



**HEALTHY FAMILIES PROGRAM
TRANSITION TO MEDI-CAL**

**NETWORK ADEQUACY ASSESSMENT REPORT
PHASE 4**

May 31, 2013

**Submitted by the California Department of Health Care Services and
Department of Managed Health Care
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)**

**HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL
NETWORK ASSESSMENT – PHASE 4**

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SECTION I. EXECUTIVE SUMMARY

Background

Pursuant to Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012), as amended by AB 1468 (Chapter 438, Statutes of 2012), the Department of Health Care Services (DHCS) plans to commence Phase 4 of the transition of Healthy Families Program (HFP) enrollees to the Medi-Cal program beginning September 1, 2013.¹ The HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), currently provides health, dental, and vision coverage to over 860,000 low-income children. Children currently enrolled in the HFP will receive their health, dental, and vision benefits through the Medi-Cal program.

The Department of Managed Health Care (DMHC) licenses and regulates health plans pursuant to the Knox-Keene Health Care Services Plan Act of 1975, as amended (“Knox-Keene Act”). MRMIB contracts with twenty health plans and five dental plans licensed by the DMHC to provide coverage for HFP enrollees.

Pursuant to the legislation, the transition of the HFP enrollees will be conducted in four phases, with the fourth phase occurring no sooner than September 1, 2013. Children who will be transitioned during Phase 4 are enrollees residing in counties that offer HFP health plans but do not currently contain any Medi-Cal managed care plans.² Approximately 37,383 children will transition during this phase. Most of these children will be able to stay in their same plan after the move to Medi-Cal, or will automatically move into the single Medi-Cal plan that operates in their county. A small group of children who cannot stay in their plan but have multiple Medi-Cal plan choices in their county will have the opportunity to choose a Medi-Cal managed care plan in advance of the transition. Dental services for Phase 4 children will change at the same time that their medical coverage changes.³

As part of the Medi-Cal rural expansion effort, the DHCS has contracted with three health plans to provide Medi-Cal managed care services in the Phase 4 counties. These plans are expected to be fully operational in those counties by September 1, 2013. As required by the legislation and in order to proceed with the Phase 4 transition, the DMHC and the DHCS (hereinafter “the departments”) have collaborated in assessing the adequacy of the Medi-Cal managed care plans’ networks in these rural counties.

¹ The Healthy Families Transition to Medi-Cal Network Adequacy Assessment for Phase 1 was submitted to the legislature on November 1, 2012. The Healthy Families Transition to Medi-Cal Network Adequacy Assessment for Phase 2 was submitted to the legislature on January 1, 2013. The Healthy Families Transition to Medi-Cal Network Adequacy Assessment for Phase 3 was submitted to the legislature on May 1, 2013. All reports and related addenda are available at the following location:

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

² A Table listing the health plans providing coverage for Phase 4 HFP enrollees and their respective enrollment is included as Attachment 1.

³ All Phase 4 children will receive dental services under Denti-Cal, the Medi-Cal Fee-for-Service dental program. All Dental Managed Care networks and Denti-Cal networks operating in Phase 1 counties were assessed in the Phase 1 report

Key Findings

The departments reviewed the following Medi-Cal plans that are currently scheduled to participate in Phase 4 of the transition: Anthem Blue Cross, California Health and Wellness, and Partnership Health Plan. The departments also requested and reviewed data from the HFP plans operating in the Phase 4 counties to evaluate how those plans will facilitate continuity of care.

At this time, the managed care plans contracted to provide Medi-Cal services in the Phase 4 counties are still in the process of finalizing their provider networks. The plans have engaged in various efforts to build their networks in the Phase 4 counties, including identifying existing HFP providers for inclusion in the network and exploring telehealth opportunities.

The Medi-Cal Plans have also identified methods for ensuring continuity of care to enrollees as they transition to Medi-Cal. Efforts to ensure continuity of care will largely depend on the availability of information regarding which providers the HFP enrollees are seeing in the HFP network. The DHCS is currently working on developing a process to share information from the HFP plans with the Medi-Cal plans prior to the transition. If that information is not available prior to transition, the plans have identified strategies for ensuring that enrollees do not experience a break in primary care services during the PCP selection process.

Ultimately, the departments note that all plans appear to have appropriate strategies for building their networks and ensuring continuity of care, and network adequacy will be fully assessed once the provider networks are finalized. The departments intend to issue an Addendum to this report once all networks have been finalized, which, at this time, is expected to be available on or about July 15, 2013.

SECTION II. INTRODUCTION

As required in Welfare and Institutions Code § 14005.27(e)(9)(A), the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) (hereinafter “the departments”) have collaborated in assessing Medi-Cal managed care plan network adequacy for the Phase 4 transition of HFP enrollees into Medi-Cal. To accomplish this, the departments collected data from the HFP plans operating in the Phase 4 counties and the Medi-Cal plans contracted to provide Medi-Cal services in the Phase 4 counties.

