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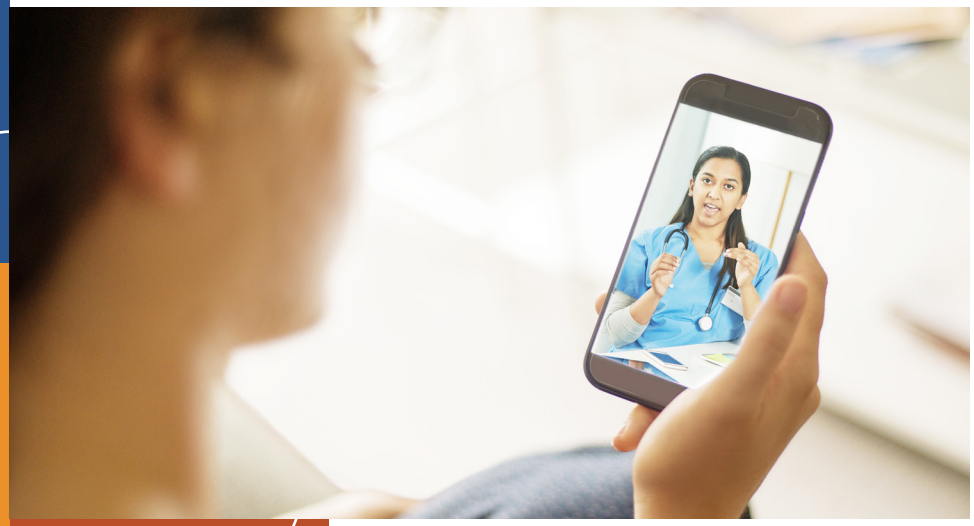


APRIL 2020

The State of Telehealth in Medi-Cal Managed Care:
Taking Stock in the Era of COVID-19

Introduction

Never have the benefits and importance of expanding access to telehealth been more evident than they are now, in the midst of a global pandemic from COVID-19, given the evidence that human-to-human contact is considered to be the primary mode of transmission. Even in normal times, telehealth increases access to care by expanding options for patients to connect with providers and by significantly decreasing wait times between a referral and a subsequent visit.[1] Its potential to help patients get the care they need when they need it is particularly great in Medi-Cal, California's Medicaid program. Twenty-five percent of Medi-Cal enrollees report difficulty finding a specialist when they need one — a rate over two times greater than for Californians with employer-based coverage.[2]

In 2019, the California Department of Health Care Services (DHCS), which administers Medi-Cal, expanded coverage for telehealth.[3] Among many changes, DHCS lifted restrictions on which services could be provided through telehealth (clinicians now have the authority to determine clinical appropriateness) and established billing codes and payment rates for specialists providing electronic consultations. In 2020, in response to the pandemic, state officials swiftly took additional action to expand access to telehealth, including allowing Federally Qualified Health Centers and other Medi-Cal providers to bill for phone visits and other visits that originate outside a clinical setting.[4] Whether these changes are temporary or take root is unknown at this time.

For the more than 10 million Medi-Cal enrollees in managed care, managed care plans (MCPs) are responsible for ensuring their members receive timely access to care. However, the extent to which Medi-Cal MCPs are using telehealth to improve access to care for their members has not been studied.

This report provides a first look at the telehealth landscape among Medi-Cal MCPs, including a snapshot of use in 2019 and insight into the priorities, approaches, and challenges of MCPs in offering telehealth services to their members. The findings reflect surveys completed by 17 of the 24 Medi-Cal MCPs, representing 88% of Medi-Cal managed care enrollees and all three plan types: County Organized Health Systems, local initiative health plans, and commercial plans.[5]

"Telehealth probably isn't listed in anyone's job description as an executive. . . . No one manages telehealth full-time."

(All quotations are from study participants.)

What Are the Different Types of Telehealth?

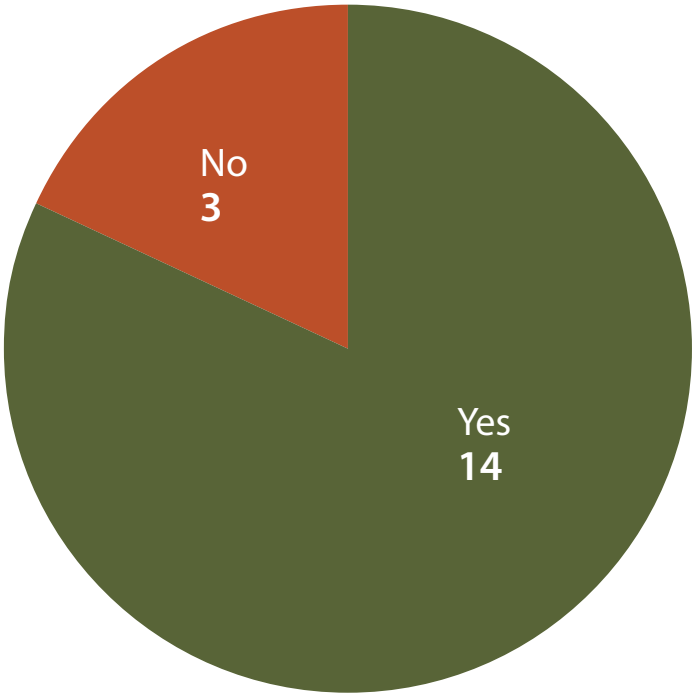
Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. The following types of telehealth and definitions were used for this survey:

- **Member-to-Provider, Synchronous or Asynchronous, Originating in Nonclinical Setting:** Interaction between a member and a provider using audiovisual telecommunications technology (e.g., live video initiated from member's cell phone, home computer, or at an in-store kiosk).
- **Member-to-Provider, Synchronous, Originating at Provider Site:** Live, two-way interaction between a member and a provider using audiovisual telecommunications technology (e.g., live video initiated at a health clinic).
- **Provider-to-Provider, Asynchronous, with Image:** Transmission of images and recorded health history by a provider through an electronic communications system to a provider, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction (i.e., "store and forward").
- **Provider-to-Provider, Consultation Only:** Electronic communication between two providers, typically where a primary care physician is consulting with a specialist (i.e., electronic consultation).
- **Remote Patient Monitoring (RPM):** Personal health and medical data collection from a patient in one location via electronic communication technologies that is transmitted to a provider in a different location for use in care-related support.
- **Mobile Health (mHealth):** Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and personal digital assistants (PDAs). Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks, to name a few examples.

