during the measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

7. Exams/Oral Health Evaluations
Percentage of Medi-Cal eligible beneficiaries who received a comprehensive or periodic oral health evaluation or, for Medi-Cal eligible beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary care giver, during the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received a comprehensive or periodic exam (D0120 or D0150) or , for Medi-Cal eligible beneficiaries under 3 years of age, who received an oral evaluation and counseling with the primary caregiver (D0145), during the measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than one-month gap in eligibility.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

8. Overall Utilization of Dental Services
Percentage of Medi-Cal eligible beneficiaries continuously enrolled for one (1), two (2), and three (3) years who received any dental service during those periods.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled for one (1), two (2), and three (3) years with no gap in coverage who received any dental service (D0100-D9999) during those periods.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled for one (1), two (2), and three (3) years with no gap in coverage respectively.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

9. Usual Source of Care
Percentage of Medi-Cal eligible beneficiaries who received any dental service each year for two (2) consecutive years.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled for two (2) consecutive years with no gap in coverage who received at least one (1) dental service in each of those years.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled for two (2) consecutive years with no gap in coverage.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

10. Use of Dental Treatment Services
Percentage of Medi-Cal eligible beneficiaries who received any dental treatment service during the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received any dental treatment service (D2000-D9999) in the measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

11. Preventive Services to Fillings
Percentage of Medi-Cal eligible beneficiaries who received one (1) or more fillings in the measurement year who also received preventive services (topical fluoride application, sealant, preventive resin restoration, education) in the measurement year.

Calculation
Numerator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received one (1) or more fillings (D2000-D2999) in the measurement year and who also received one (1) or more topical fluoride applications (D1203, D1204 or D1206), dental sealants (D1351), preventive resin restorations (D1352) or education to prevent caries (D1310 or D1330) in the measurement year.

Denominator: Number of Medi-Cal eligible beneficiaries continuously enrolled during the measurement year with no more than a one-month gap in eligibility who received one (1) or more fillings (D2000-D2999) in the measurement year.

Group by age:

0-3	9-11	19-20
4-5	12-14	0-18
6-8	15-18	

SPECIAL INSTRUCTIONS:

A. Each report is to be produced cumulatively as the measurement year progresses. For example, the January 2013 report would only contain January 2013 data. The February 2013 report would contain January 2013 and February 2013 data. At the end of the measurement year, data for all months January 2013 through December 2013, would be included in the December 2013 report.
B. A measurement year is defined as a calendar year-- January 1 through December 31
C. A Medi-Cal eligible beneficiary is defined as having fee-for-service eligibility with full scope, no share of cost.
D. Age is defined as the Medi-Cal eligible beneficiary's age as of December 31 of the measurement year.
E. Procedures are defined as paid procedures
F. Procedures received are based on Date of Service

APPENDIX 3 – Dental Continuity of Care Provisions

The Department of Health Care Services (DHCS) Medi-Cal Dental program has initiated new or modified existing policies to ensure continuity of care for children transitioning from the Healthy Families Program (HFP) to Medi-Cal. Departmental Dental Operating Instruction Letters (DOIL) were sent to the dental fee-for-service fiscal intermediary, Delta Dental of California (Delta) to implement the new or changes in policy. In addition to new/changed program policies, the DHCS will conduct further transition activities to assess the transition and identify if further actions are needed. Below is information on each new or change in policy that the program is executing.

NEW/CHANGED POLICIES – DENTAL OPERATING INSTRUCTION LETTERS

DOIL 12-176 – HFP Continuity of Care

Similar to the Medi-Cal Dental program, the Healthy Families dental plans also require providers to obtain prior authorization on certain procedures before performing and billing the program for services. In order to provide continuity of care for children transitioning from the Healthy Families to the Denti-Cal program (the Medi-Cal fee-for-service dental program), this DOIL will instruct Delta on how to handle claims for services that have previously approved Healthy Families prior authorizations.

Current Process:

The Denti-Cal Program requires approved prior authorization for certain services prior to treatment being performed by providers. When a provider submits a claim for payment of services performed, a system edit occurs to ensure all required prior authorizations were received and that the services are authorized by the Denti-Cal Program prior to payment. Services that did not receive the required prior authorization or are not a benefit of the Denti-Cal Program are denied for payment.

Change in Policy:

DHCS has instructed Delta to honor approved prior authorizations issued by the Healthy Families dental plans where the services are covered by Denti-Cal and the provider bills for a Denti-Cal approved procedure. Delta has been instructed to pay claims where:

- The child has eligibility under aid code 5C, 5D, H1, H2, H3, H4, H5
- The approved prior authorization procedure with Healthy Families, that is not a covered Denti-Cal service, has a comparable Denti-Cal procedure (regardless of material).
- The services are provided within the Healthy Families dental plan approved authorization period.
- The services are performed by an enrolled Denti-Cal provider.
- The provider submits proof of the prior authorization by the Healthy Families dental plan.