With regard to network data from the HFP plans, the departments collected all required network data from all Phase 4 HFP plans – Anthem Blue Cross, Kaiser Foundation Health Plan, and Health Net of California. The HFP plans provided their detailed provider networks and narrative explanations to questions regarding how the plans will assist in the transition and ensure continuity of care.⁴

The Medi-Cal health plans are still in the process of contracting with providers for their networks in the Phase 4 counties. Because the provider networks are not yet finalized, the Medi-Cal plans were unable to provide complete provider information to the departments for review. The departments expect that the networks will be finalized by June 15, 2013 and plan to prepare an Addendum to this report by July 15, 2013. The Addendum will focus on analyzing the detailed provider information. Given this limitation, the departments initiated their network adequacy assessment by requesting that the plans respond to detailed narrative questions.⁵ These narrative questions focused on the following items:

- The steps the plan will take to facilitate continuity of providers for transitioning enrollees;
- How the plan will facilitate continuity of care when the patient must change providers, including the transition of existing authorizations and referrals;
- Outreach and communications with enrollees regarding provider reassignment;
- The Plan’s processes for out-of-network referrals and timely access to services;
- The current status of the Plan’s efforts to contract with providers in the Phase 4 counties, including efforts to bring appropriate specialists and existing HFP providers into its network; and
- The estimated date of network finalization.

The departments analyzed the plan responses to the narrative questions and have summarized that information in this assessment. The departments intend to submit a follow-up report that

⁴ The specific request sent to all HFP plans can be found in Attachment 2 – “Data Requested from Health Plans.”

⁵ The specific request sent to all Medi-Cal plans can be found in Attachment 2 – “Data Requested from Health Plans.”

provides a detailed network analysis once the plans have finalized their provider networks in the Phase 4 counties. The departments plan to produce this report by July 15, 2013.

SECTION III. MEDI-CAL HEALTH PLAN NETWORK ASSESSMENTS

This section contains the departments’ assessment of the Medi-Cal provider networks by plan based on plan responses to narrative questions.

Anthem Blue Cross

Anthem Blue Cross (“Plan”) has been selected by the DHCS to be one of two available Medi-Cal plans in the following counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. It will be the only Medi-Cal plan available in San Benito County. Current HFP enrollment numbers indicate that 25,097 enrollees will be transitioning into Medi-Cal in these counties during Phase 4. The Plan operates an HFP line of business in each of these counties. Approximately 22,060 of these enrollees are currently assigned to the Plan’s HFP line of business in these counties; thus, 3,037 children will need to transition from their current plan to Anthem in these counties.

Provider Network Status

- **Contracting Efforts:** The Plan states that it has been contacting HFP and Medi-Cal providers in the Phase 4 counties since the fall of 2012 regarding potential Medi-Cal contracts. While the Plan has offered contracts to any physician willing to accept Medi-Cal rates, the Plan indicates that providers have been slow to agree to contracts with the Plan, partially due to concerns regarding the change to managed care. At this time, the Plan has secured 200 provider contracts and estimates it will require another 250 contracts to complete its network. The Plan has approached all of its current HFP providers for inclusion in the Medi-Cal network. The following chart identifies the current number and percent of HFP providers who have agreed to participate in the Medi-Cal network:

County	Percent of HFP providers in the Medi-Cal Network	Number of HFP Providers in the Medi-Cal Network
Alpine	No Current HFP Providers	
Amador	0%	0 out of 4 HFP providers
Butte	24%	8 out of 33 HFP providers
Calaveras	50%	1 out of 2 HFP providers
Colusa	33%	1 out of 3 HFP providers

El Dorado	14%	2 out of 14 HFP providers
Glenn	0%	0 out of 4 HFP providers
Inyo	0%	0 out of 4 HFP providers
Mariposa	0%	0 out of 1 HFP provider
Mono	50%	2 out of 4 HFP providers
Nevada	17%	3 out of 18 HFP providers
Placer	16%	5 out of 32 HFP providers
Plumas	0%	0 out of 5 HFP providers
San Benito	TBD	
Sierra	No Current HFP Providers	
Sutter	40%	4 out of 10 HFP providers
Tehama	13%	1 out of 8 HFP providers
Tuolumne	20%	1 out of 5 HFP providers
Yuba	0%	0 out of 3 HFP providers

The Plan states that it has approached all specialists in the 18 counties, plus specialists in neighboring counties, regarding contracting with the Plan’s Medi-Cal network. The Plan expects that it will face challenges locating specialists due to the rural nature of these counties. However, the Plan intends to utilize specialists in its existing contiguous Medi-Cal counties, as well as through its telehealth program, to address the specialty needs of the transitioning population.

The Plan further indicates that its efforts to contract with hospitals have been limited by a lack of premium information. The Plan must obtain further information regarding hospital costs in order to negotiate contracts with them.

- Provider Outreach and Communication:** The Plan states that its contracting teams reach out to providers on a daily basis to secure additional contracts. The Plan has utilized mailings, in-person contacts, telephonic contacts, and Town Hall meetings to reach out to providers. Additionally, the Plan has met with local stakeholder groups and provider associations to attract more providers into its network. All Phase 4 plans have

also obtained data from the DHCS related to existing Medi-Cal fee-for-service providers in the Phase 4 counties.