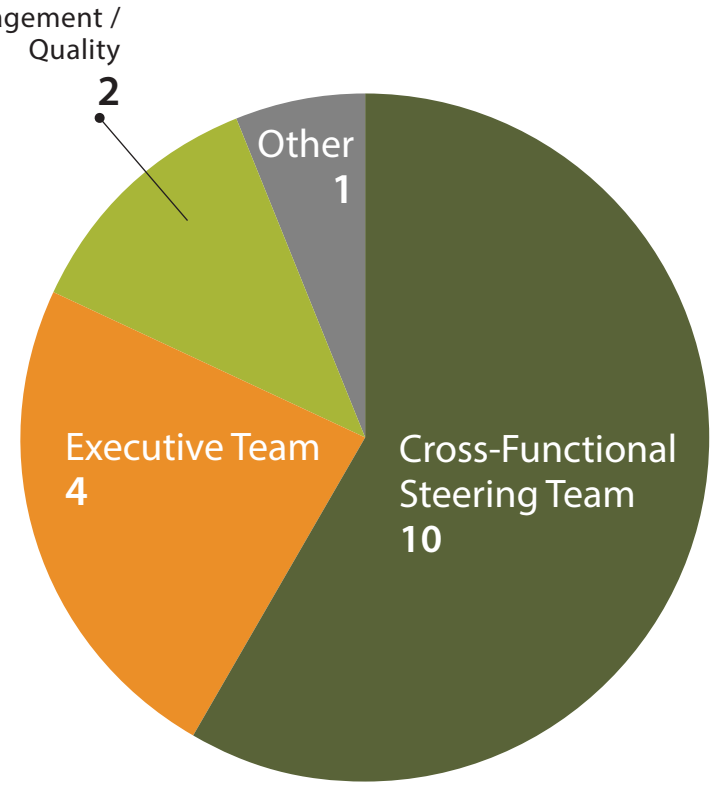
"We hadn't looked at our telehealth policies and procedures around telehealth for a while. The way we are proceeding is we would wait for the new provider manual to come out. . . . Direct, member-to-provider live video is of interest [in the next year]."

Accountability for Telehealth Strategy and Decisionmaking Is Dispersed Across MCP Departments

Does your MCP have a telehealth strategy — that is, a vision for member and provider access to telehealth with defined goals and implementation plans?



Where does your MCP's telehealth strategy or decisionmaking reside?



A majority of MCPs (14 of 17 reporting) self-report that they have telehealth strategies in place to guide and evaluate programs and initiatives.

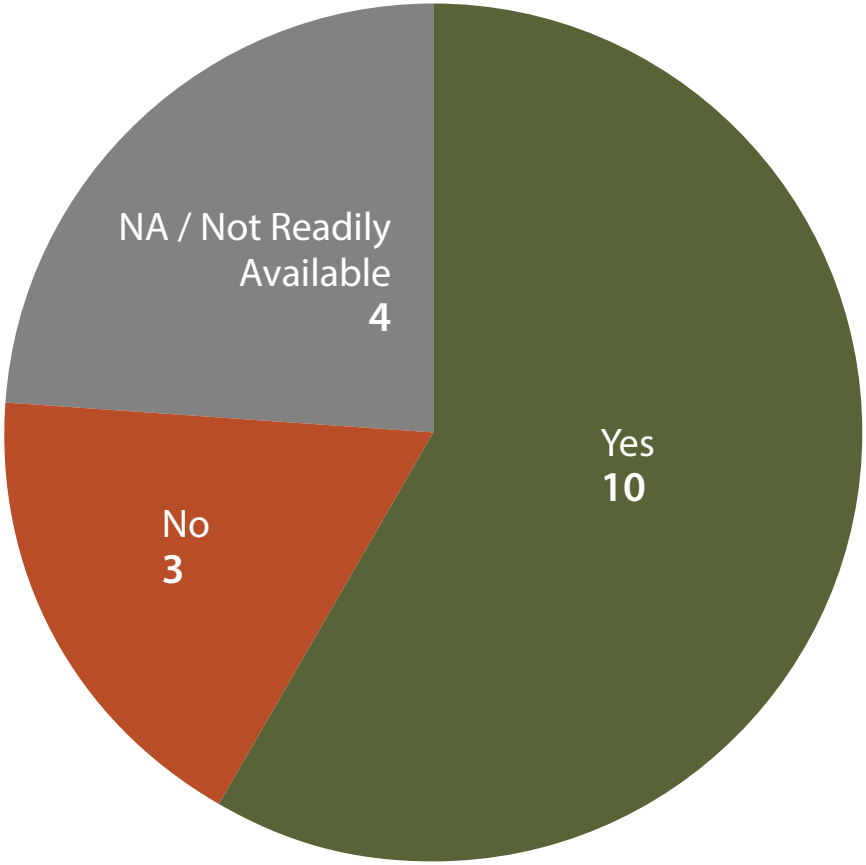
For a majority of MCPs (10 of 17), responsibility for strategy or decisionmaking resides within a cross-functional team.

Establishing a strategic vision for telehealth is critical to ensuring that members have access to telehealth when and where they need it. Dedicated telehealth teams and clear lines of organizational accountability support the successful execution of a telehealth strategy.

Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Most MCPs Say They Track Telehealth Claims or Encounters

Do you track telehealth claims and/or encounters?



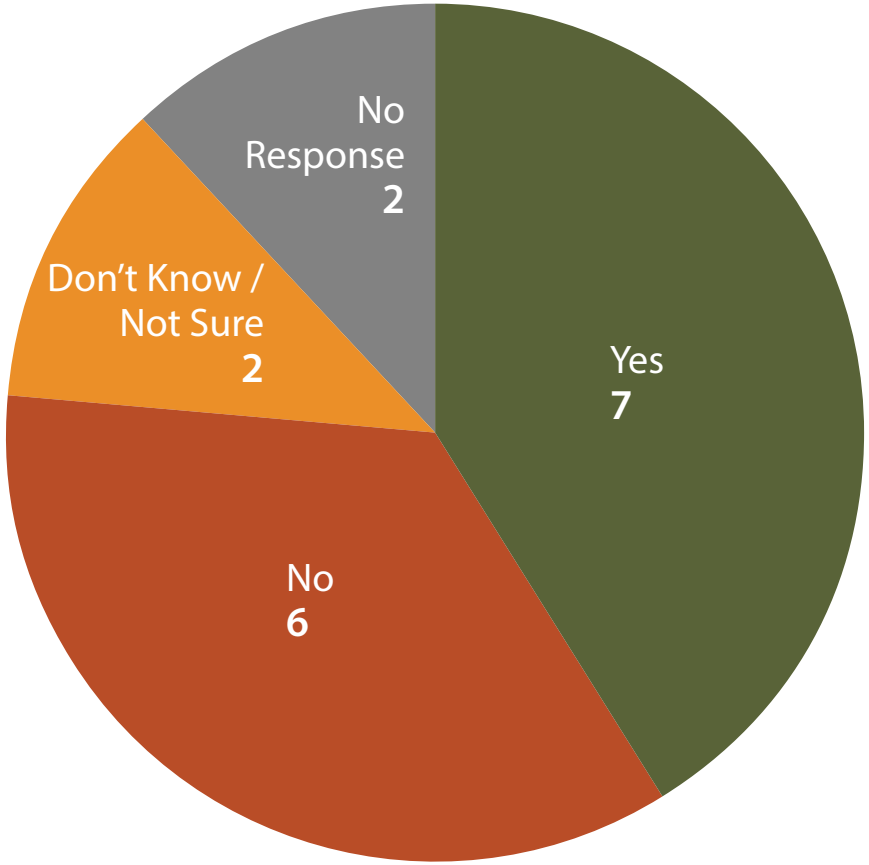
A majority of MCPs (10 of 17) report that they track telehealth claims or encounters. MCPs track these through monthly encounter reports from vendors or through claims sent directly from providers.

