California HealthCare Foundation

On the Frontier:
Medi-Cal Brings Managed Care to California's Rural Counties

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About the Author

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About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

Introduction

Beginning late in 2013, California's Medi-Cal program expanded managed care into 28 primarily rural counties that include some of the state's most geographically remote areas. Many of these counties have very limited health care provider capacity, particularly for specialty care, behavioral health services, and services and supports to seniors and persons with disabilities. All but two of the counties have a population below 200,000, and 18 of the most sparsely populated are designated as "frontier" counties or have "frontier" areas.[1]

As of July 2014, more than 400,000 Medi-Cal beneficiaries had joined Medi-Cal managed care health plans under this rural expansion.[2] This report offers a "first look" at implementation of the expansion and identifies key issues and opportunities to help guide policy and program development going forward. In particular, the report looks at:

- The unique characteristics of the health care environments in the rural expansion counties
- Managed care plan standards and how the relevant state agencies — the California Department of Health Care Services (DHCS) and the California Department of Managed Health Care (DMHC) — are and will be evaluating the performance of Medi-Cal managed care in rural areas
- What early data indicate are key issues that require state attention going forward

This report is based on interviews with a wide range of key informants, including senior DHCS and DMHC officials overseeing the program, and leading representatives of hospitals, doctors, clinics, counties, health plans, and consumers. (See Appendix A.) Interviews were conducted between November 2013 and June 2014. In addition, various publicly available documents, and information on the health plan programs obtained through Public Records Act requests to DHCS and DMHC, were reviewed.

Background on Medi-Cal Managed Care

Over 30 years ago, the State of California began transforming the Medi-Cal program from fee-for-service (FFS) delivery (state management and payment of claims for services submitted by providers) to managed care (state contracting with public and private health plans that arrange and pay for services). The state has implemented a variety of managed care models over the years, including County Organized Health Systems (COHS), in which one public plan serves an entire county, and beginning in the early 1990s, the Two-Plan Model, which in 14 counties provides beneficiaries with a choice between a private and a public plan. California also implemented Geographic Managed Care (GMC), which offers beneficiaries a variety of plan options, in two counties. With the state's managed care expansion into rural counties, California has adopted an approach that relies upon both a COHS model and a Regional Model, which offers two commercial plan options.

From the managed care program's inception, each COHS served most Medi-Cal beneficiaries in a county, including seniors and persons with disabilities, while the Two-Plan Model and GMC programs started with mandatory enrollment only of low-income women and children. In 2011, the state began requiring seniors and persons with disabilities in Two-Plan counties to enroll in a managed care plan, with certain exceptions.[3]

Responsibilities of Health Plans and the State

Health plans providing coverage in the Medi-Cal managed care program receive monthly per-person payments (capitation) from the state, which contracts with the plans to organize provider networks, including negotiation of rates, incentives, and other payment arrangements, and to assume responsibility for assuring that care delivery meets state statutory and contractual standards related to access, availability, and quality.

Under California law, all managed care plans (not including COHS plans) must be licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene).[4] In addition, each plan participating in Medi-Cal must meet specific Medi-Cal contractual and regulatory standards affecting how services are

arranged and paid for by the plan. Except for formal Knox-Keene licensure, the standards applied to COHS plans are the same as those for all other types of Medi-Cal managed care plans. The Knox-Keene standards apply to a managed care plan whether it provides services in an urban or suburban jurisdiction or in a new rural expansion county. Similarly, the regulatory and contractual standards DHCS has set for health plans operating in rural expansion counties are the same as those for health plans operating in urban and suburban counties.

Rural counties differ significantly in number and type of health care providers as compared to urban and suburban counties. In recognition of these differences, this report focuses on the early evidence of health plan performance in meeting certain DHCS standards in the rural expansion counties. These include standards pertaining to access and availability of health care services, including provider network composition and maximum travel time and distance from primary care providers, hospitals, and specialists.

Glossary of Terms: Medi-Cal Managed Care

County Organized Health System (COHS). An independent public agency that contracts with the state to be the sole administrator of Medi-Cal benefits for an entire county; all Medi-Cal beneficiaries in the county, excluding certain carved-out populations, are mandatorily enrolled in the single COHS plan.

Frontier Area. A Medical Service Study Area (MSSA) that has low population density, as designated by the California Office of Statewide Health Planning and Development. A "rural" MSSA has a population density of less than 250 persons per square mile and no census-defined area with a population exceeding 50,000. A rural MSSA is further designated as "frontier" if it has a population density of less than 11 persons per square mile.

Geographic Managed Care (GMC). A model of Medi-Cal managed care in which the state contracts with, and offers to Medi-Cal beneficiaries, multiple commercial health plan options within a single county.

Local Initiative (LI). A Knox-Keene-licensed, county-sponsored managed care plan that serves an entire county (or multiple counties) as the public plan in a Two-Plan Model. The LI is established by county ordinance but is legally independent from county government.

Medi-Cal Managed Care Delivery Models. Service delivery and contracting models for managed care in Medi-Cal, which include County Organized Health Systems, Geographic Managed Care and Two-Plan Model programs, and the Regional Model, a slightly modified version of the Two-Plan approach, created for the rural expansion.

Medical Service Study Area (MSSA). Sub-city and sub-county geographical units used to organize and display population, demographic, and physician data.

Medically Underserved Area (MUA) and Medically Underserved Population (MUP). Medically underserved areas and populations that are federally designated based on criteria established by the federal Health Resources and Services Administration. The four criteria are the ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population below the poverty level, and percentage of the population age 65 and over.

Regional Model. A model of Medi-Cal managed care developed for the rural expansion in which the state contracts with two commercial plans to administer Medi-Cal benefits in a county or counties, with Medi-Cal beneficiaries having a choice between the two plans. (In San Benito County, beneficiaries choose either a commercial plan or FFS.)

Two-Plan Model. A model of Medi-Cal managed care in which the state contracts with two plans, one a public Local Initiative and the other a commercial health plan, to administer Medi-Cal benefits in a specific county or counties, with Medi-Cal beneficiaries having a choice between the two plans.

Bringing Medi-Cal Managed Care to Rural Counties

Goals of Rural Managed Care Expansion

In public statements and in interviews for this report, DHCS summed up the benefit of managed care for rural counties as the opportunity to strengthen the organization of health care in those communities by assisting Medi-Cal beneficiaries to "get the care they need at the right time by the right provider." Within this overall purpose, DHCS's basic goals for the rural expansion effort, as described in a presentation to stakeholders in 2012, are to deliver:

- Quality care in an environment that manages costs
- Care that is medically necessary and appropriate for the beneficiary's condition
- Care by the most appropriate provider and in the least-restrictive setting

Additional benefits of managed care for rural populations identified by DHCS in that presentation include:

- A medical home that coordinates care, emphasizes prevention and wellness, and provides case management
- Supplemental support through nurse advice phone lines
- Transportation assistance
- Assistance getting appointments with specialists
- Health education
- Grievance systems
- Greater accountability through reporting of Healthcare Effectiveness Data and Information Set (HEDIS) and other data[5]

In interviews, DHCS also identified the following dynamics that particularly affect rural areas and associated expectations for health plans:

- **Rural provider options can be limited.** As a consequence, health plans will need to demonstrate access across a region by addressing geographic barriers to care.
- **Access and transportation barriers can be more significant in rural areas.** Therefore, health plans have a stronger obligation to ensure that rural beneficiaries can reach providers who offer the plans' covered benefits.
- **Hospital dynamics are different.** There may be only one hospital in a rural region, which therefore can have more control in pricing and thus create cost pressures for the health plan.
- **Providers invited to join health plan networks are accustomed to FFS payment.** Health plan efforts to switch to capitation payment arrangements may require longer-term development.

Structure of Rural Managed Care

The FY 2012-13 California State Budget, as set forth in Assembly Bill 1467, authorized DHCS to implement Medi-Cal managed care in the rural expansion counties.[6] After a competitive Request for Application process, DHCS selected four health plans to serve Medi-Cal beneficiaries in 28 expansion counties. Of these, a Regional Model, composed of two commercial health plans, operates in 19 counties; eight counties are served by a COHS; and in one county, beneficiaries have a choice of a private health plan or Medi-Cal FFS. (See Table 1 on page 6 and map on page 7.)

AB 1467 requires enrollment in a Medi-Cal managed care plan for the following Medi-Cal beneficiaries in the 28 expansion counties: low-income families with children associated with CalWORKS; pregnant women; seniors and persons with disabilities; and low-income adults newly eligible for Medi-Cal under the Affordable Care Act (ACA). Certain Medi-Cal enrollees or services are excluded, or "carved out," such as children whose condition makes them eligible for California Children's Services, beneficiaries for whom Medicare is their primary source of coverage ("dual eligibles"), and people eligible for HIV/AIDS Home and Community Based Waiver services. As a COHS, Partnership HealthPlan of California (Partnership) assumed responsibility at implementation for all the required Medi-Cal populations in the counties it serves. The health plans operating in the Regional Model started with low-income families, pregnant women, and single adults; seniors and persons with

Table 1. Health Plans in Rural Managed Care Expansion Counties

PLANS	COUNTIES	EFFECTIVE DATE
Partnership HealthPlan	Del Norte, Humboldt, Lake,* Lassen, Modoc, Shasta, Siskiyou, and Trinity	September 1, 2013
Anthem Blue Cross **California Health & Wellness**	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba	November 1, 2013
California Health & Wellness **Molina Health Systems**	Imperial	November 1, 2013
Anthem Blue Cross **Fee-for-Service Medi-Cal**†	San Benito	November 1, 2013

*Partnership HealthPlan began operating in Lake County on September 1, 2013, under a previously approved expansion.