Continuity of Care

- **Continuity of Primary Care:** For HFP enrollees who are transitioning from another plan, the Plan indicates that, if it is able to obtain enrollee provider assignment information from the HFP plan in early August, it will attempt to maintain enrollees with their existing PCPs and coordinate assignment to treating PCPs prior to the transition. If the data is received after enrollment, the Plan will not assign an enrollee to a PCP until it has received PCP assignment information. The Plan will assign the patient to the treating PCP if the PCP is available in the Plan's network.
- **Continuity of Prescriptions and Specialist Authorizations:** The Plan indicates that it expects that the transitioning HFP plans will provide all personal health information, including medical, behavioral health, and pharmacy authorization data, for current HFP enrollees to MRMIB. The Plan hopes that MRMIB will then deliver this data to DHCS and then the Plan will be able to obtain this information for all new transitioning HFP enrollees from the DHCS. At this time, such a process for sharing personal health information, including the timing and distribution method, is unconfirmed. For patients who have existing care management plans, the Plan will work to adopt those plans, so long as the relevant information can be shared by the HFP plan. The case management team will facilitate the transition of specialty services and will work with the Pharmacy Benefit Manager to provide authorization overrides for prescription medications until the enrollee has safely transitioned to the appropriate provider.
- **Out-of-Network Care:** The Plan's Medical Management Department has a process in place to ensure continued access to care with a non-network treating provider for enrollees with qualifying conditions for specified time periods.⁶ Case Managers will develop transition plans for enrollees with qualifying conditions to allow for an appropriate transition to participating providers once the approved continuity of care timeframe has been completed. Transition plans will be developed utilizing information from the enrollee, the treating provider, and the in-network provider to whom the member's care will be transferred and will include the non-network provider's treatment plan. For enrollees who do not have a qualifying condition, the Medical Management Department will assist the enrollee in transitioning to an in-network provider. The Plan also maintains an Access to Care team comprised of registered nurses who are trained to work with enrollees and providers to identify and authorize required services that are not available within the network.

⁶ Pursuant to Health and Safety Code § 1373.96, the Plan is legally required to provide completion of covered services with a non-contracted treating provider for prescribed timeframes if the enrollee has a health condition as described in the statute.

Timely Access to Care: The Plan’s Case Managers will work with enrollees with specific health conditions to ensure timely continued access to care. The Plan also utilizes outreach specialists who work with provider offices to facilitate appointments for members. All contracted providers are informed of the Plan’s Access to Care policy and are required to adhere to timely access standards.

Enrollee Outreach Efforts: The Plan will send a new member kit to all new enrollees upon joining the Plan. This kit includes an Evidence of Coverage/Member Handbook which explains how to change PCPs and other information about the health care services available through the Plan.

Assessment: The departments acknowledge that the Plan has made efforts to build its network in the Phase 4 counties; however, the departments are unable to finalize their assessment regarding the capacity or adequacy of the networks to provide care for the transitioning HFP enrollees at this time. The departments have requested that the Plan provide detailed provider networks as soon as the networks have been finalized. At that time, the departments will be able to provide a more detailed analysis regarding network capacity, provider overlap, and geographic access for primary and specialty services. The departments also note that the Plan has not clearly identified how enrollees will be informed of their right to seek out-of-network services and continued access to care with non-participating providers. The departments will follow-up with the Plan regarding this issue and will report on the Plan’s response in the forthcoming Addendum to this report.

California Health and Wellness Plan

California Health and Wellness (“Plan”) has been selected by the DHCS to be one of two available Medi-Cal plans in the following counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba. The majority of the transitioning enrollees in these counties will be auto-assigned to Anthem Blue Cross because, in most cases, that plan is the only existing HFP plan in these counties and it will be operating as a Medi-Cal plan for Phase 4. California Health and Wellness will be the only Medi-Cal plan available in Imperial County, and therefore will receive all transitioning enrollees in that county. Current HFP enrollment numbers indicate that 27,275 enrollees will be transitioning into Medi-Cal in these counties during Phase 4. Currently, the Plan does not operate an HFP line of business and it is in the process of obtaining a Knox-Keene license to operate in California.

Provider Network Status

- **Contracting Efforts:** The Plan indicates that it is currently working with providers within the Phase 4 and neighboring counties to build an adequate and accessible network. Although the Plan is a new health plan in the state of California, the Plan indicates it has built provider networks in ten other states and feels confident in its ability to assemble an appropriate provider network in the Phase 4 counties. The Plan states it started building its network by contracting with traditional and safety net providers and has obtained Letters of Intent from a variety of providers at this point in time. The Plan is currently in the process of converting these letters into executed contracts. In addition, the Plan is reviewing the provider directories for HFP in the Phase 4 counties to identify additional providers who may be willing to contract with the Plan.

With regard to ancillary services, the Plan indicates that it has national vendor relationships with certain vision, pharmacy, and diagnostic service providers. It has also conducted outreach to local independent providers in order to expand its ancillary services network.

With regard to specialist services, the Plan states that it is recruiting across all specialty areas, but is focusing specifically on the following specialty areas: obstetrics and gynecology, pediatrics, allergy and immunology, internal medicine, cardiology, general surgery, and ophthalmology/optometry.

The Plan states that it intends to make providers available to all transitioning HFP enrollees within the 10 mile/30 minute geographic access standard.

- **Provider Outreach and Communication:** The Plan states it has worked on developing a provider network over the past two years by reaching out to federally qualified health centers, critical care access hospitals, and other traditional safety net providers, as well as

local trade organizations, to secure Letters of Intent in preparation for its proposal to participate in the DHCS rural expansion of Medi-Cal managed care. The DHCS also provided the Phase 4 plans with a list of Medi-Cal fee-for-service providers in the Phase 4 counties in preparation for the development of provider networks. The Plan states that it utilizes providers who have already agreed to be in the Plan's network as a source for identifying other providers who may be willing to contract with the Plan. Additionally, the Plan has reached out to medical professional associations to identify providers for its network.