Reports from telehealth vendors are likely to be accurate. Encounter data and claims from providers may be less reliable when billing or reporting requirements are unclear, when policies are inconsistent across payers, or when data submission of a particular code is unrelated to reimbursement.

Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Telehealth Reporting Is Not Yet Routine or Standardized Across Plans or Required by State Regulators

Does your MCP include telehealth services in the following types of administrative and quality reporting it submits to DMHC and/or DHCS: member satisfaction surveys, provider satisfaction surveys, telehealth provider inclusion in network filings, provider billing manual, provider directory?



"HEDIS scores and other quality scores are important [motivators for pursing telehealth]."

"We don't know how to measure our anticipated outcomes [of our telehealth programs]."

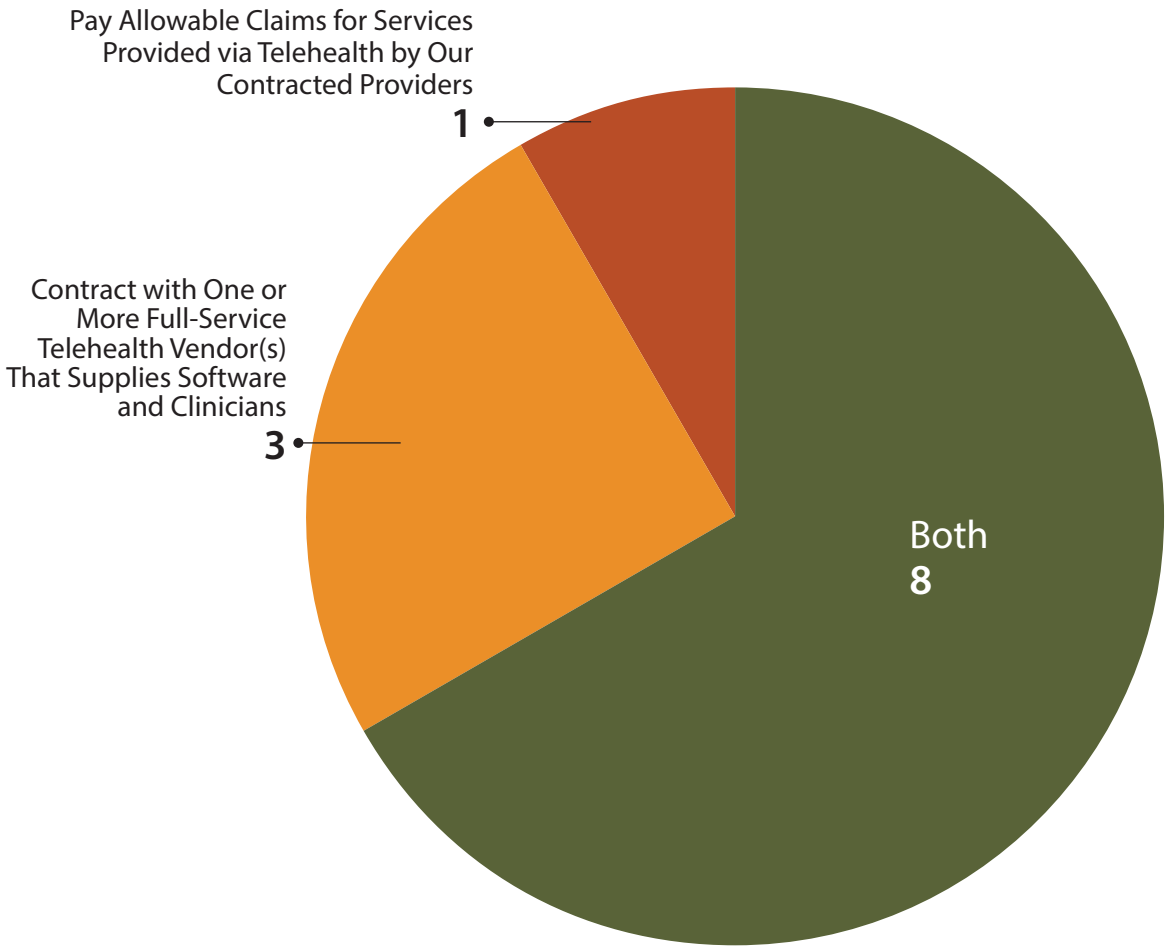
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Less than half of MCPs (7 of 17) report that they include telehealth data in one or more types of administrative or quality reporting to the Department of Managed Health Care (DMHC) or DHCS, such as member satisfaction surveys or provider directories.

Standardized and consistent reporting across all MCPs would support regulators' and policymakers' abilities to monitor access, track utilization, and measure program outcomes for enrollees and providers.

Most MCPs Deploy a Combination of Approaches to Paying for Telehealth

How are you deploying member-to-provider, synchronous or asynchronous telehealth, originating in a nonclinical setting?



"Say you want to add a telehealth urgent care service as a benefit. You need to consider if you will do it in phases. Can you add groups of providers onto the platform? How do you notify patients? Are you paying claims correctly? All these things need to work in sync."

