

## **Waiver Outline**

### I. Preface

### II. Program Description and Historical Context

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of Healthy Families Program subscribers to the Medi-Cal program commencing no sooner than January 1, 2013 and upon implementation of the transition, ceases all new enrollments into the Healthy Families Program and begins the coverage and enrollment of these children under the Medi-Cal program. The Healthy Families Program, administered by the Managed Risk Medical Insurance Board (MRMIB), currently serves over 863,000 children with health, dental, and vision coverage. Children enrolled in the HFP will be transitioned into the Medi-Cal's Targeted Low-Income Children's (TLIC) Program, administered by the Department of Health Care Services (DHCS), where they will continue to receive health, dental, and vision benefits. The TLIC Program covers children with family incomes up to and including 200 percent of the federal poverty level. The State will use less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the federal poverty level (FPL) for eligible children in the TLIC Program.

HFP subscribers will transition to Medi-Cal in the following phases:

#### Phase 1:

Part A: No sooner than January 1, 2013, children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence will be enrolled in the same plan.

Part B: No sooner than March 1, 2013, remaining children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence will be enrolled in the same plan.

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

Phase 3: No sooner than August 1, 2013, children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan will be enrolled in a Medi-Cal managed care health plan in that county. The child's primary care provider will be considered pursuant to State statutory authority.

Phase 4: No sooner than September 1, 2013, children residing in a county that is not currently a Medi-Cal managed care county will be transitioned into the Medi-Cal fee-for-service delivery system. To the extent the department is successful in its efforts to create managed care delivery systems in these counties, the child shall be enrolled into the managed care health plans.

Families seeking coverage for children eligible as a new TLIC, effective upon implementation of the transition or no sooner than January 1, 2013 will be enrolled under the Medi-Cal program.

### III. General Program Requirements (page 4-7) – CMS requirements no changes

#### IV. General Reporting Requirements

For purposes of the transition, consistent with the enabling transition legislation, AB 1494, the following reporting requirements will apply for children enrolled in the TLIC Program:

- Number of applications processed;
- Final disposition of each application including information on approved Medi-Cal program;
- Average number of days to make final eligibility determination for application submitted directly to the county and from the single point of entry (SPE) for the TLIC Program.
- Grievances related to access to care,
- Continuity of care requests and outcomes, and
- Changes to provider networks, including provider enrollment and disenrollment changes.

This information shall be reported on a quarterly basis to CMS, beginning April 2013 and will continue through the transition year.

#### State Reporting Requirements

In addition to the reporting requirements to CMS, the following reporting requirements will be implemented in accordance with AB 1494:

- Strategic Plan/Phase 1 Implementation Plan due to the Legislature October 1, 2012; completed October 2, 2012
- Phase 1 Network Adequacy due to the Legislature 60 days prior to the start of Phase 1; due November 1, 2012
- Provide Notice to Families 60 days prior to the start of Phase 1; due to families November 1, 2012
- Secure Federal Approval prior to the start of the transition; due December 31, 2012.
- Ongoing Requirements for Phases 2 - 4
  - Implementation Plans; due to the Legislature at least 90 days prior to the start of the respective phases
  - Network Adequacy Assessment; due to the Legislature at least 90 days prior to the start of the respective phases
  - Notice to Families; due to families at least 90 days prior to the start of the respective phases
  - Monthly Status Reports; due to the Legislature commencing February 15, 2012

#### Notices

In addition to the statutorily required timeframes for notices, the State, in collaboration with stakeholders, will develop written notices for families. Such notices shall be written in plain language and translated into the Medi-Cal threshold languages. The following is the schedule for the follow-up notices:

- Phase 1, there will be another notice sent 30 day prior to the implementation of the Phase 1a and 1b transitions;
- Phases 2 – 4, there will be notices sent at 60 day and 30 day timeframes in advance of the respective transition date.
- The notices will include information on the following:

- An explanation of the transition;
- A description of changes in benefit delivery systems;
- An overview of health and dental plan options – letters sent 30 days prior to an effective transition date will include the Medi-Cal delivery system the child will move into (managed care and FSS);
- Toll free contact information to answer questions and for additional assistance.
- Medi-Cal welcome packets with dental insert; and,
- Benefit identification cards with information on coverage and how to use the card.

### **Performance Metrics**

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

**Health Plans:** The DHCS performance metrics for health plans shall be integrated and coordinated with the HFP performance standards including but not limited to, child-only Healthcare Effectiveness Data and Information Set (HEDIS) measures and measures indicative of performance in serving children and adolescents. These measures shall also be in compliance with all performance requirements under the Knox-Keene Health Care Services Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and existing Medi-Cal managed care performance measurements and standards, including those in Chapter 8 (commencing with Section 14200), Title 22 of the California Code of Regulations, and all plan letters, including but not limited to network adequacy and linguistic services and shall be met prior to the transition of individuals in Phase 1. The list of measures for 2012 is available on the DHCS website at:  
<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF>.