Continuity of Care

- **Continuity of Primary Care:** The Plan is utilizing provider directories from the existing HFP plans to identify and contract with PCPs who are currently serving HFP enrollees. This strategy will allow for more enrollees to maintain their PCP post-transition. The Plan will offer a "Find-a-Doc" website function and the Member Call Center will assist enrollees in searching for their current provider or to identify a new provider that is appropriate for the enrollee. Enrollees may "nominate" their PCPs for inclusion in the network if the PCPs are not contracted at the time of enrollment. The Plan's contracting team will contact the nominated PCPs to encourage participation in the Plan's network. Furthermore, if an enrollee's PCP is not in the Plan's network but is willing to accept the Medi-Cal fee-for-service rate and has no quality of care concerns, then the Plan will allow continued access to that provider via the authorization process.

Enrollees will have an opportunity to select a PCP prior to the transition utilizing the Plan's Member Portal and Find-a-Doc function on the Plan website; however, the Plan will auto-assign enrollees who do not select a PCP within 30 days of enrollment or who select a PCP who is not accepting new patients or who have strict criteria for member assignment. Assuming the Plan is able to obtain the transitioning enrollees' HFP PCP assignment data from the DHCS, the Plan will base its auto-assignment algorithm on matching enrollees to their treating PCPs first, then to a family member's PCP if the treating PCP is not in the network. If neither of these options is available, the Plan will assign PCPs based on the enrollee's geographic location and personal attributes (e.g. age, sex).

The Plan will use multiple sources to identify enrollees with existing and ongoing health care needs. These sources will include: pharmaceutical records; telephonic response to Plan outreach; inpatient hospital notices; family contacts; provider acknowledgments; and historical information from the DHCS regarding the transitioning enrollees, including claims data, authorization information, identification of members currently under care, members who have chronic health care conditions, and members who are eligible and participating in California Children's Services ("CCS") program. The Plan will develop a care plan detailing how enrollees with specific health needs continue to receive services

that were being delivered at the time of transition. The Plan will continue existing treatment and honor existing authorizations to the extent that the services are covered under Medi-Cal.

The Plan will educate providers on the Plan's continuity of care policies through the New Provider Orientation, Provider Manual, and the Provider Portal. Specifically, providers will be educated on the Plan's policy for automatic initial authorization of any existing covered services, authorization requirements for the period beyond initial enrollment, and the safe transition of members to a participating provider or new care plan.

- **Continuity of Prescriptions and Specialist Authorizations:** With regard to specialists, the Plan is recruiting specialists based on the providers who are currently available in the HFP network and based on current utilization patterns identified through sources such as claims history, authorization data, PCP referral patterns, and specialty alignment through hospital outreach. If enrollees are not able to stay with their treating specialists, the Plan will assist in facilitating transition to other physicians. As with PCPs, enrollees may “nominate” their treating specialists and the Plan will attempt to contract with those providers. The Plan will utilize health risk assessments, Notifications of Pregnancy, provider requests for authorizations, and member contacts to identify members who have special health care need that may require ongoing care with a non-participating treating provider. The Plan will allow enrollees with disabilities, multiple diagnoses, or chronic conditions to select a specialist as their PCP, if the specialist is willing to serve in that role.

With regard to pharmacy services, the Plan will continue existing, non-formulary prescriptions for up to 30 calendar days. During that time, the Plan will work with the prescribing physician to transfer the enrollee to a formulary medication, if appropriate.

- **Out-of-Network Care:** The Plan states it will authorize up to 12 months of PCP services with an out-of-network treating PCP, as long as the provider accepts the Medi-Cal fee-for-service rate.⁷ Pregnant members in their second or third trimester will be able to continue seeing their non-network treating OB/GYNs through delivery and the six-week post-partum visit. The Plan will honor all other existing authorizations to continue medically necessary covered services with an out-of-network treating physician for up to 30 days during the initial transition period. The Plan's Care Manager will complete an assessment to determine if enrollees who cannot continue seeing their treating provider can be transitioned safely to a participating provider. The Care Management staff will also reach out to the treating physician to attempt to bring that physician into the network.

⁷ This conforms to the DHCS contract which requires Medi-Cal plans involved in the HFP transition to pay for out-of-network primary care services with a treating PCP for a period of 12 months if the provider is willing to accept the Medi-Cal fee-for-service rate or the Plan's contracted rate and the provider does not have any quality of care concerns.

If an enrollee cannot be safely transitioned to a participating provider, the Plan will enter into a Single Case Agreement with the non-participating provider.

Timely Access to Care: The Plan states its provider network will meet or exceed all required geographic and appointment access standards. If an enrollee is assigned to a new PCP, the Plan will inform the PCP of the new patient within 10 calendar days of the date of selection or assignment. The Plan continually updates provider panel information via its provider web application. All providers are required to adhere to appointment access standards. Case Managers will also be available to assist enrollees in locating providers and obtaining timely appointments.

Enrollee Outreach Efforts: The Plan will educate its enrollees on its continuity of care policies, enrollee rights to continue receiving existing services, the assistance available through the Care Management Program, and the Plan's process for determining whether and how a person is transitioned to a participating provider. Enrollees will be instructed to contact the toll-free Member Call Center if they are in need of services. If an enrollee qualifies for ongoing care with a non-participating treating provider, pursuant to state law or plan policies and procedures, the Plan will instruct that enrollee to continue accessing their existing services and supplies during the transition period.

Assessment: The departments acknowledge that the Plan has made efforts to build its network in the Phase 4 counties; however, at this time, the departments are unable to finalize their assessment regarding the capacity or adequacy of the networks to provide care for the transitioning HFP enrollees. The departments have requested that the Plan provide detailed provider networks as soon as the networks have been finalized. At that time, the departments will be able to provide a detailed analysis regarding network capacity, provider overlap, and geographic access for primary and specialty services.