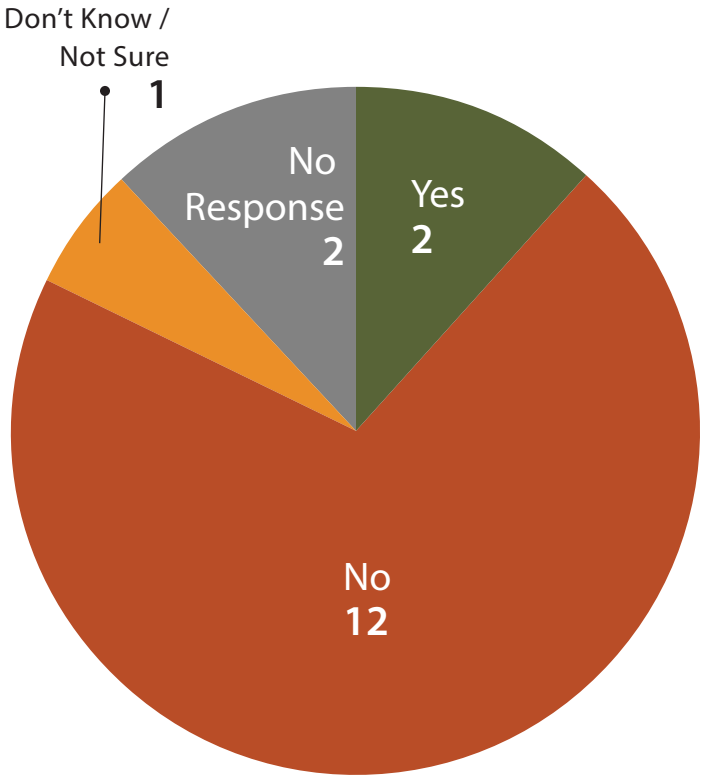
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Most MCPs (8 of 12) pay allowable claims for telehealth services from contracted providers and contract with third-party vendors to provide telehealth services. Four other MCPs do one of these but not both.

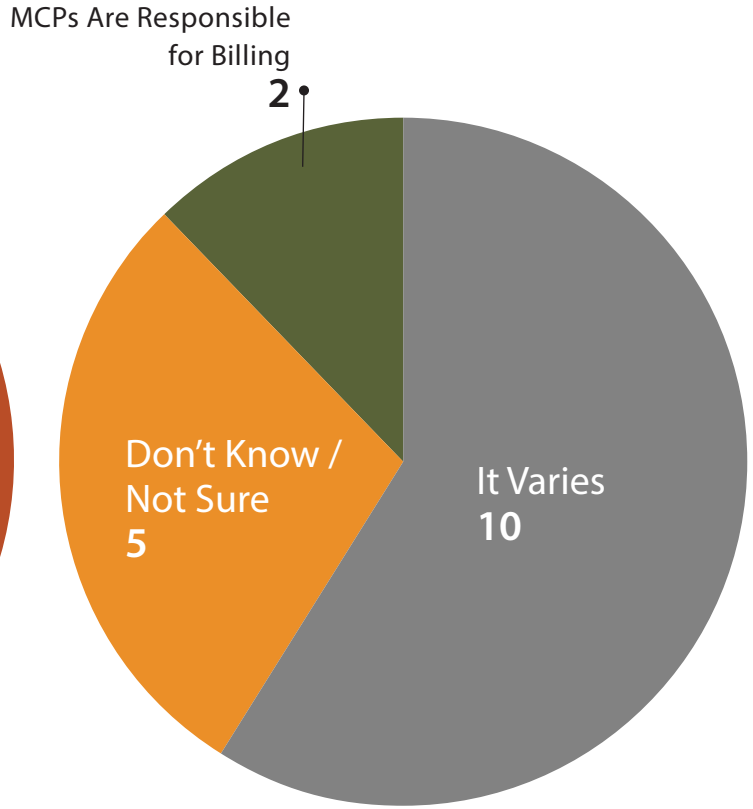
Lack of Contractual Requirements for Providers, and Variable or Unclear Responsibility for Paying for Telehealth, Are Common

Do you have telehealth requirements in your contracts with providers?

Note: MCPs were asked to report telehealth requirements based on provider type; data displayed have been aggregated.



For delegated, risk-bearing contractors, which organization is responsible for paying for billable telehealth encounters (e.g., live video and store-and-forward)?



"The MCP and delegated entity both think the other should be handling billing."

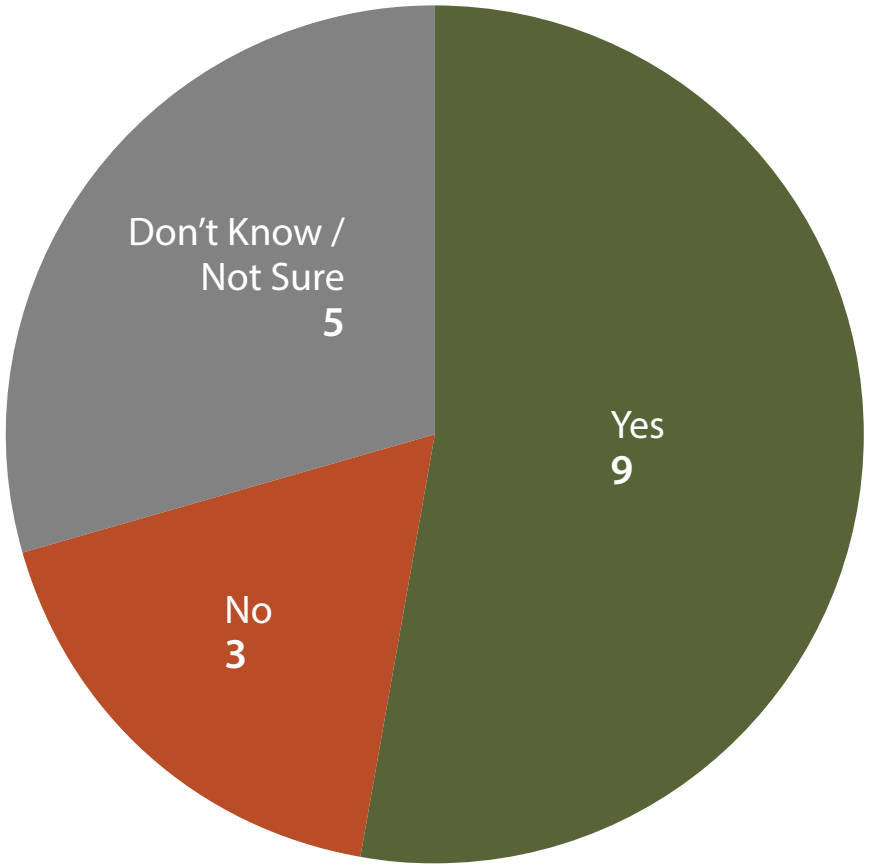
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Only two MCPs report that they have telehealth requirements in their provider contracts, and only two report consistent policies regarding whether they are delegated entities responsible for paying for telehealth.

A lack of contractual requirements suggests that local networks are not widely engaged in MCP telehealth efforts, or that MCPs lack insight into their provider network offerings. The lack of requirements not spelled out in the contract may also be the reason for the confusion over responsibility for billing and payment.