All current DHCS HEDIS measures are applicable across populations. For example, well child visits, immunizations, comprehensive diabetes care and annual monitoring of patients on persistent medications are just a few of the currently required HEDIS measures that apply equally to MCP beneficiaries, SPDs, Healthy Families, dual-eligibles, and rural expansion populations.

**Medi-Cal Dental Program:** Both the dental managed care (DMC) plans and Denti-Cal are required to report on eleven performance measures. The DMC plans will provide encounter data and Denti-Cal will provide claims data. The data will be monitored on a monthly basis and publicly reported quarterly.

New Dental Managed Care plan contracts will include eleven performance measures – annual dental visits (the only dental HEDIS performance measure), continuity of care, use of preventive 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 preventive services to filling. These measures include HFP performance measures as well as two CMS performance measures.

**Public Engagement:**

- DHCS has created a HFP Transition web site with current documents available for stakeholder review, HFP informational documents, and contact information for the HFP Transition email address, which receives questions and concerns. Various program staff monitors the email box regularly.
- DHCS is developing written county policy via All County Welfare Director Letters with information on how HFP cases will transition to Medi-Cal, and the use of ongoing policies for HFP cases under Medi-Cal.
- DHCS is convening meetings with counties, consortia, and stakeholders to discuss eligibility data reports and performance standards. Data reports will be available monthly and available to the public on the HFP Transition website.
- DHCS is amending health plan contracts to include protections that allow transitioning children to stay with their primary care physician, to the extent that the family does not choose otherwise.

V. General Financial Requirements Payments for Medicaid-Eligible Patients

- A. Safety Net Care Pool
- B. Funding Limitations on the LIHP - Health Care Coverage Initiative (HCCI)
- C. **Targeted Low-Income Children’s (TLIC) Program Cost Sharing**

36. **Targeted Low-Income Children’s (TLIC) Program Premiums.** The State will not impose monthly premiums for family incomes at or below 150 percent of the FPL after the application of the less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the FPL. The State will impose monthly premiums for family incomes above 150 percent of the FPL and up to and including 200 percent of the FPL. Monthly premiums are equal to thirteen dollars (\$13) per child, per month with a maximum of thirty-nine dollars (\$39) per family, per month. Families that pay three months of premiums in advance will receive the fourth consecutive month of coverage with no premium required. Families that pay their premium by means of electronic funds transfer including credit card payment will receive a twenty-five percent discount on their

premium. Eligibility will be terminated for failure to pay after a grace period of 90 days after the premium due date.

37. **Targeted Low-Income Children's (TLIC) Program Copayment.** The State will not impose co-payment for children under the age of 18 in accordance with federal Medicaid requirements. However, the State may impose co-payments on individuals over the age of 18 and under the age of 19. A family's monthly cost sharing amount (premium and copayment combined) will not exceed five percent of the family's monthly income consistent with sections 1916 and 1916A of the federal Social Security Act and the California Title XIX proposed State Plan Amendment, 12-018. Native Americans and Alaskan Natives will be exempted from premiums and co-payments in accordance with California's proposed State Plan Amendment, 12-018.

VI. State Plan and Demonstration Populations Affected by the Demonstration;

- A. Low Income Health Program (LIHP)
  - 1. Medicaid Coverage Expansion (MCE)
  - 2. Health Care Coverage Initiative (HCCI)
- B. California Children Services (CCS)
- C. Seniors and Persons with Disabilities (SPD)
- D. 1915(b) Waiver Populations –
- E. Community Based Adult Services (CBAS) Populations:
- F. **Targeted Low-Income Children's (TLIC) Program Populations (pursuant to 1902(a)(10)(A)(ii)(XIV))** – Children newly eligible under this category beginning January 1, 2013, using less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent and up to and including 250 percent of the FPL with income disregards pursuant to Section 1902(r)(2) of the federal Social Security Act; and, children who were determined eligible for the State's Healthy Families Program with family income below 200 percent of the FPL, or family income at or above 200 of the FPL and up to and including 250 percent of the FPL with income disregards pursuant to Section 1902(r)(2) of the federal Social Security Act that will be transitioned into Medi-Cal in phases (described below) based upon their Healthy Family Program income eligibility determination and will have their Medi-Cal eligibility redetermined on the individual's Healthy Families Program annual review date, based on the following FPLs:

<b>Ages</b>	<b>Federal Poverty Level</b>
0-1	At 200 percent FPL (after application of the income disregard)
1-6	Above 133 percent and up to 200 percent of FPL
6-19	Above 100 percent and up to 200 percent of FPL
6-19	Above 133 percent and up to 200 percent of FPL (Effective January 1, 2014)

VII. Demonstration Delivery Systems

VIII. Operation of Demonstration Programs

**Enrollment:** HFP subscribers will transition to Medi-Cal in the following phases:

Phase 1:

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No phase will commence until the state ensures network adequacy.