It appears that the Plan has a multi-faceted strategy for identifying enrollees who may have special health needs and has policies in place to allow for ongoing care with treating physicians during the transition. These strategies and policies will assist the Phase 4 HFP enrollees in continuing to receive services during the transition period. Upon receipt of the Plan's finalized provider network, the departments will be able to better assess how many enrollees will need to utilize these policies because their treating providers are not participating in the Plan's network.

The departments note that, while the Plan has detailed the types of information it intends to share with enrollees regarding continuity of care, the Plan has yet to identify *how* it will share this information with enrollees. The departments will follow-up with the Plan regarding this issue and will report on the Plan's response in the forthcoming Addendum to this report.

Partnership Health Plan

Partnership Health Plan (“Plan”) is a County Organized Health System. It has been selected by the DHCS to be the only Medi-Cal managed care plan in the following counties: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Current HFP enrollment numbers indicate that 8,502 enrollees will be transitioning into Medi-Cal in these counties during Phase 4. The Plan does not currently operate an HFP line of business in these counties, so all transitioning enrollees will be changing health plans.

Provider Network Status

- **Contracting Efforts:** The Plan indicates that it is currently conducting outreach to providers within the Phase 4 counties to build an adequate and accessible network. The Plan is reviewing the provider directories for the HFP program in the Phase 4 counties to identify additional providers who were not already targeted by the Plan’s Provider Relations Department.

With regard to specialist services, the Plan states that it currently monitors specialty access in accordance with DHCS requirements and will ensure that specialists available in each Phase 4 county are listed in its provider directories. The Plan is also exploring the use of telehealth in the Phase 4 counties and is looking for opportunities to strengthen and expand the use of telehealth. The Plan continues to contract with specialists in the Phase 4 counties and expects to make an updated list of contracted specialists available in June 2013.

- **Provider Outreach and Communication:** The Plan states its Provider Relations Department has conducted outreach to existing provider networks in the Phase 4 counties to identify contracting opportunities. All Phase 4 plans have also obtained data from the DHCS related to existing Medi-Cal fee-for-service providers in the Phase 4 counties.

Continuity of Care

- **Continuity of Primary Care:** The Plan states that it will treat all transitioning HFP enrollees as “special members” for the first month of eligibility and will assign them to a safety net provider for October 1, 2013, based on the enrollee’s zip code and language preference if the enrollee does not select a PCP by that date. If the Plan is able to obtain provider linkage data identifying the enrollees’ current treating PCPs, the Plan will auto-assign enrollees to their treating PCPs if those PCPs contract with the Plan’s network, rather than assigning to a safety net provider as described above. This will allow for a smooth transition for those enrollees whose PCPs participate in the Plan’s network.

Upon enrollment, enrollees will be notified of their option to select a PCP from the Plan network and make a request to continue seeing a non-contracted PCP. If a non-

contracted PCP is requested, the Plan will contact the provider to attempt to bring that provider into the contracted network. If the provider is not willing to participate in the Plan's network, the Plan will review the request according to the DHCS continuity of care requirements.⁸ The Plan will identify enrollees needing continuity of care services via enrollee calls to the Plan's Member Services Department.

- **Continuity of Prescriptions and Specialist Authorizations:** With regard to prescription benefits, the Plan will communicate with pharmacies regarding the transition of HFP enrollees into the Medi-Cal managed care so that the pharmacies will properly identify who is responsible for paying for prescription medications for transitioning enrollees. The pharmacy benefits will largely remain the same, except for those non-capitated or "carve out" medications, which are covered through Medi-Cal fee-for-service, rather than through the managed care plan.⁹ The Plan will alert its network providers, including physicians and pharmacies, that they must contact Medi-Cal fee-for-service for any payment or approval requests related to these medications.
- **Out-of-Network Care:** The Plan will conduct a "new member welcome call" for all transitioning enrollees. During that call, the Plan will identify if the enrollee is undergoing an existing course of treatment or has a special health care circumstance about which the Plan should be aware. This information is passed to the Plan's Care Coordination Department to help preserve continuity of care and consider whether the patient would qualify for ongoing care from a non-network provider, pursuant to the Plan's policy and state law.

Timely Access to Care: The Plan states its Care Coordination team will help facilitate the transition of enrollees to new providers in order to ensure timely care is obtained during the transition. Furthermore, the Plan closely monitors access through member complaints, provider feedback, and Plan staff involved in the coordination and facilitation of patient care. The Plan may also conduct periodic surveys to ensure timely access standards are being met for new enrollees.

Enrollee Outreach Efforts: The Plan indicates that it is largely relying on the existing relationships between HFP enrollees and their providers to educate enrollees and assist in linking enrollees with appropriate PCPs. The Plan has developed a process for primary care sites that are contracted in the Plan's Medi-Cal network and also participate in the HFP network to assist HFP enrollees who are currently assigned to these providers in selecting a PCP or medical home prior to the transition. The primary care sites will provide current HFP enrollees with a PCP selection form and will forward completed forms to the Plan so that the enrollee's treating PCP is identified on the Member Card at the time of enrollment. The Plan has also provided primary

⁸ According to the contract between the DHCS and the Plan, the Plan must provide for 12 months of care with an out-of-network treating PCP if the PCP is willing to accept the Medi-Cal rate and the PCP does not have any quality of care concerns.