†Maintained by DHCS to provide a second choice for beneficiaries in San Benito county.

Sources: "Medi-Cal Managed Care Program Fact Sheet — Managed Care Models," www.dhcs.ca.gov; Medi-Cal Managed Care Models map, www.dhcs.ca.gov; DHCS Interested Parties Letter, February 28, 2013.

disabilities began joining these plans in a second-phase expansion that started December 1, 2014.

Characteristics of Rural Expansion Counties and Their Health Care Systems

Until quite recently, health care delivery in rural California, whether privately or publicly funded, has relied on the FFS delivery model. Under this FFS system, to participate in Medi-Cal a hospital, community health center, private physician, or other provider executed a Medi-Cal provider agreement. DHCS directly administered the treatment authorization process and contracted with a fiscal intermediary to process and pay medical claims. In contrast, under a managed care arrangement DHCS steps back from direct benefit administration while health plans assume responsibility for the organization and delivery of care, including network development, treatment authorization, and claims payment.

While data are limited, the evidence of past efforts to bring managed care to rural areas in California indicates that these areas have not offered a hospitable environment for it. In a 2002 study, California's Legislative Analyst looked at reasons for withdrawal of managed care plans from the state's rural areas from 1997 through 2002.[7] According to the Legislative Analyst, the plans withdrew due to a combination of factors:

- Rural residents were more expensive to cover because the populations as a whole were older, had lower incomes, were more likely to be unemployed, and had poorer health than those in urban areas.
- Plans had difficulty distributing risks and costs of health care across a small population of covered enrollees because there were insufficient numbers of healthy enrollees to offset higher-cost enrollees.
- Plans faced shortages of health care providers, including primary care physicians (PCP), who were needed to fill plan networks.
- Plans had difficulties building comprehensive provider networks due to geographic distances and a limited number of specialists in certain areas.
- Plans had concerns about low payer reimbursement rates and their ability to fund the costs of care.

According to informants for this report, most of the dynamics identified by the Legislative Analyst in 2002 still exist. However, the context has changed. First, the Medi-Cal populations to be enrolled in rural managed care are now potentially large enough to offset historic health plan concerns about distributing risks and costs. Second, most of the participating health plans have had more than a decade of experience delivering managed care in the Medi-Cal program since the 2002 study. Nonetheless, the underlying dynamics of limited provider availability, particularly for specialty care, and the demographic composition of these rural areas remain the same.

Figure 1. The 28 Medi-Cal Managed Care Rural Expansion Counties and Their Health Plans

Demographics of the Rural Expansion Counties

The economies of most of the 28 rural expansion counties are based on agriculture, recreation, or tourism. Nearly all were hit hard by the economic recession that began in 2007, and the lingering effects are still felt in most. Many of the Legislative Analyst's 2002 findings on the challenges facing rural counties remain true today, as evidenced by poverty, unemployment, and public program participation data. (See Table 2 on page 8.)

A recent report by The Robert Wood Johnson Foundation (RWJF), *County Health Rankings 2014: California*, offers a portrait of health disparities across California's 58 counties by looking at certain health outcomes (length of life, health/mental health status, birth outcomes) and health factors (health behaviors, clinical care, social and economic factors, physical environment). The RWJF report shows that 19 of the 28 rural expansion counties (68%) rank in the bottom half of all California counties for at least one of these two measures and 15 counties (54%) rank in the bottom quarter for at least one of the measures. (See Appendix B.)

Further, for residents of the 28 rural expansion counties, medical underservice is a regular challenge. Geographic

Table 2. Selected Demographics of the 28 Rural Managed Care Expansion Counties

	POPULATION	POVERTY RATE	UNEMPLOYMENT RATE	CALFRESH ENROLLMENT	MEDI-CAL ENROLLMENT	MUA/ MUP	RURAL MSSA	FRONTIER MSSA
California	**38,340,074**	**15%**	**8%**	**4,288,454**	**7,594,872**	n/a	n/a	n/a
Alpine	1,079	14%	11%	180	193			x
Amador	36,151	11%	8%	3,400	4,606	x	x	
Butte	222,316	21%	9%	30,349	62,008	x	x	x
Calaveras	44,650	10%	9%	5,077	6,701		x	
Colusa	21,660	15%	20%	1,788	4,710		x	x
Del Norte	28,131	22%	10%	5,143	8,219	x	x	
El Dorado	182,404	8%	7%	12,323	19,110	x	x	
Glenn	28,353	20%	11%	3,666	7,202	x	x	x
Humboldt	134,648	20%	7%	18,180	27,304	x	x	x
Imperial	180,672	23%	22%	36,840	68,088	x	x	x
Inyo	18,590	11%	7%	2,179	3,641	x	x	x
Lake	64,699	24%	10%	10,814	18,109	x	x	
Lassen	32,581	15%	10%	3,230	6,146	x	x	x
Mariposa	18,467	15%	8%	2,050	2,888	x	x	x
Modoc	9,197	20%	11%	997	2,084	x		x
Mono	14,143	10%	7%	915	1,381		x	
Nevada	97,225	12%	6%	7,792	11,668	x	x	
Placer	366,115	8%	6%	18,252	31,026		x	x
Plumas	19,140	14%	12%	1,951	3,112	x	x	x
San Benito	57,517	13%	11%	6,303	10,336	x	x	
Shasta	179,412	18%	10%	24,156	41,918	x	x	x
Sierra	3,089	17%	12%	302	487	x		x
Siskiyou	45,231	20%	12%	7,003	10,671	x	x	x
Sutter	95,733	17%	15%	12,740	23,430	x	x	
Tehama	63,717	20%	10%	10,860	18,073	x	x	x
Trinity	13,389	18%	12%	1,771	2,826	x	x	x
Tuolumne	53,604	13%	8%	5,536	8,283	x	x	x
Yuba	73,682	21%	13%	13,089	20,868	x	x	

Notes: **CalFRESH** is California's version of the federal Supplemental Nutrition Assistance Program (SNAP) that provides food assistance for low-income families. **MUA/MUP** stand for Medically Underserved Area and Medically Underserved Population, which are defined by the number of primary care physicians per population, plus other factors. **Rural MSSA** (Medical Service Study Area) refers to an area with less than 250 persons per square mile and no population center exceeding 50,000. **Frontier MSSA** refers to a Rural MSSA with less than 11 residents per square mile.

Sources: California Department of Finance, "Population Estimates for Cities, Counties, and the State — January 1, 2013 and 2014"; US Bureau of the Census, American Community Survey, "5-Year Estimate (2008-2012) for Poverty Rate"; California Economic Development Department, *Monthly Labor Force Data for Counties for 2013, Report 400C;* California Department of Social Services, *Food Stamp Program Participation and Benefit Issuance Reports (DFA256),* April 2014; California Department of Health Care Services, "Number of Medi-Cal Beneficiaries by County: July 2011," July 2012; California Office of Statewide Health Planning and Development, "Medically Underserved Areas and Populations" (map), October 2010 and "California Medical Service Study Areas, Urban, Rural and Frontier Defined Areas," September 2010.

isolation and transportation difficulties are common barriers to obtaining medical care, particularly specialty care. Of the 28 counties, 23 include designated Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP). (See Table 2.)

Health Care Providers in the Rural Expansion Counties

The starting point for developing Medi-Cal managed care in the 28 rural expansion counties has been each county's existing health care infrastructure. Most of the expansion counties have basic infrastructure, but several lack essential health system building blocks. For example, there are 17 hospitals in the eight new counties served by Partnership HealthPlan of California, and 29 hospitals in the 20 counties served by Anthem Blue Cross (Anthem) and California Health & Wellness (CHW). Three counties, however, have no hospital. (See Appendix D for a complete list of hospitals in the 28 counties.)

Community health centers (CHC) and rural health clinics (RHC) form the backbone of the ambulatory care delivery system in these rural California counties. (See Table 3.) CHCs, including Federally-Qualified Health Centers (FQHCs), FQHC look-alikes, and community health clinics, free health clinics, and Indian health clinics, are nonprofit or public, community-directed health care providers serving low-income and medically underserved communities. Almost one-quarter of the 995 CHCs in California are located in rural communities and many serve the 28 expansion counties.

RHCs are clinics specifically dedicated to increasing primary cares services for Medicare and Medicaid patients in underserved rural areas. RHCs may be nonprofit or for-profit. As of summer 2014, there were 285 RHCs in California, the large majority of them either private practices or hospital-based programs. Of those, 120 were in the 28 expansion counties.

While both CHCs and RHCs in California are reimbursed via the Prospective Payment System (PPS) — a fixed, per-visit payment — there are differences between the two types of entities. For example, CHCs are required to provide a full range of primary and preventive care services. They must serve all ages and all residents of their service area regardless of insurance status or ability to pay, and have a sliding scale of charges. RHCs do not have minimum service requirements and generally do not see uninsured patients.

A 2011 DHCS study of Medi-Cal beneficiary health care access underscores the important role FQHC and RHC providers play in serving Medi-Cal beneficiaries in the 28 expansion counties. According to this study, in nearly half of these counties more than 50% of beneficiaries with medical claims had 70% or more of their visits at an FQHC or RHC. In three-quarters of the counties, more than 40% of Medi-Cal beneficiaries received 70% or more of their visits at an FQHC or RHC. (See Figure 2 on page 10.)