MCPs Expect to Change How They Are Currently Deploying Live Video Telehealth

Do you expect how you are deploying provider-to-member live video telehealth and/or store-and-forward to change in the next 12 months?



"We're looking for a vendor whose current network includes specialists to increase access and choice for our members."

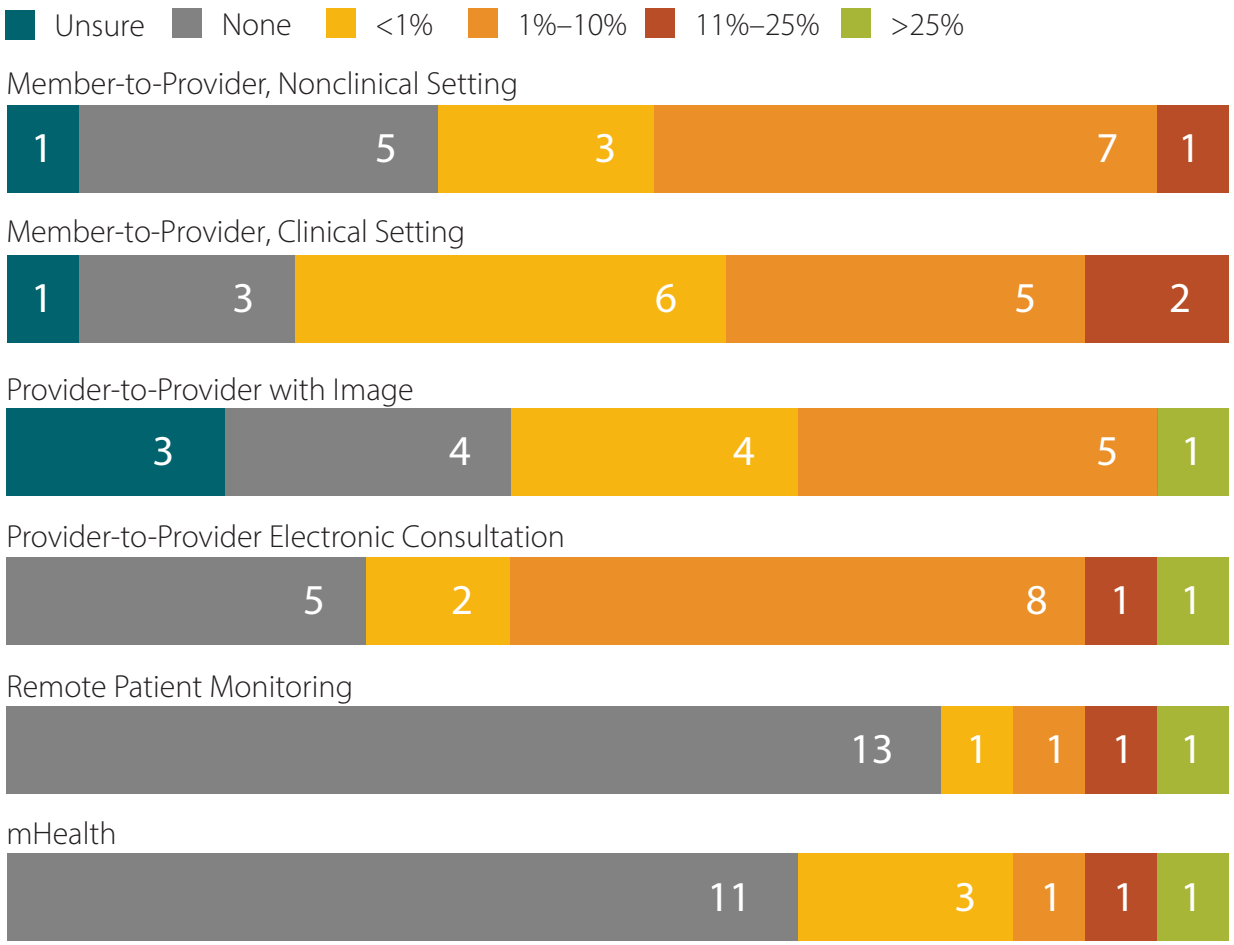
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Most MCPs (9 of 17) expect to change how they deploy telehealth. In subsequent interviews, MCP representatives cited recent Medi-Cal policy updates as the reason they would change their practices.

For example, several MCPs indicated they are planning to deploy live video urgent care telehealth for members in 2020.

Across Most MCPs, Member and Provider Use of Telehealth Across Modalities Is Low

What percentage of your members or providers use the following form of telehealth?



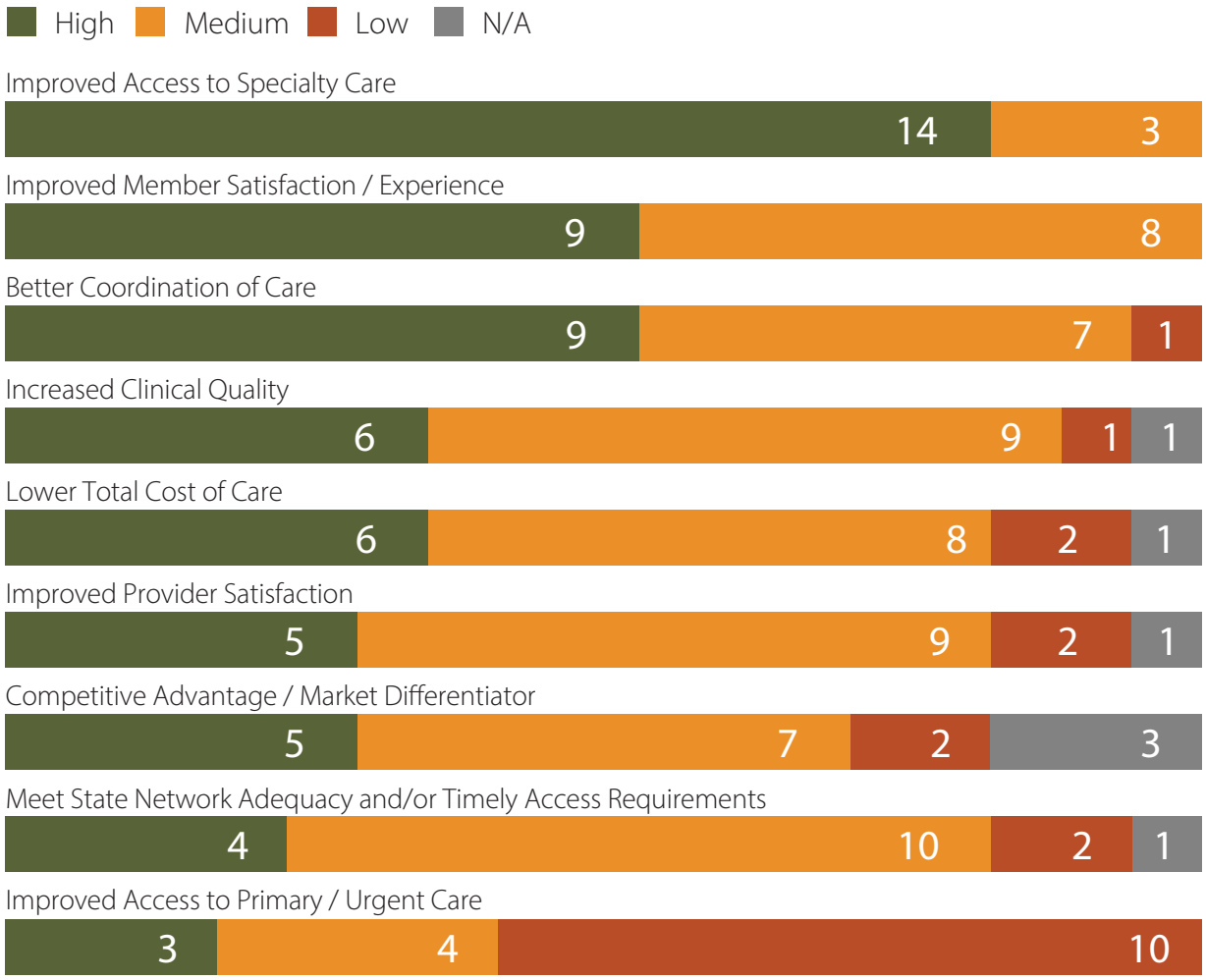
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Provider-to-provider electronic consultation (eConsult) accounted for the greatest number of MCPs reporting use rates of 1% or greater, followed closely by member-to-provider telehealth in a nonclinical setting and provider-to-provider with image. Remote patient monitoring (RPM) and mHealth accounted for the lowest number of MCPs reporting use rates of 1% or greater.