⁹ These non-capitated or "carve out" benefits include HIV medications, psychotherapeutics, and detoxification medications.

care offices with a Toolkit which contains informational flyers, talking points, selection forms, and other materials the office may use to assist transitioning enrollees. In addition, the Plan will distribute flyers through safety net providers, engage in radio interviews, deliver press releases to general media, and call local newspaper reporters in order to inform the population in the Phase 4 counties of the transition to Medi-Cal managed care.

Assessment: The departments acknowledge that the Plan has made efforts to build its network in the Phase 4 counties; however the departments are unable to finalize their assessment regarding the capacity or adequacy of the networks to provide care for the transitioning HFP enrollees at this time. The departments have requested that the Plan provide detailed provider networks as soon as the networks have been finalized. At that time, the departments will be able to provide a detailed analysis regarding network capacity, provider overlap, and geographic access for primary and specialty services.

It appears that the Plan has a strategy for ensuring that enrollees do not experience a break in primary care services and for identifying enrollees who may be able to continue with their treating PCP. Upon receipt of the Plan's finalized provider network, the departments will be able to better assess how many enrollees will be able to continue seeing their treating PCP after the transition.

The Plan's strategy for ensuring continuity of specialty care and its recruitment efforts with regard to specialists is less clear. The departments will follow-up with the Plan regarding its specialist network and how it will ensure that current referrals and authorizations for specialty care are appropriately identified and seamlessly transitioned to the Plan.

The departments note that, while the Plan has a strategy for providing continuity of care to enrollees who request it, the Plan has yet to identify how enrollees will be informed of their right to continuity of care and ongoing treatment with an out-of-network provider. The departments will follow-up with the Plan regarding this issue and will report on the Plan's response in the forthcoming Addendum to this report.

SECTION IV. HEALTHY FAMILIES HEALTH PLAN ASSESSMENTS

This section contains a summary of the efforts HFP plans will undertake to help preserve continuity of care for Phase 4 HFP enrollees as they transition into Medi-Cal Managed Care. This information is based on plan responses to narrative questions.

Anthem Blue Cross

Continuity of Care: Anthem Blue Cross (“Plan”) currently operates an HFP line of business in the following Phase 4 counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba. The Plan states that provider data for transitioning Phase 4 HFP enrollees will be collected by MRMIB and forwarded to DHCS for distribution. The Plan will follow its continuity of care policy for transitioning enrollees with qualifying medical conditions. Transitioning enrollees who do not meet eligibility requirements for continuity of care may seek assistance from the Plan in selecting a participating provider.

Kaiser Foundation Health Plan

Continuity of Care: Kaiser Foundation Health Plan (“Plan”) currently operates an HFP line of business in the following Phase 4 counties: Amador, El Dorado, and Placer. The Plan contracts exclusively with The Permanente Medical Group (“TPMG”) to provide medical services to all of the Plan’s members in the Northern California Region. The Plan currently does not participate in Medi-Cal Managed Care in portions of Amador, El Dorado, and Placer counties; however, the Plan indicates it intends to continue providing services for these enrollees after they transition into Medi-Cal.

The Plan utilizes the same provider network for all lines of business. Transitioning enrollees will continue to have access to the same providers, specialists and hospital providers currently available to them in the HFP program, unless the enrollee requests to change providers. The Plan will follow its existing continuity of care policy in the unique situation that a non-member joins the Plan as a result of this transition.

The Plan is working with MRMIB and DHCS in regards to Mental Health, Behavioral Health, and Substance Use Disorder services not covered in Medi-Cal managed care program. Transitioning enrollees will receive medical services and prescribed medications in accordance with the Medi-Cal managed care rules. The Plan has convened a statewide multi-disciplinary team responsible to ensure a smooth transition for Kaiser HFP enrollees into Medi-Cal managed care. Additionally, the Plan intends to make outbound calls and to send explanatory letters to all transitioning enrollees to assure enrollees they will retain coverage with their current providers post transition.

Health Net

Continuity of Care: Health Net Community Solutions, Inc. (“Plan”) currently operates an HFP line of business in Placer County. The Plan states it will make provider data, prescription authorizations, and referral data available to the departments and the receiving Medi-Cal plan in order to establish PCP linkages and continuity of care. The Plan will assist the Medi-Cal health plan in facilitating continuity of primary and specialty care with its providers who treated HFP members.

ATTACHMENTS

**ATTACHMENT 1 – PHASE 4 HEALTHY FAMILIES PROGRAM
HEALTH PLAN ENROLLMENT**

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 and Wellness Plan	Denti-Cal
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

**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
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 California Health and Wellness Plan	Denti-Cal
San Benito	San Benito 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

**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
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

ATTACHMENT 2 – DATA REQUESTED FROM THE HEALTH PLANS
Template Request to Phase 4 Healthy Families Plans

Dear [Plan Name] (“Plan”) -

Assembly Bill 1494 (2011-2012 Sess.) requires the California Health and Human Services Agency to move all enrollees in the Healthy Families Program (HFP) into the Medi-Cal program throughout 2013. Phase 4 of the transition requires enrollees in HFP managed health care plans operating in counties that did not previously offer Medi-Cal managed care to transition into a Medi-Cal managed care plan. Your plan has been identified as a managed care plan that operates an HFP line of business in the following Phase 4 counties: [county names].