### **Network Adequacy**

The following criteria will be used to as the standard for the network adequacy analysis:

- Knox Keene Act (KKA) full-service standards: 15 mi/30min, 1:2000 Primary Care Provider (PCP) ratio, 1:1200 physician ratio, access to specialists, timely access to care.
- KKA dental plan standards: 1:2000 Primary Care Dentist (PCD) ratio.
- DHCS contract requirements: 10 mi/30 min. Physician extender ratios: no more than 1000 members assigned to a non-physician extender, 1 supervision physician to 4 nurse practitioners, 1 supervising physician to 2 physician assistants, and 1 supervising physician to 3 nurse midwives.

The Medi-Cal dental provider adequacy standard is based on the Knox-Keene standard of a 1:2000 ratio as an initial assessment for provider adequacy for timely access to quality dental care.

### **Continuity of Care**

The DHCS and DMHC will, as part of their collaborative ongoing health plan medical surveys, ensure that enrollees affected by the HFP transition are assisted and protected under California's strong patient rights laws.

- The DMHC will enforce all Knox Keene provisions related to the completion of covered services (section 1373.96).

After all phases of the transition are complete, the following will occur to monitor performance:

- DHCS and DMHC intend to monitor networks on a quarterly basis to evaluate accessibility and availability of providers.

- DMHC intends to conduct medical surveys of all licensed health plans once every 3 years to assess availability of services in compliance with language assistance regulations.
- DMHC intends to conduct plan surveys once every 3 years to evaluate compliance with Knox Keene provisions related to health care operations.
- DHCS intends to conduct plan member rights monitoring reviews every 2 years and medical audits annually to monitor all aspects of contractors operation for compliance with contract provisions and federal and state laws and regulations.

**Delivery System-** Transitional members will receive Medi-Cal through both the fee-for-service (FFS) and managed care plan (health, dental (as appropriate) and mental health). Covered benefits, as children transition over per their respective Phase, will be the same as what is currently provided to full-scope, no cost Medi-Cal beneficiaries which will include the provision of Early Periodic Screening, Diagnosis and Treatment services as currently approved under the current Medi-Cal State Plan.

**Dental Coverage**

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

All children residing in Sacramento County will transition into a Medi-Cal Dental Managed Care (DMC) plan during the phase in which their medical benefits transition. If the child’s HFP dental plan is a Medi-Cal DMC plan, the child will be automatically enrolled into that plan. If the child’s HFP dental plan is not a Medi-Cal DMC plan, the child will be automatically enrolled into a plan based on where their HFP primary care dentist is an in-network provider. All transitioning children will have the choice to change dental plans once they are transitioned. Additionally, if these children experience difficulty accessing timely dental services after being transitioned into DMC, these children may receive dental services under the Denti-Cal program under the Beneficiary Exception Process.

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

Dental Plan Crossover			
Healthy Families Program vs. Medi-Cal Dental			
Dental Plan	Healthy Families Program	Medi-Cal Dental (Sacramento)	Medi-Cal Dental (Los Angeles)
Access Dental	YES	YES	YES
Delta Dental	YES	NO	NO
DeltaCare	YES	NO	NO
Health Net Dental	YES	YES	YES

Safeguard Dental	YES	NO	YES
Western Dental	YES	NO	YES

**Mental Health Coverage:**

Transitioned children will access mental health services as follows: if a child is receiving "basic" mental health services provided by his/her primary care physician (PCP) or one of the HFP mental health network providers and she/he moves into a Medi-Cal managed care plan, his/her non-specialty mental health services (or basic mental health services) will continue and will be provided by the Medi-Cal managed care plan, usually by a PCP, or, if the service is one that is not covered by the plan, a Medi-Cal FFS provider. If a child is receiving HFP Seriously Emotionally Disturbed (SED) services through the county mental health plan, the county mental health plan will assess the child to determine if she/he meets medical necessity criteria to receive Medi-Cal specialty mental health services. If those criteria are met, the county mental health plan will continue to provide services, if those criteria are not met, the mental health plan will refer the child back to the Medi-Cal managed care plan for services, or to a Medi-Cal FFS provider if the child is not in a Medi-Cal managed care plan.

- A. Low Income Health Program (LIHP)
- B. Seniors and Persons with Disabilities (SPD)
- C. Community Based Adult Services
- D. California Children Services
- E. Targeted Low Income Children’s Program

- IX. Other Administrative Requirements
- X. General Financial Requirements Under Title XIX
- XI. General Financial Requirements Under Title XXI
- XII. Monitoring Budget Neutrality for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

**Questions for CMS:**

- **Confirm whether changes are needed in the attachments. The current language in the attachments has some exemptions for "Healthy Families" populations, but after this transition, they wouldn't be Healthy Families any longer.**
- **Confirm if changes are needed in section XII – budget neutrality.**