Provider-initiated telehealth modalities may have greater uptake than others due to the comparative ease of billing and reimbursement under current Medi-Cal rules. These encounters may be captured within the electronic health record and have billing codes associated with encounters.

MCPs Are Confident Telehealth Will Improve Specialty Care Access, Member Satisfaction, and Care Coordination

How confident are you that your MCP will realize the outcomes below through telehealth?



"We are using telehealth in different areas: dermatology, behavioral health, physical therapy. . . . Specialty care access in some areas is very, very sparse."

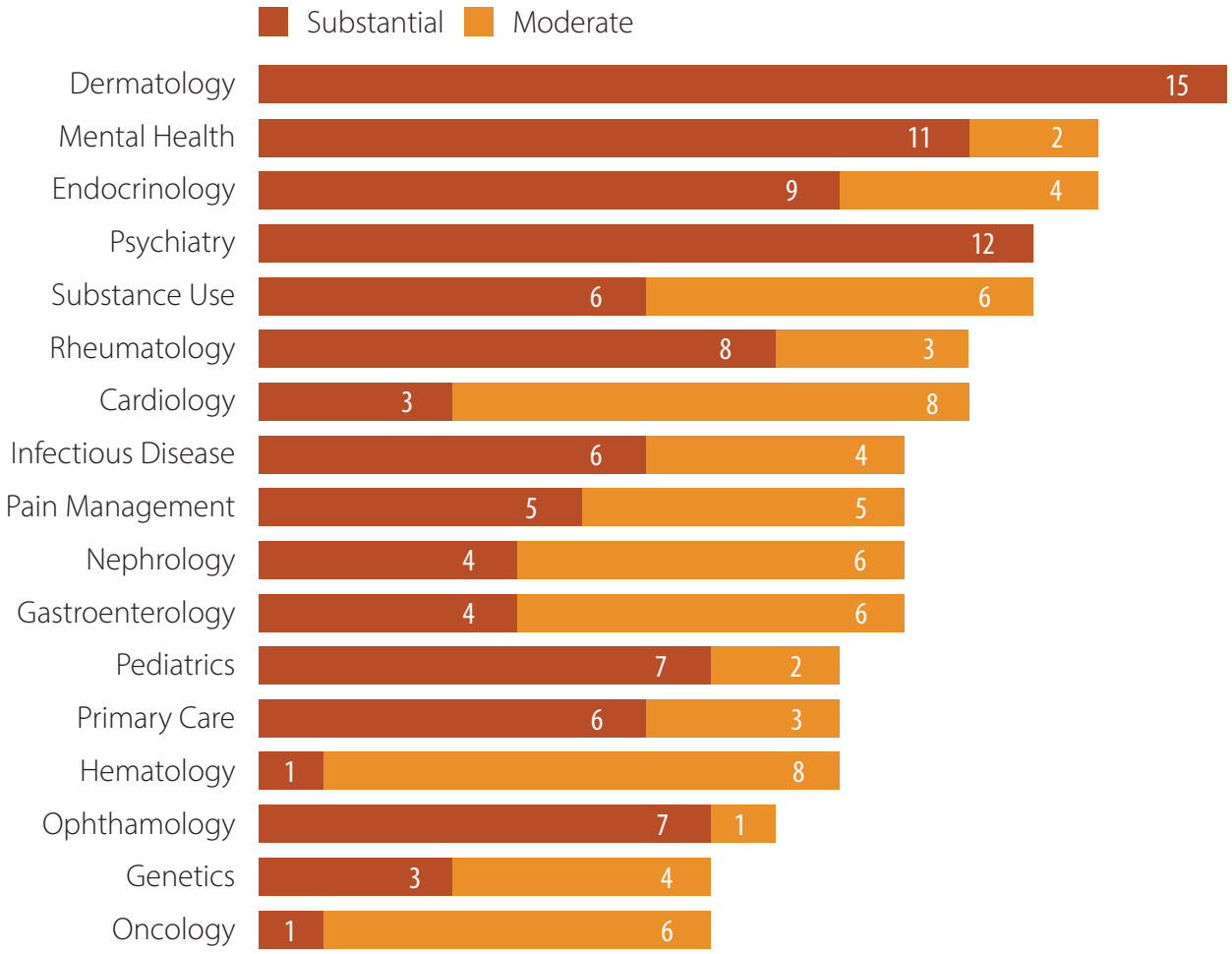
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

MCPs are confident that telehealth will improve access to specialty care, as well as improve member satisfaction and care coordination. Fewer MCPs are confident it will lower total cost of care or improve access to primary care.

Specialty care access may be a driver of telehealth adoption due to noted access issues in Medi-Cal. eConsult, where there is also a clear return on investment, may also drive adoption.