Finally, California Medical Board records show approximately 3,900 licensed physicians in the 28 expansion counties in 2011-12, although this figure does not necessarily reflect active physicians. This level of physician licensure has remained flat since 2007-08. (See Appendix C.)

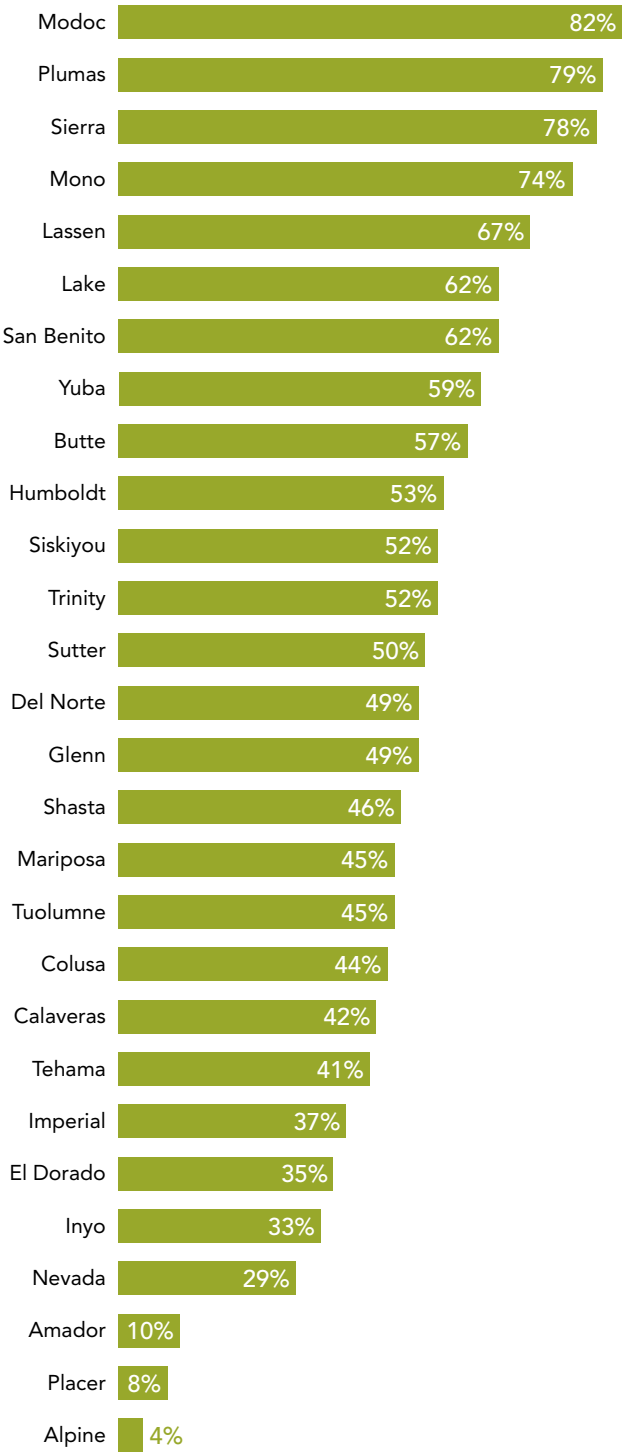
Table 3. Community Health Centers and Rural Health Clinics in Rural California, 2013-2014

HEALTH CENTER TYPE	NUMBER
Community Health Centers (CHC) in Rural/Frontier MSSAs	**249**
▶ Federally Qualified Health Centers (FQHC)	189
▶ FQHC Look-Alikes	14
▶ Community/Free Clinics	29
▶ Indian/Tribal Health Center Licensed Sites	17
95-210 Rural Health Clinics (RHC)	**285**
TOTAL*	**510**

*Total reflects that 24 clinics are simultaneously designated as CHCs and 95-210 RHCs.

Sources: California Primary Care Association, email communications, April 2014 and February 2015, citing OSHPD 2013 data; Centers for Medicare and Medicaid Services, CASPER Report 0006D, Name and Address Listing for Rural Health Clinics – California (August 2014).

Figure 2. Medi-Cal Beneficiaries* Receiving 70% or More of All Medical Services at FQHCs/RHCs, 28 Rural Expansion Counties, 2009



*Among those with claims.

Source: Department of Health Care Services, *Measuring Access to Medi-Cal Covered Healthcare Services: Physicians, Physician Groups, Clinics, and Hospital Emergency Departments,* September 2011.

Implementation of the Rural Expansion

Key informants for this report were interviewed in the late fall of 2013 and winter of 2014. Among questions asked were those soliciting their views about the implementation process for the new managed care program. These views provide a useful framework for understanding some of the difficulties associated with implementation and key issues needing attention as the rural expansion proceeds.

Initial Implementation Difficulties

DHCS set an ambitious timeline for the rural expansion. The initial "go-live" date for the expansion was June 1, 2013, less than one year after statutory authorization. Provider and county informants agreed that this timeline was unrealistic, given the procurement process required for the selection of health plans, associated planning and development, and the number of counties involved. DHCS released the Request for Applications for prospective plans in early November 2012, with the selected plans to be announced by the end of February 2013.[8] Ultimately, the start date for the expansion was pushed back to September or November of 2013, depending on the county, to address various implementation issues.

In support of this process, DHCS held stakeholder meetings and community forums in five counties — Imperial, Mariposa, Sacramento, San Benito, and Shasta — between July and December 2012 and conducted several webinars in summer 2012 and spring 2013. Following the announcement of health plan contracts, the plans themselves organized dozens of community meetings during late 2013 and into 2014. Despite these activities, provider and county informants said that DHCS's tight timeframe for selecting health plans and implementing the program resulted in a rushed process with limited opportunities in many expansion counties for active stakeholder involvement to address local issues and concerns.

Informants across the spectrum were also critical of the process used to inform Medi-Cal beneficiaries about the impending shift to managed care. DHCS reported that written notices were sent to each beneficiary at 90 days, 60 days, and 30 days prior to the beneficiary's date of enrollment into managed care, and that the notices were prepared with stakeholder input. DHCS also reported

that phone calls were made to beneficiaries who had not selected a plan after the 30-day notice. However, some informants interviewed for this report asserted that this DHCS beneficiary education process was inadequate. First, informants reported that some of the information beneficiaries received from Health Care Options, contracted by DHCS to assist beneficiaries with plan selection, was incomplete or out-of-date, which created confusion for beneficiaries. Second, informants reported that DHCS notices to beneficiaries about the change to managed care were difficult for some beneficiaries to understand, and some notices went to the wrong people, which created additional beneficiary confusion.

Better Transition in Certain Counties

Informants reported that in certain counties the managed care rollout was less disruptive and better oriented to local needs. According to these interviewees, in Imperial County and in the seven northern counties where Partnership was selected as the sole health plan, local stakeholders had more opportunity to engage with the process and thereby to facilitate implementation and improve outcomes.

In the seven northern counties, these transition efforts grew from the work of a local health alliance of Shasta County providers and other stakeholders that began meeting after the passage of the ACA in 2010. The group came to the conclusion that managed care was inevitable with implementation of the ACA. As a consequence, the alliance initiated discussions with Partnership about bringing Medi-Cal managed care to the county. These initial contacts did not yield an agreement to proceed, but when DHCS proposed expansion of Medi-Cal managed care to rural counties, Shasta County stakeholders, including provider groups, reopened their discussions with Partnership.

After more than a year of collaborative work, Partnership, already approved for expansion into Lake County, determined that it would need seven contiguous counties to support an overall expansion of Medi-Cal managed care into this rural region. The collaborative ultimately obtained the support of the Boards of Supervisors of seven counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, and Siskiyou) for Partnership to be their sole Medi-Cal managed care provider. DHCS initially held to its intent of having two health plans in each county but eventually accepted Partnership as the sole plan after hearing from the county Boards of Supervisors, key legislators, local health care providers, and other stakeholders. Stakeholders in the seven counties now credit the trust built over several years of collaborative "prework" for the success of the managed care rollout there.

In Imperial County, a previously established health leadership group chaired by a local physician had been meeting to look at changes on the horizon, including meaningful use of electronic health records, health care reform under the ACA, and accountable care organizations. When DHCS announced its intention to implement the rural expansion, the local leadership group reached out to and incorporated a health care stakeholder group that included several dozen local physicians. This expanded group developed and recommended a Two-Plan Model to include an LI plan (a public, countywide plan) and a private plan, and the county Board of Supervisors endorsed the concept. A steering committee devised and implemented a process for selecting the LI plan, and several plans were considered. While the county ultimately concluded that development of an LI plan was not feasible in the near term and recommended that DHCS approve a single commercial plan, CHW, to serve the county, the local planning effort resulted in a managed care plan with broad-based support in the county. DHCS approved CHW and later added Molina Health Systems (Molina) as a second commercial plan to provide beneficiary choice.

Health Plan Standards for the Rural Expansion

All of the health plans participating in the rural managed care expansion have executed contracts with DHCS, and all of them are subject to DHCS regulatory oversight. In addition, Anthem, CHW, and Molina are licensed under the Knox-Keene Health Care Act and therefore are also subject to regulatory oversight by DMHC. As a COHS, Partnership is not a Knox-Keene plan and so is subject to DHCS but not DMHC regulation.