The Department of Managed Health Care (DMHC) will be conducting a review of the Plan’s HFP provider network in order to assess the impact on continuity of care to enrollees who will be participating in Phase 4 of the transition from HFP to Medi-Cal managed care, in accordance with the legal requirements as stated in Welfare and Institutions Code Section 14005.27(e)(9) (added as part of AB1494, SEC. 11), and the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 commencing with Section 1340 of Division 2 of the Health and Safety Code).

The Phase 4 transition of HFP beneficiaries into Medi-Cal managed care plans will begin no earlier than September 1, 2013. The DHCS and the DMHC must assess the impact of network changes on beneficiaries and present their findings to the California State Legislature 90 days prior to the beginning of the transition. Therefore, we are asking each Plan to complete the provider network data requests contained in Attachments A and B **no later than May 10, 2013**.

In **Attachment A**, the Plan is required to provide a detailed response to qualitative network questions addressing how the Plan is preparing for the HFP transition in accordance with legislative requirements. The Attachment A is intended to encompass all counties, so the Plan need only complete this document once.

Attachment B is a provider network assessment workbook containing several spreadsheets that the Plan is required to complete. The Plan is required to submit a **separate workbook, including all spreadsheets, for each county** that is part of the Phase 4 transition. The provider network assessment workbook has two major components:

- 1) The first three tabs are for Plans to list each PCP, Specialist, and Physician Extender within their Medi-Cal provider network. **Please read the instructions on each worksheet carefully before completing.** Be sure to report all providers who are available within the Plan’s network.
- 2) The last tab is a data summary request. Plans must provide summary data regarding the number and type of providers in the Plan’s HFP network and the number of HFP beneficiaries who will be transitioning.

Please submit the requested information to the DMHC through its e-filing portal by **May 10, 2013**. When submitting, please file this as an Amendment with the Attachment B provider

network assessment workbook submitted as an **Exhibit I-1** and the responses to qualitative questions in Attachment A submitted as an **Exhibit I-8**. Please include a brief summary of the filing in an **Exhibit E-1** as well. In the subject line, please identify this filing as “Phase 4 Healthy Families Program transition to Medi-Cal managed care network adequacy data elements.” This will allow the DMHC to effectively track related filings.

The DMHC looks forward to receiving the Plan’s submission as we work toward assessing Medi-Cal managed care plan provider networks to ensure plans provide access and quality care to Medi-Cal beneficiaries, both present and future.

If you have questions for the DMHC regarding this request, please contact Kacey Kamrin at 916.324.9028 or kkamrin@dmhc.ca.gov.

Sincerely,

Gary L. Baldwin
Deputy Director, Plan and Provider Relations
Department of Managed Health Care

ATTACHMENT 2 – DATA REQUESTED FROM THE HEALTH PLANS
Template Request to Phase 4 Medi-Cal Plans

Dear [Plan Name] (“Plan”) -

Assembly Bill 1494 (2011-2012 Sess.) requires the California Health and Human Services Agency to move all enrollees in the Healthy Families Program (HFP) into the Medi-Cal program throughout 2013. Phase 4 of the transition requires enrollees in HFP managed health care plans operating in counties that did not previously offer Medi-Cal Managed Care to transition into a Medi-Cal Managed Care plan. Your plan has been identified as a managed care plan that has been selected to serve as a Medi-Cal Managed Care plan in Phase 4 counties.

The Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) (hereinafter “the departments”) will be conducting a review of the Plan’s Medi-Cal provider network in order to assess the impact on continuity of care to enrollees who will be participating in Phase 4 of the transition from HFP to Medi-Cal managed care, in accordance with the legal requirements as stated in Welfare and Institutions Code Section 14005.27(e)(9) (added as part of AB1494, SEC. 11), and the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 commencing with Section 1340 of Division 2 of the Health and Safety Code).

The departments understand that the Plan has not yet finalized its provider network in the Phase 4 counties. The Phase 4 transition of HFP beneficiaries into Medi-Cal managed care plans will begin no earlier than September 1, 2013. The departments will be submitting an Implementation Plan to the California State Legislature 90 days prior to the beginning of the transition. In this Implementation Plan, the departments will report on the status of the Phase 4 Medi-Cal networks and the Plan’s efforts to ensure continuity of care. Although the Plan does not yet have a final, contracted provider network in Phase 4, the departments would like to review the Plan’s efforts to build its network and to ensure continuity of care for transitioning enrollees. Therefore, the departments are requesting that the Plan respond to the inquiries in Attachment A **no later than May 21, 2013**.

In **Attachment A**, the Plan is required to provide a detailed response to qualitative network questions addressing how the Plan is preparing for the HFP transition in accordance with legislative requirements. The Attachment A is intended to encompass all counties, so the Plan need only complete this document once.

Please submit the requested information to the DMHC through its e-filing portal by **May 21, 2013**. When submitting, please file this as an Amendment with the responses to qualitative questions in Attachment A submitted as an **Exhibit I-8**. Please include a brief summary of the filing in an **Exhibit E-1** as well. In the subject line, please identify this filing as “Phase 4 Healthy Families Program transition to Medi-Cal managed care network adequacy data elements.” This will allow the DMHC to effectively track related filings.

The departments look forward to receiving the Plan’s submission as we work toward assessing Medi-Cal managed care plan provider networks to ensure plans provide access and quality care to Medi-Cal beneficiaries, both present and future.

If you have any questions for the DHCS regarding this request, please contact Justine Reyes at 916.449.5080 or mmcdpmb@dhcs.ca.gov.