MCPs Anticipate Telehealth Will Improve Access and Quality Across Many Specialties

In your opinion, for the following specialties, how much can telehealth improve access and quality for your members in the next two years?



"Dermatology is a classic example that lends itself to volume [with telehealth]. Most PCPs just don't see enough skin cancer to know what it is, but your remote dermatologist can examine with a photo."

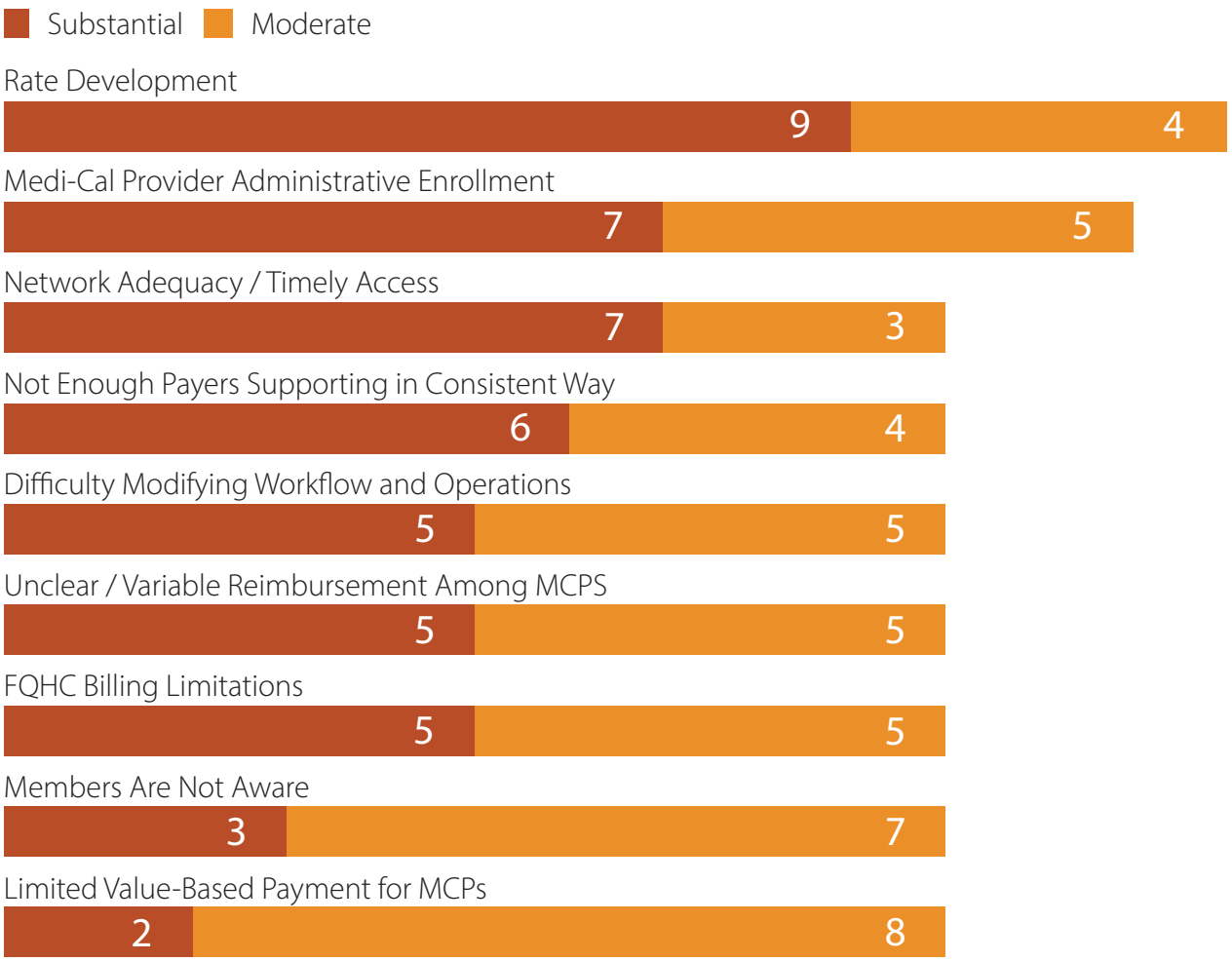
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Dermatology, psychiatry, endocrinology, psychiatry, and substance use were cited as specialties where telehealth can have substantial impact on access and quality over the next two years.

Certain specialties may rank higher due to relative ease of use of technology, such as capturing and sending dermatologic images. Psychiatry, mental health, and substance use treatment may rank high because of the efficacy of virtual protocols or decreased stigma attached to accessing care that does not require in-person office visits.

MCPs Point to Several Barriers to the Broader Use of Member-to-Provider Telehealth

Number of MCPs reporting that the following are substantial or moderate barriers to the broader use of member-to-provider telehealth in a nonclinical setting.



"Time and distance standards [in network adequacy] are not meaningful when it comes to telehealth. It doesn't capture the behavioral health provider in San Francisco treating my member in Southern California."

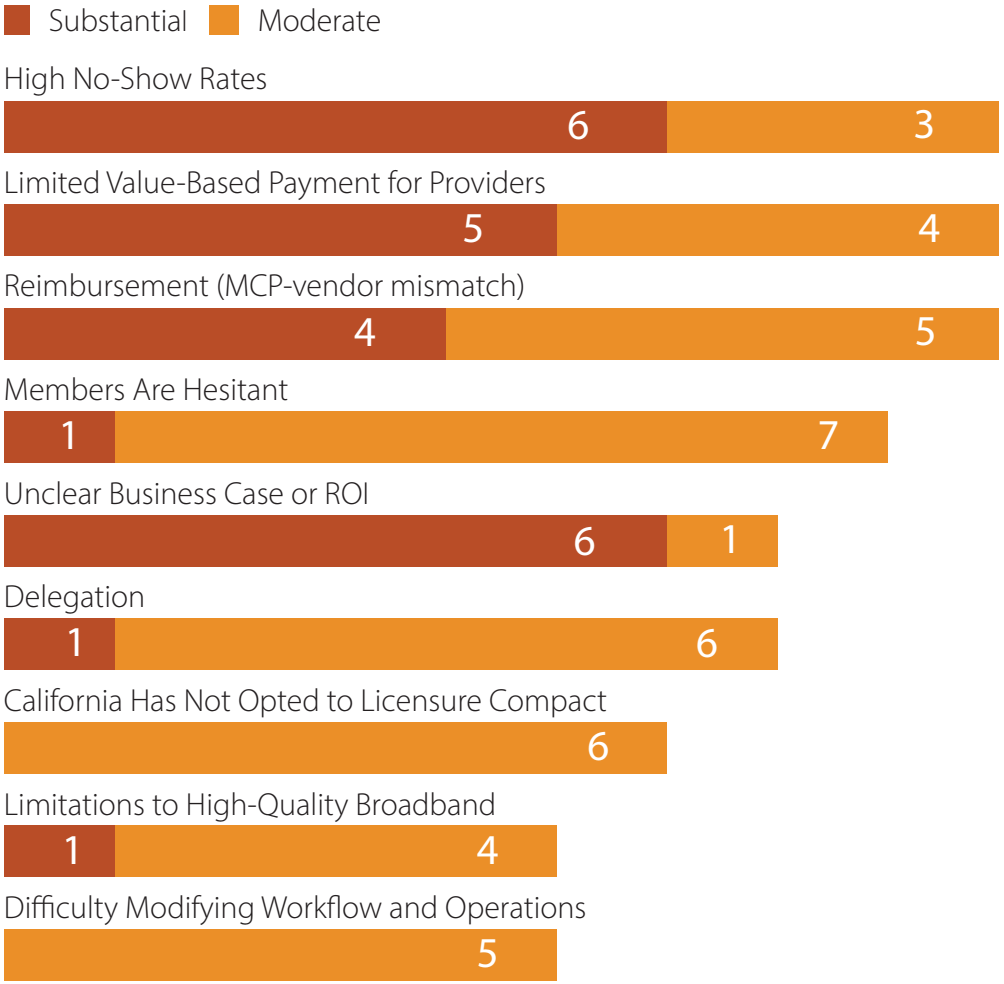
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