Nothing in Knox-Keene, in the enabling statutes for the expansion, or in the DHCS contract identifies unique circumstances or conditions associated with rural health care delivery that must be addressed as a part of health plan responsibilities for the rural managed care expansion. Rather, existing access and availability requirements concerning Medi-Cal managed care that were defined for more populated areas have been carried over and applied to the rural expansion counties. The remainder of

this section examines the early evidence on plans' adherence to DHCS and DMHC standards for provider access and availability of services, which are outlined in Table 4. Hereafter, the report highlights some of the difficulties that plans have experienced in meeting these access and availability standards in certain counties.

Table 4. Provider Access and Availability Requirements for Medi-Cal Managed Care Plans

General Requirements	▸ Each plan member has a primary care physician (PCP) who is available and physically present for sufficient time to ensure access. ▸ Members have access to specialists for all medically necessary services. ▸ Health care plan has a procedure to monitor waiting times in providers' offices and for telephone calls. ▸ Members are offered appointments for covered health care services within a time period appropriate for their condition..
Minimum Number of Providers	▸ PCPs — ratio of 1:2,000* ▸ All physician providers — ratio of 1:1,200* ▸ Specialty care providers — ratio not specified; number subject to approval by DHCS and DMHC based on plan proposals to meet specialty care needs
Time/Distance Standards	▸ PCPs — 10 miles/30 minutes† ▸ Specialty care providers — discretionary standard determined by DHCS/DMHC

Appointment Waiting Times	▸ Emergency care —available in the service area 24 hours/day
	▸ Urgent care:
	  ▸ No prior authorization required — available within 48 hours
	  ▸ Prior authorization required — available within 96 hours
	▸ PCP (non-urgent) — available within 10 business days
	▸ Ancillary services (non-urgent) — available within 15 business days
	▸ Specialty care — available within 15 business days

Specialty Care	▸ Members have access to specialty services in accordance with Title 28 CCR Section 1300.67.2: "Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees."
	▸ Plan has procedures for:
	  ▸ Member to receive a standing referral to a specialist if member needs continuing specialty care
	  ▸ Member with a condition or disease that requires specialized medical care over a prolonged period of time to receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease

Other Requirements	▸ Appointment timeframes may be shortened or extended, as clinically appropriate, by a qualified health care professional and must be documented in the member's medical records. ▸ Plan shall arrange for a member to receive timely care as necessary for a health condition if timely appointments within the time and distance standards required are not available. ▸ Plan shall refer members to, or assist members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the member's needs. ▸ If services are not available in network, the plan must adequately and timely cover these services out of network for member.

*The ratio is one provider per general population figure within the plan area.

†Medi-Cal managed care plans are subject by contract to a stricter time and distance standard than required by Knox-Keene, which requires PCPs to be available within 15 miles/30 minutes of where enrollees work or reside. DMHC enforces the Medi-Cal standard for the Medi-Cal plans under its jurisdiction.

Source: Medi-Cal Managed Care COHS and Two-Plan contracts, Exhibit A, Attachments 6 (www.dhcs.ca.gov) and 9 (www.dhcs.ca.gov).

Assessment of Health Plan Readiness at Go-Live

For the rural expansion counties served by Partnership, the go-live date for the program was September 1, 2013. For counties served by other health plans, the rollout date was delayed until November 1, 2013. By these implementation dates, the health plans were required to have organized provider networks in place that included contracts with a sufficient number of key providers, including hospital, primary care, specialty care, and ancillary services.

Network approval involved both DHCS and DMHC, and both agencies approved the networks submitted by the plans as meeting required standards. DMHC's focus was review of the networks for licensure purposes and review of alternative standards of accessibility, as applicable. DHCS reviewed the networks to determine contract regulatory compliance and comparability to FFS access.[9]

Key informants were asked about the readiness of the provider networks and the overall system at the time of implementation. Informants from health plans stated that the provider networks were ready at the go-live date. Molina, which was not designated by DHCS as the second plan in Imperial County until late in the fall of 2013, reported that the network was "ready enough" to begin initial service delivery at the go-live date, with improvements expected over the first months of operation. Health plan informants stated they generally expected to see improvements in all of the networks over time as the plans reached out to providers who initially had declined to participate. DHCS informants shared this view. As discussed immediately below, however, provider and county informants were not as positive about network readiness.

Initial Shortcomings Identified by Providers and Counties

Provider and county informants were somewhat more critical than the health plans and DHCS about the readiness of provider networks at the time of implementation. These informants suggested that provider networks "were a work in progress," particularly with regard to specialty care. On this key point, health plan informants acknowledged that access to specialty care providers, depending on the provider type and county, was a continuing challenge because of the limited number of these providers in rural counties.

In particular, provider and county informants reported the following concerns about initial network readiness:

- Provider networks were not fully worked out; many contracts were still in development.
- In various instances, patient assignments to contracting PCPs were being made by the plans without regard to actual availability of those local providers for all the patients assigned.
- Delays in health plan contracting with county-operated clinics created service delays and the need for clinics to submit repeated authorization requests for patients who had long been in their care.
- Specialty care presented manifold problems: many specialty care providers chose to limit the number of new Medi-Cal patients, travel times to contracted specialty providers presented a new barrier for some patients, and health plans referred patients out-of-county for certain specialty care consults, often requiring a wait of several months.
- Because of a lack of contracted specialists, one health plan encouraged PCPs to "find the specialist" they wanted their patient to see; the plan would then attempt to execute a contract with that provider.
- Because of new health plan requirements and plan changes to drug formularies, PCPs spent a lot of additional time getting prior authorizations for specialty care and prescription drugs, and there were new challenges in obtaining coverage for non-formulary medications.
- Hospitals had difficulties with prior authorization processes, including hospital transfer authorizations, and with the process for billing for services provided under treatment authorization requests previously approved by Medi-Cal.
- Mental health provider networks were not ready, and the role of plans versus county mental health programs was unclear.

Many of the issues identified by these informants could be expected with a transition to a new health care delivery system — the movement from FFS Medi-Cal to managed care operated by four different health plans across 28 counties presented a massive planning and

logistical challenge. In the present case, though, provider and county informants felt that many of these problems could have been mitigated by better DHCS planning and communication, by additional work with local stakeholders, and by a longer lead time before implementation.

Specific Contracting Challenges Identified in Some Regional Model Counties

Some provider informants reported that certain providers in the 18 counties served by Anthem and CHW, particularly hospitals and specialty providers, experienced difficulties with the execution of provider contracts. Some of these difficulties reportedly stemmed from the lack of time plans had to engage providers while others were the result of differing expectations about payment rates.

Provider and county informants reported that some specialty providers already participating in Anthem did not understand that they were now included in the Medi-Cal network by virtue of an "all-products" provision in their existing Anthem contracts, which required them to provide care to enrollees in any of Anthem's products. Typically, providers can terminate their entire relationship with a health plan if they do not want to accept a new business arrangement via an all-products clause, but they cannot reject only a specific new product or program. A number of these Anthem providers reportedly responded to this contractual difficulty by accepting the new contract terms but then limiting the number of Medi-Cal referrals they accepted.

Provider informants also reported that payment rates, particularly for specialty care, were a continuing concern in the Regional Model counties. Even where health plans in those counties offered rates higher than traditional FFS rates, some participating providers limited the number of Medi-Cal plan patients they accepted. As one informant stated, "A specialist can *say* they will participate. That doesn't mean full access to that specialist." That is, specialists may contract with a plan but then limit the number of referrals they will accept under the plan, whether because of rates or other reasons.

Health Plan Networks Approved by the State

To understand the overall composition of health plan networks approved by DHCS and DMHC in the fall of 2013, research for this report included a review of selected health plan network submissions approved by DHCS and DMHC, along with information posted by the health plans on their websites. These submissions to DHCS and DMHC provided information on each health plan's contracted primary care, hospital, and specialty care providers. All of the health plans provide this information to DHCS as a contractual requirement. Also, Knox-Keene-licensed plans file certain of these reports with DMHC by March of each year as part of their annual timely access reporting.

The health plan–reported data provided by DMHC for this review had certain limitations. In particular, the data did not follow a single format. For example, data from DMHC on Anthem was aggregated and did not clearly delineate Medi-Cal business versus other lines of business or clearly present the data by county for the 19 counties in which it was doing Medi-Cal business. For the other health plans, DMHC data was disaggregated and provided a clearer picture of the networks at the county level.

The health plan submissions to DHCS followed a more consistent format. Accordingly, the analysis that follows relies primarily on the DHCS data and on information collected from the health plans' websites regarding provider availability. This information is supplemented by data the plans provided to DMHC, where available and applicable.

Primary Care and Hospital Care Access

As shown in Table 5, above, DHCS's contracts with Medi-Cal managed care plans establish specific time and distance standards that the plans must meet for access to PCPs and hospital care. Overall, health plan reporting to DHCS and DMHC in the fall of 2013 showed mixed results by the plans in meeting the PCP access standard of at least one provider within 10 miles and 30 minutes driving time in the rural expansion counties. In summary:

- Partnership reported that it could meet the 10-mile and 30-minute PCP standards for the majority of Medi-Cal beneficiaries served in its eight expansion counties, except for beneficiaries in certain Zip Codes in Del Norte, Humboldt, Modoc, Shasta, Siskiyou, and Trinity Counties, and nearly all beneficiaries in Lassen County.
- Anthem reported that it could only meet the 10-mile PCP standard for roughly half of the beneficiaries in the 19 rural counties it served. Anthem could not meet this standard for most beneficiaries in the

counties of Colusa, El Dorado, Inyo, Mono, Nevada, Plumas, Sierra, and Tehama. However, Anthem reported that most beneficiaries could access a PCP within 11 to 20 miles, excluding those in Inyo, Mono, Nevada, Plumas, and Sierra Counties, for whom travel distances would be considerably greater. Anthem reported that it could meet the 30-minute standard for most beneficiaries, except those in Mono, Nevada, Plumas, and Sierra Counties.