A provider bulletin (Volume 28, No. 17), titled *Healthy Families Program Transition: Continuing Dental Treatment of Your Healthy Families Program Beneficiaries*, was

posted in the month of December on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-177 – Provider Referral Procedure Change and Improvement – Implement A "Warm" Transfer Process for Beneficiaries Requesting Provider Referral Information

DHCS has received ongoing feedback from advocates and stakeholders that the current provider referral process for beneficiaries is ineffective.

Former Process:
When beneficiaries currently call the Denti-Cal Beneficiary Telephone Service Center (TSC) for a provider referral, they are given a list of up to three providers to contact in their area. However, it is possible that one or all of the providers referred to the beneficiary may not be valid or accepting new patients. Additionally, in many instances when the beneficiary calls the providers given to them from TSC, he/she is unable to find a provider who will provide the needed services. As a result, the beneficiary may call the TSC multiple times before he/she finds a provider that will treat him/her.

Change in Policy:
To ensure that a Denti-Cal provider is located and will treat the beneficiary, Delta was directed to implement a "warm" (conference) calling process for all beneficiaries who call the Denti-Cal Beneficiary TSC to locate a provider in their area.
When a beneficiary calls the Denti-Cal Beneficiary TSC for a provider referral, TSC contacts a provider to confirm with the provider that he/she is accepting Denti-Cal patients and can provide the services required by the beneficiary. Once this confirmation is received, TSC conferences in the provider to the beneficiary to schedule an appointment on that phone call. Delta is to research most cost effective feature to transfer (conference) these calls.

Delta tracks the number of provider referral calls on a daily basis and provides a report that shows the number of calls per day by month. The report also lists outcomes, including *Received*, *Unresolved*, and *Resolved*, on locating provider to provide the necessary services to the beneficiary. Delta also uses manual tracking process to identify provider referral calls from beneficiaries transitioning from the Healthy Families to Medi-Cal and to identify beneficiaries who are referred to provider office outside the 10 miles or 30 minutes time and distance standard from the address requested or is referred to a provider outside the county they requested.
In addition, Delta is to develop internal processes to identify providers listed on the referral list who are not actively accepting new patients and to document those geographical areas that are lacking providers willing to accept new patients. Delta is to incorporate this new process into the Provider Outreach Strategy submitted for approval annually.

A provider bulletin will be posted in the month of January on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-178 – Denti-Cal Provider Referral Form and Call Campaign
The Medi-Cal Dental program providers currently have access to a free referral service for accepting Denti-Cal patients. This referral service is a resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service to the State's medically needy. DOIL 12-181 dated November 14, 2012 instructed Delta that signatures are no longer required on the Medi-Cal Dental Patient Referral Service (Provider Referral) forms.

Former Process:
The Provider Referral form is included in provider enrollment packets, mailed out annually, and accessed online on the Denti-Cal website. Providers mail the form to Denti-Cal to request to be added to the Provider Referral list, to be removed from the referral list, or to update their information.

Change in Policy:
DHCS instructed Delta to replace the Provider Referral form currently located on the Denti-Cal website and included as part of the provider enrollment packet with the attached revised Provider Referral form. Additionally, a signature is no longer required for the provider to be placed onto or removed from the Provider Referral list, or to update their existing information. Delta is adding providers to the Provider Referral List via phone calls into the Provider Customer Service line, mail, email, and fax. Providers emailing the form are directed to send the form to a specified departmental email address.

Delta was instructed to call the providers to capture any additional information needed to complete the revised Provider Referral form and notify the provider once he/she has been added to the Provider Referral List.
A provider bulletin was posted in the month of January on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

DOIL 12-181 – Denti-Cal Provider Referral List
The Medi-Cal Dental Program providers currently have access to a free referral service for accepting Denti-Cal patients. This referral service is a resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service to the State's medically needy.

Former Process:
Providers cannot be added to or deleted from the Provider Referral list, or update their existing information without a signed Referral form.

Change in Policy:
DHCS instructed Delta that signatures are no longer required on the Medi-Cal Dental Patient Referral Service (Provider Referral) forms. Effective immediately, DHCS instructs Delta Provider Outreach staff to identify and add all active Denti-Cal billing

providers to the Provider Referral List who stated in the Provider Survey that they want to be added to the list.
DHCS instructed Delta to input the below information, gathered from the survey, and update the Provider Master File (PMF) in CD-MMIS:

1. Provider Referral
2. Wheelchair Accessible
3. Special Needs
4. Specialist

If the survey results do not have data to complete all fields in the PMF when adding the provider to the referral list, Delta is instructed to leave those field(s) blank in the PMF.

