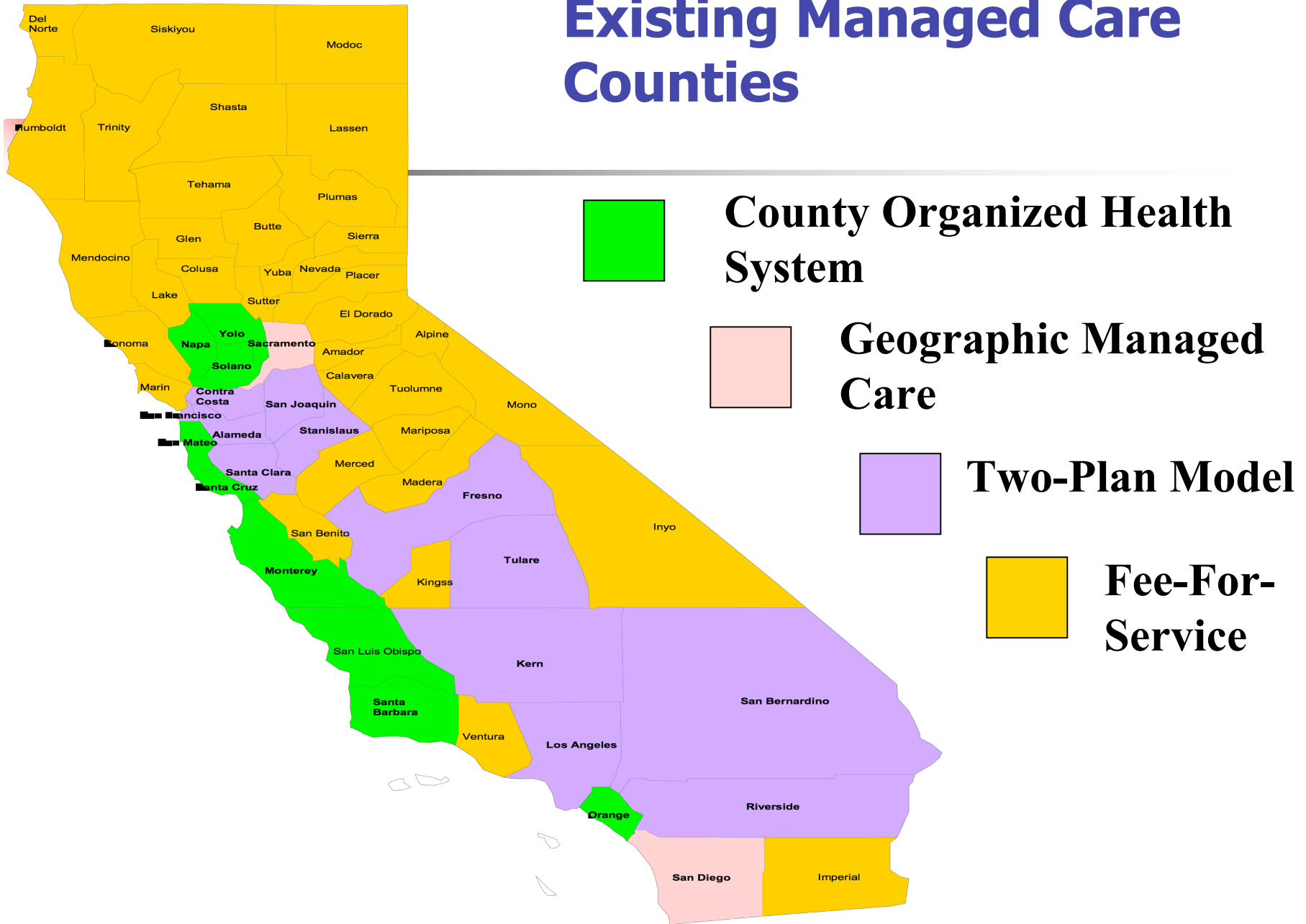


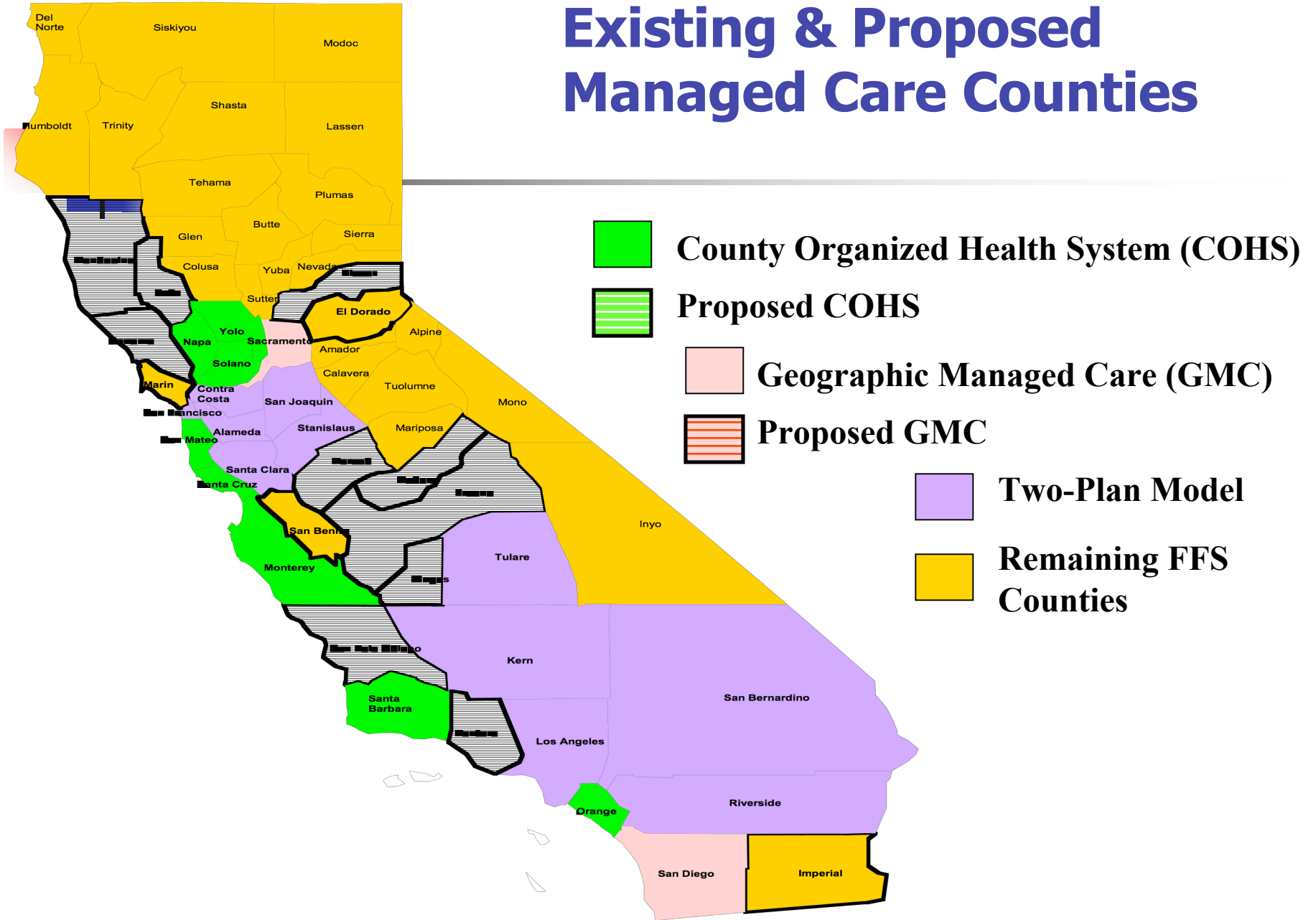
# MEDI-CAL MANAGED CARE PROGRAM HIGHLIGHTS DHCS

Presented by Willie Anderson  
June 6, 2008

# Existing Managed Care Counties



# Existing & Proposed Managed Care Counties





# Eligibility

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- Individual/family applies to County Welfare Department for eligibility
  - Determination of aid code.
  - Can be:
    - **full scope,**
    - **restricted services, or**
    - **share of cost**
  - Every 6 months family must undergo redetermination of eligibility



# Fee-For-Service Delivery

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- Family seeks services from any willing certified Medi-Cal provider
- If necessary, provider submits a Treatment Authorization Request (TAR) to Medi-Cal Operations Field Office
- Provider submits claim to EDS
- EDS adjudicates and pays claim



# Managed Care Full Risk Contracting

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- *Assumption of risk on a prospective basis with a periodic prepayment (Title 28)*
- Specific scope of services
- Premium payment – capitation PMPM
- Actuarially determined rates (GHC/COHS negotiated by CMAC)
- Requirements of state law, Title 22, contract