- CHW reported that it could meet the 10-mile PCP standard for most beneficiaries in the 19 counties it served, except for small portions of each county and for 40% or more of beneficiaries in the counties of Amador, Inyo, Mono, and Plumas. CHW reported that it could meet the 30-minute standard for most beneficiaries, except for parts of Inyo and Mono Counties.
- Molina reported no problems meeting the 10-mile and 30-minute PCP standards in Imperial County, except for small populations in the northern areas of the county.

With respect to the hospital-access standard of 15 miles and 30 minutes, health plans could meet the requirement for the most part but reported some problem areas, including:

- CHW identified alternative hospital-access standards for parts of most counties, ranging from 60/60 (miles/minutes) to 150/150, depending on the county. For Mono, Nevada, Sutter, and Tehama Counties, CHW identified countywide alternative standards.
- Partnership identified no problems with the hospital care access standard for Del Norte and Lake Counties, but identified problems meeting the standard for certain Zip Codes in its other six expansion counties.
- In the DHCS records concerning Molina, there was no documentation of an alternative standard for hospital care, but the network data Molina provided showed small populations in the northern part of Imperial County for which Molina's network hospital did not meet the 30-minute standard.
- Information on Anthem's hospital coverage provided by DHCS and DMHC for this review did not allow for evaluation of whether Anthem's hospital network meets the access standard, but Anthem did identify hospital contracts in place across the range of its 19 expansion counties.

Specialty Care Access

There are no uniform state-mandated time and distance standards for specialty care services. Instead, the DHCS contract states generally that, "Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care." The contract references existing law and regulations, which define adequacy as "adequate numbers of specialists and subspecialists to provide access to preventive and managed health care services to . . . members."[10] In addition, health plans are required to "maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and . . . [to] make it available to enrollees, at a minimum, by phone, written material, and Internet Web site."[11]

In light of the broad definition of what constitutes adequacy of specialty care access, the determination of adequacy in any specific county and specialty is generally left to the health plans, with the state regulator, either DHCS or DMHC, accepting or rejecting a plan's proposed standard. DHCS reported that the basic metric it used to determine specialty care adequacy for each new health plan's network was the level of availability that previously existed under FFS Medi-Cal. To make this determination, both DHCS and DMHC reviewed plan networks for the expansion counties. Plans were required to submit geographic access mapping and to demonstrate their ability to contract with out-of-network providers for any of 16 core specialties not in their network. If these conditions were met, the network was approved as adequate.

Specialty Care Provider Access in Summer 2014

To get a snapshot of specialty care access under the rural expansion about 10 months into the program, research for this report included review of selected specialty provider availability as posted on the websites of the participating health plans. For illustrative purposes, the review focused on 6 of the 16 "core specialties" identified by DHCS: cardiology, gastroenterology, neurology, orthopedic surgery, otolaryngology (ENT), and urology. (For detailed data regarding these six specialties under each plan in the 28 expansion counties, see Appendix E.) Because distances to health care providers in rural areas can be long, particularly for specialty care, a standard of

50 miles was used to determine relative availability of these six specialties in the Regional Model counties and in Imperial County, while a different standard was used for counties served by Partnership, as described below.

Health plan networks for specialties beyond these six may be more or less robust, depending on the county and health plan involved. For example, notwithstanding a comparably robust level of participation in these six specialties, CHW identified alternative time and distance standards for other specialties and for parts of most of the counties it serves.

Regional Model Counties

In the Regional Model two-plan counties, the data show that the number of contracting providers offered by CHW in the six high-need specialties is substantially more robust than that offered by Anthem. For the selected specialties, a CHW-contracted specialty provider is not available within 50 miles of the county border only 6% (7/108) of the time. In contrast, an Anthem-contracted specialty provider is not available within that distance nearly 60% (62/108) of the time. (See Appendix E.)

In its filing with DHCS, Anthem reported on strategies to compensate for its specialty care provider shortfalls. In addition to its provider contracts, Anthem stated that it operates an Access to Care Unit designed to assist beneficiaries locate not only in-network specialty care but also out-of-network care when in-network care is not reasonably available. According to Anthem, this unit is tasked with locating appropriate out-of-network specialty providers as needed, negotiating reimbursement terms, assisting in scheduling an appointment for the beneficiary, and coordinating transportation if necessary to ensure that beneficiaries have access to needed specialty services. Anthem stated that it developed this unit because providers are often unwilling to contract for a small volume of patients and prefer to accept referrals on a case-by-case basis in anticipation of higher rates.

While Anthem's Access to Care Unit may be effective in promoting access to specialty care, the absence of contracting providers for specialty services formally listed on the Anthem website leaves Medi-Cal beneficiaries, and the PCPs caring for them, with limited information about the specialty care options available through the plan. Further, it is not clear how DMHC or DHCS monitors this type of arrangement to assure network specialist adequacy.

Reported Specialist Provider Availability Is Not the Same as Actual Availability

The data posted on the health plan websites for the six high-need specialties — the source for the analysis above and in Appendix E — were comparable, but not identical, to the data the health plans reported to DHCS in the fall of 2013 in preparation for implementation. In some instances, the availability of providers in these specialties appeared greater in the later website data than in the fall 2013 submissions to DHCS. In other instances, it was less than described in those submissions.

However, while the posted networks show contracted providers, they do not reflect the willingness of those providers to take new patients. The willingness of providers to participate became even more important when the two Regional Model health plans serving 19 counties expanded to cover roughly 24,000 seniors and persons with disabilities as of December 1, 2014.

The provider finder function on the Anthem, CHW, and Molina websites can show whether a provider is "taking new patients." However, the reliability of this information depends on whether the provider keeps this information current with the health plan and whether the health plan updates its website with sufficient frequency. A spot check made for this report found that the number of contracted network providers listed on the plan websites as taking new patients was frequently less than the overall number of contracted providers. Moreover, the listing of a specialist as taking new patients did not guarantee that the provider was actually still doing so.

The health plans are required by statute to "maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site." Timely and regular website updates will be important for plans to meet legal requirements and to accurately inform beneficiaries and their providers about the true state of their care options, including specialty care.

Partnership Counties

The Partnership website does not allow a user to judge the distance of a provider from a beneficiary's home, so it is not possible to determine how many providers are within 50 miles of each county. As a result, the assessment for Partnership counties is of reported specialty care availability *within* each county. For the eight expansion counties served by Partnership, the data show that access to the six specialties is most widely available in Humboldt, Mendocino, and Shasta Counties, with more limited access in the other counties. (See Appendix E.)

Depending on the beneficiary's county of residence, obtaining needed specialty care often involves significant driving distance and time. For the six specialties in the eight counties served by Partnership, specialty providers were not available anywhere in the county nearly 60% (28/48) of the time.

To address specialty care needs in counties with limited access, Partnership reported that it recently initiated a number of local efforts to promote greater access. These include an Innovations Grant program to provide funding for local provider network development and support for provider recruitment in counties with the most significant shortages of primary care and specialty care providers.[12]

Imperial County

Availability for the six high-need specialty providers in Imperial County reported by CHW and Molina shows comparability between the two plans. (See Appendix E.) For only one of the six specialties (ENT) did Molina not offer a provider within 50 miles of the county; the nearest was 70 miles away. CHW offered at least one provider within 50 miles in each specialty category.

Other Matters Affecting Access to Care

In addition to the number and distribution of providers, several other aspects of managed care take on particular importance in rural areas. These include standards concerning transportation, telehealth, and grievances and appeals. As with provider networks, the DHCS standards for these matters are the same for plans operating in the rural expansion counties as for those serving urban and suburban counties.

Transportation

Access to transportation services is critical for rural residents, where distances to sites of care are great, public transport is scarce, and transportation options for low-income beneficiaries are limited. In interviews in late 2013, senior DHCS officials indicated an understanding that access and transportation barriers can be more significant in rural areas, and suggested that health plans therefore have a stronger obligation to ensure that beneficiaries can reach providers who offer the covered benefits. However, nothing in Medi-Cal statutes or regulations or in the DHCS contract with health plans establishes a "stronger obligation" on health plans to provide transportation support for rural Medi-Cal beneficiaries.

For adults, Medi-Cal regulations define covered medical transportation as ambulance, litter van, and wheelchair van services, which are to be provided "when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care."[13] The regulations also state that any nonemergency medical transportation necessary to obtain covered services requires a physician's, dentist's, or podiatrist's prescription, plus prior authorization, except when it involves transfer of the patient from an inpatient hospital to a skilled nursing facility. Both nonemergency medical transportation and nonmedical transportation are covered benefits under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children enrolled in Medi-Cal.

The DHCS Medi-Cal managed care contract requires health plans to describe coverage of both medical and nonmedical transportation services in their member services guide, specifically:

- A description of both medical and nonmedical transportation services
- Procedures for obtaining any transportation services offered by the plan or available through the Medi-Cal program
- The conditions under which nonmedical transportation is available[14]

Research on plan coverage for nonemergency medical transportation offered by the participating health plans

was conducted through a review of member guides and other information provided on the health plan websites in late summer 2014. Overall, while discussion of coverage for nonemergency medical transportation services varied by health plan, none of the plans' policies indicated that transportation support is provided to assist beneficiaries to get to regular medical or specialty care appointments, even those that require long travel distances or times. Legal services informants reported confusion among beneficiaries about the availability and extent of transportation coverage, particularly in the Regional Model counties.