DOIL 12-183 – Medi-Cal Dental Provider Enrollment Transformations – Preferred Provisional Provider Status and Changing Effective Dates to Date an Application Is Received

The Welfare and Institutions (W&I) Code Section 14043.26(d) allows providers who meet the criteria identified in that section to be considered within 60 days for enrollment in the Medi-Cal program as preferred provisional providers. Based upon the authority granted to the director of the DHCS in W&I Code Section 14043.75(b), the director has established the procedures described in the Instructions section of this DOIL. The described procedures below must be followed for a provider to request enrollment in the Medi-Cal Dental program as a preferred provisional provider.
In order to align Delta's enrollment process with that of DHCS, Provider Enrollment Division (PED), this DOIL is to reform the current effective date of enrollment for providers to the date in which Delta initially received the enrollment application package.

Former Process:
Delta currently validates the enrollment of providers through an initial, manual credentialing process for new Denti-Cal enrollment applications. Delta does not currently perform any credentialing for the preferred provisional provider status as specified in the Instructions section of this DOIL.
Also, the effective date of enrollment for an applicant being credentialed through Denti-Cal is the date the credentialing analyst determines that the application has been thoroughly reviewed and qualifies under the requirements articulated by law. Delta does not currently input an effective date which reflects the date the application was received.

Change in Policy:
The effective date of enrollment will be granted to qualified providers with the date the provider's application is received. Providers currently in Denti-Cal's enrollment inventory who wish to invoke the preferred provisional provider status must submit the cover letter certifying the four criteria.
Delta shall report the status of providers applying under the preferred provisional provider status to DHCS upon request. A provider bulletin, titled *Medi-Cal Dental Provider Enrollment: Preferred Provisional Provider Status*, will be posted in the month

of December on the Denti-Cal website (www.denti-cal.ca.gov) informing providers of change in policy.

OTHER DENTI-CAL TRANSITION ACTIVITIES

PROVIDER NETWORK ASSESSMENT AND OUTREACH BY COUNTY

DHCS is assessing beneficiary assignment data received from MRMIB to identify what providers are not enrolled in Denti-Cal by counties in each phase. Once any un-enrolled providers are identified, Denti-Cal is contacting providers to encourage enrollment into program while also informing them of enrollment webinars and online tutorials available to them. Denti-Cal is holding series of webinars to educate providers on how to enroll in the Denti-Cal program and to answer questions. Online training videos are available to educate providers on the Denti-Cal enrollment process. Active recruiting is currently a process across all counties prior to their transition.

DENTAL MANAGED CARE

Included in the contracts between DHCS and the dental managed care plans are requirements for the dental plans to ensure continuity of care for beneficiaries transitioning from the Healthy Families to Medi-Cal. The requirements include:

- Dental managed care plans will provide children who are transitioning from the Healthy Families to Medi-Cal continued access to their current Primary Care Dentist if the Primary Care Dentist is a contracted provider in the dental plan's Medi-Cal provider network. The dental plans will also provide continued access if the Primary Care Dentist is not within the dental plans' Medi-Cal provider network, if the nonparticipating provider agrees in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracting providers providing similar services and who are practicing in the same or a similar geographical area as the nonparticipating provider, including, but not limited to, payment for services, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements.

- Dental managed care plans will provide for the completion of covered services for the treatment of certain specified conditions if: (a) the services were being provided by a provider that is within the dental plan's Medi-Cal provider network at the time of the transition, or (b) the covered services were being provided by a nonparticipating provider who agrees to comply with the plan's contractual terms and conditions. Beneficiaries are entitled to continuation of services from such providers for the following circumstances and timeframes:

    a. An acute condition (defined as a dental condition that involves a sudden onset of symptoms due to an illness, injury, or other dental problem that requires prompt dental attention and that has a limited duration).
    b. A serious chronic condition. Completion of covered services under this paragraph shall not exceed 12 months from the transition date or 12 months from the effective date of coverage for a newly covered beneficiary.
    c. Performance of a surgery or other procedure that is authorized by the plan as part of a documented course of treatment and has been recommended and

documented by the provider to occur within 180 days of the transition date or within 180 days of the effective date of coverage for a newly covered beneficiary.

- Dental managed care plans will develop care plans on how beneficiaries will continue to receive services which they had been receiving at the time of transition, if the beneficiaries, that transition into Medi-Cal, are not able to remain with their Primary Care Dentists. The dental plans will report this care plan to the Department to show continuity of care is being provided and the outcome of the dental plan's care plan.

APPENDIX 4 – Number of Denti-Cal Providers on Referral List – By County

Referral List Data for Counties in Phase 4	
County	**Number of Providers on Referral List**
Alpine	0
Amador	1
Butte	8
Calaveras	0
Colusa	1
Del Norte	0
El Dorado	3
Glenn	1
Humboldt	2
Imperial	12
Inyo	0
Lake	2
Lassen	1
Mariposa	0
Modoc	2
Mono	0
Nevada	0
Placer	8
Plumas	0
San Benito	2
Shasta	3
Sierra	0
Siskiyou	1
Sutter	7
Tehama	0
Trinity	0
Tuolumne	1
Yuba	0