# Medi-Cal Managed Care Models

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- County Organized Health Systems (COHS)
- Geographic Managed Care (GMC)
- Two-Plan



# County Organized Health Systems (COHS)

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- CenCal Health
  - Santa Barbara & San Luis Obispo Counties
- Health Plan of San Mateo
  - San Mateo County
- Partnership Health Plan of California
  - Solano, Napa, & Yolo Counties



## COHS (con't)

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- CalOptima
  - Orange County
  
- Central Coast Alliance for Health
  - Santa Cruz County and Monterey County



# COHS Qualities

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- Locally developed & operated managed care organization (MCO)
  - Governing Board approved by County Board of Supervisors
- Capitated arrangements and full risk contracts
- Providers must be Medi-Cal certified
- Enrollment is mandatory
- No fee-for-service option in county



# Geographic Managed Care (GMC)

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- Sacramento County
  - Molina Health Plan
  - HealthNet
  - Blue Cross
  - Kaiser
  - Western Health Advantage



## GMC (con't)

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- Sacramento dental covered by either
  - **Access Dental,**
  - **Delta Dental,**
  - **Health Net Dental, or**
  - **Western Dental**



# GMC (con't)

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- San Diego County
  - Community Health Group
  - Health Net
  - Molina
  - Care 1<sup>st</sup>



# GMC Model

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- Noncompetitive application process
- No local/community health plan
- Capitated arrangements & full risk contracts
- Mandatory enrollment for specific aid codes
- Members choose from several commercial plans
- No fee for service option for mandatory beneficiaries



# Two-Plan Model

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- Members choose between Commercial Plan or Local Initiative (LI)
- LI is a community developed HMO (quasi - governmental)
- Commercial plan is selected via competitive procurement
- Capitated Arrangements & full risk contracts
- Enrollment mandatory for specific aid codes
- No fee-for-service option for mandatory beneficiaries



# Two-Plan Counties:

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- Alameda
- Contra Costa
- Fresno
- Kern
- Los Angeles
- Riverside
- San Bernardino
- San Francisco
- San Joaquin
- Santa Clara
- Stanislaus
- Tulare



# Medi-Cal Managed Care Enrollment

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- County Organized Health Systems (COHS) enrollment is automatic at time of eligibility determination.
  - All beneficiaries, all aid codes
  - County submits electronic data tape to State (MIS/DSS)
  - State forwards data to Plans



# Two-Plan and GMC Enrollment

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- Mandatory aid codes
  - Public assistance aid codes
  - Percent of poverty aid codes
- Voluntary aid codes
  - Aged, blind and disabled
- Ineligible
  - Some restricted aid codes and share of cost



# Medical Exemption Requests (MERs)

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- MERs reviewed for mandatory aid code beneficiaries
- Exemption criteria include:
  - Pregnancy
  - AIDS/HIV
  - Critical Medical Condition
  - Transplants
  - Dialysis
  - Cancer



## MERs (con't)

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- Forms completed by beneficiaries' physician
- MERs are evaluated by MMCD nurses in the Utilization Review Section, Office of Clinical Standards & Quality



# Health Care Options Program

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- DHCS enrollment contractor is Maximus
- HCO presentation
- HCO enrollment package
- Choice and automatic assignment process



# Provider Networks

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Health Plans have sub-contracts with:

- Individual physicians
- Medical clinics
- Physician groups
- Hospitals
- Pharmacies
- Labs
- Ancillary providers
- FQHCs
- Indian Health Clinics
- Rural Health Clinics
- Etc.



# Provider Network Requirements

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- Ratio of 1 primary care physician to 2,000 members.
- PCP must be located within 30 minutes or 10 miles of members' residence. Unless health plan has an approved alternative time and distance standard.
- Health plan must have a physician available 24 hours per day 7 days a week for coordination with ER.



# Provider Network Requirements

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- Demonstrate contracts or arrangements with over 28 specialty physicians
- Members must have access to 24 hour oral interpreter services



# Carved Out Services

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- Major organ transplants (not kidney)
- Long Term Care
- Calif. Children Services (CCS)
- Specialty mental health
- Alcohol and substance abuse treatment
- Dental Services
- Acupuncture
- Adult Day Health Care
- Some Psychotherapeutic drugs
- Some HIV and AIDS drugs