In describing the availability of nonemergency transportation, the plans generally gave vague and sometimes contradictory information. For example, Anthem's member services guide stated that it will approve nonemergency transportation when it is "medically necessary" and a provider asks for the service, but elsewhere stated, "We will approve a ride for you as long as the request is for a medical service. We do not cover public transport, such as airplane, car, or taxi rides, unless it involves transport to a kidney transplant center that is outside the service area."[15] In its filing with DHCS, Anthem also noted that it "will coordinate transportation if necessary to ensure members are able to access needed primary care and other medically necessary services." However, evidence of plan coverage for this transportation support was not apparent from available public documents.

CHW's website stated that nonemergency medical transportation must be approved by both the plan and the patient's PCP, and lists criteria "to get medically necessary health care services" and "when it is not medically advisable for you to use a public or private vehicle." Elsewhere, the site said, "Information on nonemergency transportation will be posted soon."[16]

Partnership's website included a one-page document that described emergency transport, nonemergency transport, and a supplemental transport benefit. Nonemergency transport required prior approval, while the supplemental benefit would be provided when the beneficiary does not meet the criteria for Medi-Cal-covered transportation and the beneficiary is "considered high risk" due to a medical condition that makes transportation "critical to the well-being of the member and/or fetus."[17]

Molina's website stated that doctor-prescribed nonemergency medical transportation is covered when a medical condition "does not allow" regular means of transportation. Molina also covers nonmedical transportation if a beneficiary is recovering from a "serious injury or medical procedure" that prevents them from driving to a medical appointment and no other transportation is available.[18]

None of the referenced health plan terms and conditions indicated that transportation support is provided to assist beneficiaries to get to regular medical or specialty appointments, or how to address barriers to access resulting from long travel distances or times and a lack of transportation options. Further, none offered beneficiaries clear information about procedures for requesting transportation assistance. In follow-up discussion, DHCS confirmed that there are no transportation requirements on the health plans serving the expansion counties beyond those specified in the global reference to the state regulations, as quoted above.

DHCS reported in December 2014 that it had recently surveyed the health plans to assess the status of transportation access, particularly in rural counties, and found that all of the plans polled either have a nonemergency medical transportation network in place or are developing contracts for such a network. Additionally, all plans polled have processes in place to evaluate their beneficiaries' needs for transportation services. However, DHCS did not provide plan-specific information on this topic.[19]

In sum, based on the information publicly available, it appears that coverage for nonemergency medical transportation is potentially available from each health plan based on medical necessity or other plan criteria, but beneficiary access to this information and awareness of the coverage appear to be limited.

Telehealth

An area of promise for the delivery of specialty care in rural and remote areas is telehealth services, which involve the delivery of care, including diagnosis, consultation, and treatment, through telecommunications technologies. The DHCS managed care contract with the health plans authorizes delivery of telehealth services but does not require it, and to date the health plans serving the expansion counties have incorporated telehealth services only to a very limited extent.

Of the contracting plans, Anthem has presented the most defined telehealth strategy. According to Anthem's compliance report to DMHC, the plan's telehealth program has 62 primary care presentation sites across California where the patient can connect to a remote specialist via telecommunication. Of these 62 presentation sites, 21 are in provider offices in the rural counties of Butte, Colusa, Glenn, Imperial, Nevada, Plumas, Sierra, Tehama, and Yuba.

Partnership has a small number of telehealth services available, including dermatology, ophthalmology, and optometry services, and is working with providers to add more specialty care telehealth services.[20] For example, Partnership recently initiated development of three telemedicine sites in Humboldt, Lassen, and Shasta Counties focused on care for hepatitis-C and on endocrinology.

The other health plans have not yet introduced telehealth services, and plan materials submitted to DHCS were vague about their intent to do so. CHW reported that it is exploring options regarding telehealth in the expansion counties it serves. Molina stated that telehealth initiatives had not been needed with its prior book of Medi-Cal business. However, with Molina's entry into Imperial County and the beginning of the Cal

New Behavioral Health Coverage

New Mental Health Responsibilities. Beginning January 1, 2014, all Medi-Cal managed care plans were given new responsibility for providing mental health services to Medi-Cal enrollees with "mild to moderate" mental health conditions. County Mental Health Plans (MHP) continue to be responsible for Medi-Cal beneficiaries with serious mental illness.

Provider and county informants expressed concern about the separation of responsibility between health plans and counties for delivery of mental health services and the coordination required to make this work. "What has not been fully recognized is the movement of people across the continuum of mental illness and the fact that patients can't be pigeonholed into one diagnosis of mild, moderate, or severe," said one provider informant.

The roles and responsibilities of mental health providers at the county level are defined in a memorandum of understanding (MOU) between each participating health plan and each county in which it operates. Beyond these MOUs, health plans and counties will need to build business and clinical relationships around the provision of care in order to address the unique care needs of persons with mental illness.

In many of the 28 expansion counties, community health centers provide mental health services to Medi-Cal beneficiaries either independently or under contract with the county. With health plans now required to deliver the expanded Medi-Cal mental health benefit, they will need to coordinate closely with these community health centers in the delivery of services, particularly where the county infrastructure to address severely mentally ill Medi-Cal beneficiaries is most limited. A variety of issues will need to be addressed regarding the continuing mental health service role for community health centers, including payment structures and how health centers fit within the MOUs between health plans and counties.

New Medi-Cal Substance Use Disorder Benefit. An expansion of Medi-Cal coverage for Substance Use Disorders (SUD) was approved as a part of the FY 2013-14 State Budget and will affect the managed care health plans in the rural expansion. Beginning January 1, 2014, all Medi-Cal beneficiaries are entitled to screening, brief intervention, and referral to treatment (SBIRT) for addiction; intensive outpatient treatment; residential treatment; and inpatient detoxification. Among these services, Medi-Cal managed care plans have responsibility only for SBIRT and will refer beneficiaries to county SUD programs for additional services.

In most of the 28 expansion counties, there is very limited SUD treatment capacity, particularly for residential treatment. In general, rural counties do not have many Drug Medi-Cal Treatment Program providers and have experienced a low state investment in SUD treatment services. For example, of approximately $131 million allocated in FY 2011-12 under the Drug Medi-Cal Treatment Program, the 28 rural counties received roughly $7 million, or 5.3%.[21]

DHCS is developing a federal Medicaid Rehabilitation Waiver for the delivery of SUD services. To the extent this waiver supports rural provider expansion efforts, including opportunities to regionalize service delivery across several counties, there may be an opportunity to expand the existing small investment in this type of care in the 28 counties.

MediConnect program (California/federal partnership to provide coordinated care to Medi-Cal/Medicare dual eligibles) in several of its service areas, the plan "will look for opportunities" to utilize telehealth.

Appeals and Grievances

Medi-Cal beneficiaries' ability to file grievances and appeals concerning benefit coverage or other matters is essential to assuring effective review and oversight of plan decisions. The DHCS contract requires health plans to establish procedures for beneficiaries to file a grievance or appeal with the plan, either in writing, in person, or by phone. This includes appealing decisions regarding the beneficiary's coverage, benefits, relationship to the health plan, or other matters of dissatisfaction. Explanations of these procedures are to be included in the plan's membership guide provided to the beneficiary.

Further, the contract and DMHC regulations describe the rights of beneficiaries concerning appeals of plan decisions about medical services. In the Regional Model counties, where the plans are Knox-Keene licensed and thus regulated by DMHC, beneficiary rights include (1) requesting an Independent Medical Review (IMR) from DMHC, which involves a clinician decisionmaker, and (2) requesting a State Fair Hearing from DHCS if dissatisfied with the IMR decision. The State Fair Hearing process generally takes considerably longer than an IMR, according to legal aid informants, and does not include a clinician decisionmaker. Beneficiaries enrolled in Partnership, which is a COHS not licensed under Knox-Keene or regulated by DMHC, may only request a State Fair Hearing from DHCS. Thus, depending on their location, Medi-Cal beneficiaries across the rural expansion counties may have different appeal protections.

DHCS has reported that it will assess grievance and appeal data as a part of its consideration of health plan performance. Legal services representatives reported that the grievances and appeals filed with the state represent only a small fraction of the numerous issues beneficiaries and their representatives address locally. This is due in large part to the need of beneficiaries and their representatives to resolve immediate health-related issues that cannot wait for a protracted appeal process. In light of this dynamic, additional information about the beneficiary experience in the rural managed care expansion would provide greater context for aggregated reporting on beneficiary grievances and appeals. To this end, DHCS has said that it conducted a baseline member satisfaction survey among Medi-Cal beneficiaries in rural counties prior to implementing the managed care expansion, and will repeat that survey 18 months later, in spring 2015.[22]

Rural Expansion Going Forward

State Monitoring of the Expansion

With the delegation of responsibility to health plans for delivery of health care services to Medi-Cal beneficiaries in the 28 rural expansion counties, the role of the state has evolved from a direct payer of care to one of contracting with health plans, monitoring their performance and holding them accountable, and providing leadership to address issues facing rural health care access. As one provider informant for this report said, "If the state wants to get out of the business of health care and contract with health plans, the state needs to monitor the delivery of care. The state's role is to assure that the health plans have adequate networks." According to DHCS, that is the state's intention, and the state's joint agency oversight will incorporate a variety of qualitative and quantitative methods. (See sidebar on page 21.)