If you have questions for the DMHC regarding this request, please contact Kacey Kamrin at 916.324.9028 or kkamrin@dmhc.ca.gov.

Sincerely,

Gary L. Baldwin
Deputy Director, Plan and Provider Relations
Department of Managed Health Care

Javier Portela
Branch Chief
Department of Health Care Services

ATTACHMENT 2 – DATA REQUESTED FROM HEALTH PLANS
Qualitative Data Elements for Healthy Families Plans

As required by law, the Department of Health Care Services and the Department of Managed Health Care are assessing the ability of Medi-Cal managed care plans to provide adequate provider networks and continuity of care to current Healthy Families Program (HFP) members who will be transitioned to Medi-Cal Managed Care starting in September 2013. Please provide clear and detailed explanatory answers to the following questions with regard to Phase 4 of the transition:

1. Please explain how the Plan will assist the Medi-Cal health plans in determining whether the HFP enrollees will be able to continue to see their treating PCP. Specifically, address whether the Plan will be sharing provider data with the Medi-Cal plans in order to establish PCP linkages.
2. For the HFP members who will have to change PCPs or specialists as a result of the transition, will the Plan take any steps to assist the Medi-Cal health plan in preserving continuity of primary and specialty care to ensure a smooth transition?
3. Please describe how the Plan will work with the HFP health plan to transition existing physician and prescription authorizations and referrals to the Medi-Cal plan for HFP members.
4. Please explain whether the Plan assigns enrollees to primary care physicians, primary care clinics, and/or facilities for primary care services. Please complete the PCP tab on Attachment B accordingly. If the template provided in Attachment B does not allow the Plan to accurately describe its primary care arrangement, please provide a narrative description of the arrangement here.

ATTACHMENT 2 – DATA REQUESTED FROM HEALTH PLANS
Qualitative Data Elements for Medi-Cal Plans

As required by law, the Department of Health Care Services and the Department of Managed Health Care are assessing the ability of Medi-Cal managed care plans to provide adequate provider networks and continuity of care to current Healthy Families Program (HFP) members who will be transitioned to Medi-Cal Managed Care starting in January 2013. The Departments recognize that the Plan has not yet completed contracting with providers in its Medi-Cal network. The following questions are aimed at understanding how the Plan intends to effectuate the transition of HFP enrollees from HFP into Medi-Cal during Phase 4 of the transition. Please answer to the best of the Plan's ability based on the steps the Plan has taken or intends to take to prepare for the transition. Please provide clear and detailed explanatory answers to the following questions with regard to Phase 4 of the transition:

Continuity of Care

1. Assuming the Plan has completed contracting with its network providers, please explain how the Plan will identify whether an HFP member transitioning into the Plan will be able to keep the PCP they have been seeing in the HFP health plan.
2. Assuming the DHCS is able to receive provider linkage information, how would the Plan utilize this information to ensure HFP members are able to remain with their PCP or specialist?
3. For the HFP members who will have to change PCPs or specialists as a result of the transition, what steps will the Plan take to preserve continuity of care to ensure a smooth transition? Please describe:
 - a. The Plan's transition process relating to continuity of care, including how the Plan will identify enrollees that may require continuity of care services and how the Plan will communicate continuity of care policies to members and providers.
 - b. Please include a copy of the Plan's current continuity of care policy and procedure.
4. Please describe how the Plan will ensure access to specialists and prescription medication so that there is no disruption in services. Specifically address how the Plan will work with the HFP health plan to transition existing authorizations and referrals into its Medi-Cal line of business for HFP members.
5. Please describe any current or proposed outreach and/or communications that will explain the PCP reassignment process to Phase 4 enrollees.
6. Please describe the Plan's processes for out-of-network authorizations. Specifically address how the Plan will ensure that, under circumstances where a patient cannot be

transitioned to a new provider, the Plan is able to preserve continuity of care for transitioning HFP members whose treating providers are not in the Plan's network.

7. What steps will the Plan take to ensure that individuals moving to new providers as a result of the Healthy Families transition will have timely access to their new provider and will not have a disruption in services?
8. Has the Plan made any administrative changes to ensure there are minimal disruptions in services as a result of the transition (e.g. care management staff, expedited utilization management services, etc.)?

Provider Network Availability

9. Please provide an update as to the status of the Plan's efforts to contract with providers for its Medi-Cal network.
10. Please describe the steps the Plan has taken to build a Medi-Cal provider network in the Phase 4 counties.
11. Please describe what steps, if any, the Plan has taken to bring current HFP providers into its Medi-Cal network in Phase 4 counties.
12. Please describe what steps the Plan has taken to identify the specialty areas that should be available in the Plan's Medi-Cal network. Please identify, for each Phase 4 county, the types of specialists the Plan expects to make available through its contracted Medi-Cal network.
13. If your plan is currently operating an HFP line of business in a Phase 4 county in which the Plan will also be serving as a Medi-Cal plan, please estimate the percentage of HFP providers who are likely to participate in the Medi-Cal network. Please provide a separate estimate for each Phase 4 county in which the Plan will be operating a Medi-Cal product line.
14. Please estimate the date by which the Plan will have its full contracted Medi-Cal network in place.
15. Please identify the patient age ranges accepted by each of the Plan's PCP specialty types (i.e. pediatrics, family practice, OB/GYN, general practice, or internal medicine).
16. Please explain whether the Plan will assign enrollees to primary care physicians, primary care clinics, and/or facilities for primary care services.