Under the terms of the state's Medicaid waiver, DHCS has been reporting to the federal government on the status of the rural expansion since implementation in late 2013. This reporting has focused on: enrollment; beneficiaries assigned to a PCP and those who change a PCP; beneficiaries who change a plan due to access to care or continuity of care concerns; additions and deletions from the provider network; continuity of care requests and outcomes; health plan call summaries; grievance reporting; and calls to the Office of the Ombudsman. In preparing this report, a request was made to DHCS for copies of the information submitted to the federal government, but this request was denied.

DHCS made its first public report on the status of the rural managed care expansion in December 2014 at a meeting of the department's Stakeholder Advisory Committee. The report was a summary discussion of experience to date and presented only enrollment data. Results of the comprehensive interagency monitoring of the rural expansion (see sidebar on page 21) were not yet available for a formal report on plan performance.

DHCS and DMHC Health Plan Assessment and Monitoring

DHCS Medical Audits. Performed by the Audits and Investigations Division, Medical Review Branch; conducted annually beginning in 2015; address utilization management, care coordination, access to care, members rights / quality management, administrative capacity

DMHC Routine Medical Surveys. Performed by DMHC; conducted at least every three years; address quality management, member complaints, access and availability, referrals and authorizations, overall plan performance

DHCS and DMHC Interagency Agreements. Coordinated joint agency review of rural expansion (as well as other transitions); includes financial audit, network adequacy, and medical survey

DHCS and DMHC Audit and Survey Coordination. Coordinated audit schedule with teams from both agencies onsite concurrently; findings consolidated in the Corrective Action Plan process (see below)

Non-routine Audits and Surveys. Other reviews as needed

Corrective Action Plans. Administered by DHCS for DHCS Medical Audits, Interagency Agreement surveys, and other unscheduled audits or surveys

Other monitoring indicators for rural expansion:

Transition Data. Grievance reports, continuity-of-care reports, provider network additions and deletions, PCP assignment and changes, consumer satisfaction, fraud and abuse

Ongoing Data. All-member grievance reports, detailed provider network reports, continuity-of-care reports, grievance logs, geo access reports, out-of-network reports, network adequacy reports

Source: "Network Assessments and Monitoring," Sarah C. Brooks and Nathan Nau (DHCS) and Nancy Pheng Street (DMHC), presentation to DHCS Stakeholder Advisory Group, September 11, 2014.

Staff from both agencies repeated their commitment to conducting coordinated reviews of plan performance and beneficiary experience, including the post-expansion beneficiary survey.[23]

More than a year into the rural managed care expansion, summary reporting on the new program is helpful, but it offers little description of the range of experiences across the 28 rural expansion counties. Further, in the absence of more detailed reporting, continuing issues of restricted health care access experienced in many rural counties are at risk of being overlooked at the state level. Most key informants interviewed for this report expressed a desire for a more collaborative, transparent, ongoing process with DHCS to discuss and consider findings associated with the managed care expansion as they occur, and to focus on actual beneficiary and provider experiences.

State Opportunities for Ongoing Leadership

Going forward with the rural Medi-Cal managed care program, DHCS has the opportunity to demonstrate leadership in two areas: monitoring and enforcement of health plan performance, and affirmative efforts to address the underlying challenges with rural Medi-Cal provider access.

With respect to monitoring and enforcement, DHCS and its partner agency DMHC should utilize available information to report regularly and specifically about the rural managed care program in each of the 28 expansion counties. DHCS and DMHC should consider including the following matters:

- Specific information about the composition and other aspects of the provider networks that DHCS and DMHC have approved for the health plans serving the 28 expansion counties
- Specialty care access standards accepted for each plan
- Alternative network standards that DHCS and DMHC have approved for the health plans and the justification for approving them
- Specific steps by DHCS and DMHC to monitor network standards and address deficiencies with each participating plan

- Within the context of nonemergency and non-medical transportation provided by health plans, clear documentation of plan services and criteria, and of processes for beneficiary use of these services
- Reporting of grievance and appeal filings with DHCS and DMHC at a county and plan level
- DHCS efforts to document the beneficiary and provider experience under the new program, including any DHCS plans to obtain rural health stakeholder feedback through county site visits and surveys of consumer and provider satisfaction
- Steps by DHCS to promote growth of specialty care provider capacity across the 28 expansion counties, including the use of telehealth services

With respect to the underlying challenges of rural Medi-Cal provider access, DHCS can demonstrate renewed leadership for rural health in partnership with the health plans now carrying out state responsibilities and with providers, beneficiaries, counties, and other community stakeholders. This state leadership could produce long-term strategic goals for improved provider access and availability and necessary community supports for Medi-Cal beneficiaries in the 28 rural expansion counties, and define specific state policy, program, and financing approaches to achieve those goals. In its December 2014 presentation on the rural expansion, DHCS identified the state's next Medicaid waiver as a vehicle through which to consider rural workforce issues. DHCS has the opportunity to use this Medicaid waiver to lay out a strategic plan for rural health that focuses on the health care services and supports needed by all Medi-Cal beneficiaries.

Finally, the Legislature itself, particularly the Committee on Budget, which authored AB 1467, should give renewed attention to the rural managed care expansion in order to learn more about how this important programmatic change is working and to fulfill its essential oversight role. The timing for renewed legislative attention to the rural expansion could not be more important. Beginning December 1, 2014, roughly 24,000 seniors and persons with disabilities in the Regional Model two-plan counties began joining these health plans. (In the expansion counties served by Partnership, this population joined managed care at the outset.) These new entrants to managed care have higher-level needs, particularly for specialty care, than the first group of plan enrollees. DHCS, DMHC, and the health plans should be asked to report on network readiness for these populations and on their experience so far.

Moving from an FFS system to a more highly organized managed health care system, through Medi-Cal health plans, marks an important step toward improving rural health care delivery for Medi-Cal beneficiaries. But it is only a first step. Moving ahead, DHCS, DMHC, and the Legislature should focus on the key questions and issues that have been raised by rural health stakeholders, many of which are identified in this report, and develop the next level of improvement in rural health care delivery. Rural Californians and the rural health system need this affirmative state leadership.

Appendix A. List of Key Informants

ORGANIZATION	INFORMANT	TITLE
Providers		
Adventist Health	Gail Nickerson	Director, Rural Health Services
California Hospital Association	Peggy Wheeler Sherree Kruckenberg	Vice President, Rural Health & Governance Vice President, Behavioral Health
California Medical Association	Richard Thorp, MD	President
California Primary Care Association	Carmela Castallano-Garcia	President/CEO
Central Valley Health Network	Cathy Frey	CEO
Health Alliance of Northern California	Doreen Bradshaw	Executive Director
Hospital Council of Northern and Central California	Suzanne Ness	Regional Vice President
Shasta Community Health Center	Dean Germano	CEO
Western Sierra Medical Clinic	Scott McFarland	CEO
Health Plans		
Anthem Blue Cross	Steve Melody	President, California Medicaid Health Plan
California Health and Wellness Plan Centene Corporation	Greg Buchert, MD Wade Rakes	President/CEO Director of Business Development
Molina Medical	James Novello	COO
Partnership HealthPlan of California	Jack Horn	Executive Director/CEO
Consumers		
Health Access of California	Anthony Wright Beth Capell	Executive Director Lobbyist/Policy Advocate
Legal Services of Northern California	Liza Thantranon	Staff Attorney
Counties		
California Institute for Mental Health	Sandra Naylor Goodwin	President/CEO
CMSP Governing Board	Alison Kellen	Program Manager
Imperial County Public Health Department	Robin Hodgkin	Director
Plumas County Public Health Department	Mimi Hall	Director
Sutter County Human Services Department	Tom Sherry	Director
Tehama County Health Services Agency	Valerie Lucero	Executive Director
State Regulators		
California Department of Health Care Services	Toby Douglas Mary Cantwell Jane Ogle	Director Chief Deputy Director Chief Deputy Director
California Department of Health Care Services, Medi-Cal Managed Care Division	Javier Portela Sarah Brooks Karen Thalhammer	Plan Management Branch Chief Program Monitoring and Medical Management Branch Chief Policy and Contracts Branch Chief
California Department of Managed Health Care	Shelley Rouillard Katie Coyne Gary Baldwin	Director Deputy Director, Office of Plan Licensing Deputy Director, Plan and Provider Relations

Appendix B. State Ranking of Health Outcomes and Health Factors in the 28 Medi-Cal Rural Expansion Counties

COUNTY	HEALTH OUTCOMES* RANK OF 58 COUNTIES	HEALTH FACTORS† RANK OF 58 COUNTIES
Placer	2	2
El Dorado	7	9
Nevada	8	7
San Benito	10	28
Colusa	13	37
Mono	19	19
Tuolumne	21	21
Mariposa	24	25
Glenn	25	34
Imperial	27	55
Sutter	29	36
Calaveras	32	23
Amador	33	20
Plumas	34	32
Lassen	36	39
Humboldt	38	26
Sierra	39	27
Butte	45	33
Shasta	48	41
Trinity	49	46
Tehama	50	47
Inyo	51	22
Yuba	52	56
Modoc	53	29
Siskiyou	55	42
Del Norte	56	43
Lake	57	52
Alpine	NR	NR

*Health outcomes include length of life, health/mental health status, and birth outcomes.

†Health factors include health behaviors, clinical care, social and economic factors, and physical environment.

Source: "California Rankings Data," Robert Wood Johnson Foundation, www.countyhealthrankings.org; for ranking methodology, see www.countyhealthrankings.org/ranking-methods/ranking-system.

Appendix C. California Medical Board Physician Licenses in the 28 Medi-Cal Rural Expansion Counties

COUNTY	2007-08	2009-10	2011-12
Alpine	1	2	2
Amador	66	65	62
Butte	476	461	482
Calaveras	54	49	52
Colusa	9	10	9
Del Norte	48	44	40
El Dorado	303	288	293
Glenn	12	11	9
Humboldt	290	291	284
Imperial	127	129	136
Inyo	47	42	41
Lake	80	77	73
Lassen	37	37	37
Mariposa	16	11	13
Modoc	5	5	6
Mono	36	30	29
Nevada	258	303	246
Placer	966	947	1,104
Plumas	37	30	27
San Benito	43	43	40
Shasta	467	439	426
Sierra	0	0	0
Siskiyou	84	80	81
Sutter	201	196	192
Tehama	50	48	49
Trinity	14	9	8
Tuolumne	126	125	117
Yuba	53	41	43
Total	**3,906**	**3,813**	**3,901**

Source: "Physician and Surgeon License by County," California Medical Board, www.mbc.ca.gov.

Appendix D. Hospitals in the 28 Medi-Cal Rural Expansion Counties

COUNTY	HOSPITALS
Alpine	none
Amador	Sutter Amador Hospital
Butte	Adventist Health/Feather River Hospital Enloe Medical Center Orchard Hospital Oroville Hospital
Calaveras	Mark Twain St. Joseph's Hospital
Colusa	Colusa Regional Medical Center
Del Norte	Sutter Coast Hospital
El Dorado	Barton Memorial Hospital Marshall Medical Center
Glenn	Glenn Medical Center
Humboldt	Jerold Phelps Community Hospital Mad River Community Hospital Redwood Memorial Hospital St. Joseph Hospital
Imperial	El Centro Regional Medical Center Pioneers Memorial Health Care District
Inyo	Northern Inyo Hospital Southern Inyo Hospital
Lake	St. Helena Hospital Sutter Lakeside
Lassen	Banner Lassen Medical Center
Mariposa	John C. Fremont Healthcare District
Modoc	Modoc Medical Center Surprise Valley Health Care District

COUNTY	HOSPITALS
Mono	Mammoth Hospital
Nevada	Sierra Nevada Memorial Hospital Tahoe Forest Hospital District
Placer	Kaiser Permanente Roseville Medical Center Sutter Auburn Faith Hospital Sutter Roseville Medical Center
Plumas	Eastern Plumas Health Care Plumas District Hospital Seneca Healthcare District
San Benito	Hazel Hawkins Memorial Hospital
Shasta	Mayers Memorial Hospital District Mercy Medical Center Redding Shasta Regional Medical Center Vibra Hospital of Northern California
Sierra	none
Siskiyou	Fairchild Medical Center Mercy Medical Center Mount Shasta
Sutter	none
Tehama	St. Elizabeth Community Hospital
Trinity	Trinity Hospital
Tuolumne	Sonora Regional Medical Center/ Adventist Health
Yuba	Rideout Memorial Hospital

Sources: "List of Hospitals in California, USA," OSHPD, gis.oshpd.ca.gov; Hospital Council of Northern and Central California, email communication, May 30, 2014.

Appendix E. Availability of Providers in Six Core Specialties

The following three tables provide data obtained from the websites of the managed care health plans participating in the 28 rural expansion counties. They show the number of individual Board Certified providers for six core specialties for each of the counties served by the plans.

E1. California Health & Wellness Plan (CHW) and Anthem Blue Cross (AN) (providers within 50 miles of the county)

	CARDIOLOGY		GASTRO-ENTEROLOGY		NEUROLOGY		ORTHOPEDIC SURGERY		OTOLARYNGOLOGY (ENT)		UROLOGY	
COUNTY*	CHW	AN	CHW	AN	CHW	AN	CHW	AN	CHW	AN	CHW	AN
Alpine	6	0	1	0	1	0	>10	0	1	0	1	0
Amador	>10	>10	2	0	5	1	>10	1	4	0	5	0
Butte	>10	8	>10	8	9	5	>10	>10	7	6	8	3
Calaveras	8	0	3	0	5	0	>10	0	4	0	5	0
Colusa	>10	1	5	0	6	0	10	0	5	0	4	0
El Dorado	>10	>10	7	1	4	4	>10	8	5	1	3	0
Glenn	>10	0	7	0	5	0	>10	0	7	0	7	1
Inyo	1	5	1	0	0	0	0	1	0	0	0	0
Mariposa	2	0	4	0	3	0	6	0	2	0	3	0
Mono	0	0	0	0	1	0	4	1	0	0	1	0
Nevada	>10	>10	7	5	8	1	>10	>10	6	1	3	2
Placer	>10	8	6	7	8	8	>10	6	6	6	4	3
Plumas	4	0	3	1	1	1	7	2	3	0	2	0
Sierra	5	0	7	0	1	0	>10	0	3	0	3	0
Sutter	>10	>10	>10	3	8	1	>10	9	3	3	4	2
Tehama	>10	0	7	0	6	0	>10	0	8	1	6	0
Tuolumne	3	0	2	1	3	0	7	1	2	0	3	2
Yuba	>10	1	>10	1	>10	0	>10	0	9	0	8	0

E2. California Health & Wellness Plan (CHW) and Molina (MOL) (providers within 50 miles of the county)

	CARDIOLOGY		GASTRO-ENTEROLOGY		NEUROLOGY		ORTHOPEDIC SURGERY		OTOLARYNGOLOGY (ENT)		UROLOGY	
COUNTY	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL
Imperial	4	8	5	7	1	4	2	1	5	0	3	2

*No review was conducted for San Benito County.

Note: If a specialty is listed as "0," beneficiaries in that county must travel more than 50 miles for these specialty care services.

Sources: "Find a Provider," California Health & Wellness, accessed August 22, 2014, www.cahealthwellness.com; "Provider Directory," Anthem Blue Cross, accessed August 23, 2014, www.anthem.com; California Health & Wellness and Anthem Blue Cross provider network filings to DHCS; "Find a Provider," Molina Healthcare, accessed August 26, 2014, eportal.molinahealthcare.com.

Appendix E. Availability of Providers in Six Core Specialties, *continued*

E3. Partnership HealthPlan (providers within the county)

COUNTY	CARDIOLOGY	GASTROEN-TEROLOGY	NEUROLOGY	ORTHOPEDIC SURGERY	OTOLARYNGOLOGY (ENT)	UROLOGY
Del Norte	0	0	0	1	0	0
Humboldt	3	2	5	4	2	3
Lake	6	0	1	1	2	0
Lassen	0	0	0	0	0	0
Modoc	0	0	0	0	0	0
Shasta	>10	2	2	>10	5	3
Siskiyou	1	0	0	6	0	0
Trinity	1	0	0	0	0	0

Note: If a specialty is listed as "0", beneficiaries in the county must travel to another county for these specialty care services.

Source: Medi-Cal Specialist Directory, Partnership HealthPlan of California, www.partnershiphp.org.

Endnotes

1. As defined by the California Office of Statewide Health Planning & Development, a "frontier" Metropolitan Statistical Service Area (MSSA) is one with less than 11 people per square mile.
2. "Medi-Cal Managed Care Enrollment Report — July 2014," California Department of Health Care Services, www.dhcs.ca.gov.
3. Carrie Graham, *In Transition: Seniors and Persons with Disabilities Reflect on Their Move to Medi-Cal Managed Care,* California HealthCare Foundation, April 2014, www.chcf.org.
4. California Health and Safety Code §1340 et seq.
5. California Department of Health Care Services, *28-County PowerPoint,* November 19, 2012.
6. Committee on Budget, Chapter 23, Statutes of 2012.
7. *HMOs and Rural California,* Office of the Legislative Analyst, August 8, 2002.
8. Medi-Cal Managed Care Regional Expansion Request for Applications (Number 28RFA2012/2013), California Department of Health Care Services.
9. Sarah Brooks, "Timely Access and Network Adequacy: Rural Expansion Counties" (presentation to the California Department of Health Care Services Stakeholder Advisory Committee, December 3, 2014), www.dhcs.ca.gov.
10. Title 22 CCR § 53853(a).
11. California Welfare and Institutions Code § 14182(c)(2).
12. Northern Region Outreach/Program Activities, Partnership HealthPlan, via email from Amy Turnipseed, Director of Policy and Program Development, October 15, 2014.
13. Title 22 CCR § 51323.
14. Two-Plan California Department of Health Care Services Contract (DHCS MMCD TwoPlanBoilerPlate-Web.6-1-11), p. 102.
15. *Medi-Cal Health Plan,* Anthem Blue Cross, July 2013, www22.anthem.com.
16. "Benefit Information," California Health & Wellness, www.cahealthwellness.com; "Transportation Services," California Health & Wellness, www.cahealthwellness.com.
17. "Transportation Coverage," Partnership HealthPlan of California, www.partnershiphp.org.
18. "Transportation," Molina Healthcare, www.molinahealthcare.com.
19. Personal communication from California Department of Health Care Services to author, December 9, 2014.
20. Partnership Rural Expansion GeoAccess Report to California Department of Health Care Services, p. 4.
21. "2012-13 Percent Allocations Based on 2011-12 Substance Abuse Subaccount Allocations," California Department of Health Care Services, September 7, 2012.
22. "Rural Expansion Survey Questions," accessed February 2, 2015, www.dhcs.ca.gov.
23. "Rural Expansion Survey Questions."