MCPs identified many barriers to broader use of member-to-provider telehealth. Barriers most frequently ranked as substantial or moderate include Medi-Cal capitation rate development, Medi-Cal provider enrollment, and network adequacy and timely access rules.

Capturing MCP spending on telehealth as part of the DHCS rate development is a concern for ongoing telehealth program sustainability. Additionally, requiring providers to be enrolled in Medi-Cal for telehealth visits to be counted for rate-setting and access requirement purposes is often a barrier due to the length of time to enrollment approval.

Other Barriers Still Rank High for Member-to-Provider Telehealth

Number of MCPs reporting that the following are substantial or moderate barriers to the broader use of member-to-provider telehealth in a nonclinical setting.



"No-shows are a hot potato that nobody wants to touch. We can't penalize members [for not making it to appointments] and don't want to. We need a group convened. How do we positively incentivize members to show up?"

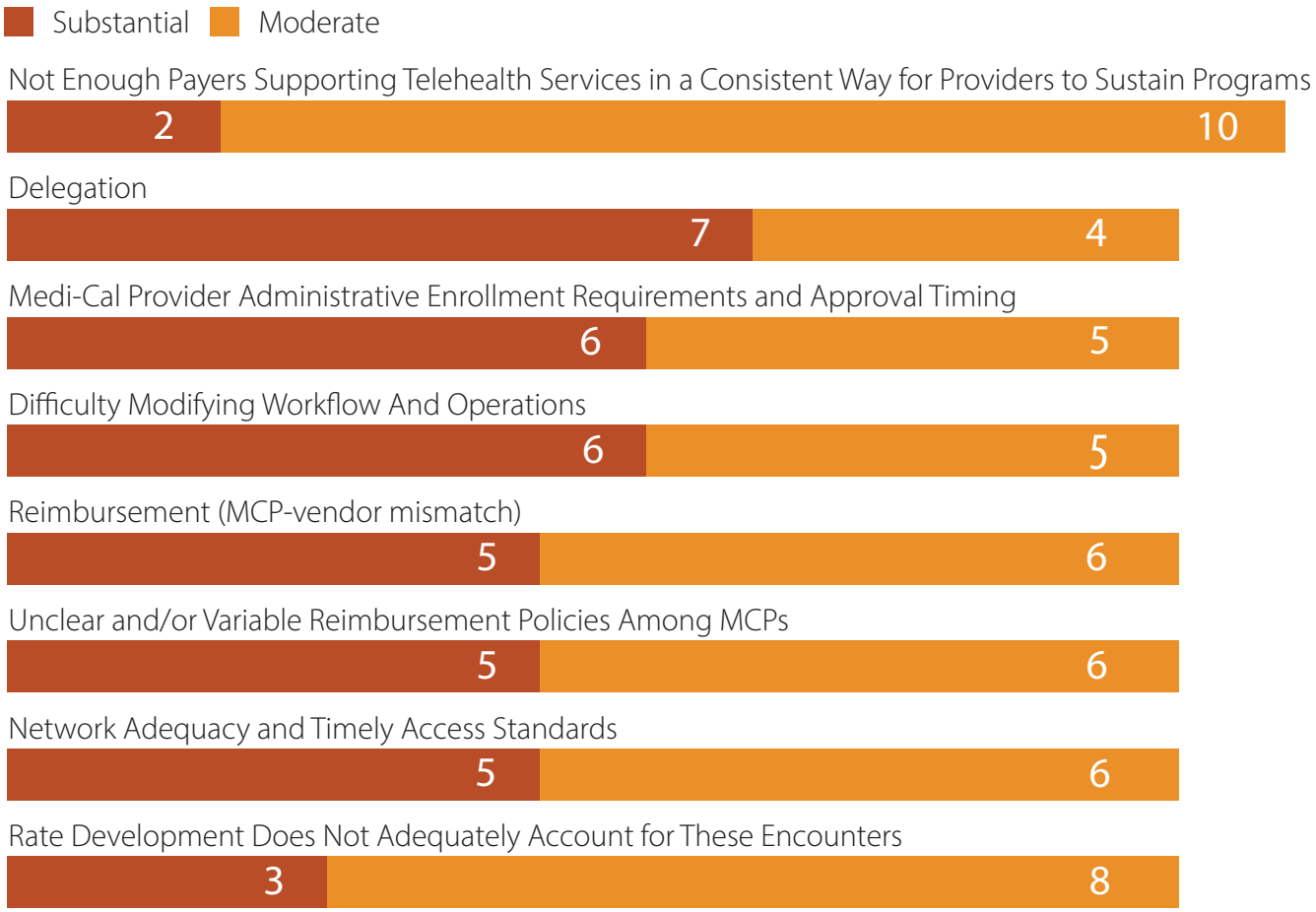
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

MCPs ranked many additional barriers to member-to-provider telehealth as substantial or moderate.

Prioritization, focus, and multistakeholder collaboration will likely be required to tackle the barriers to widespread telehealth adoption and use.

Lack of Consistency in Payer Support, Delegation Largest Barriers to eConsult

Number of MCPs reporting that the following are substantial or moderate barriers to the broader use of eConsult.



"[It is] hard to launch an eConsult program in a multipayer environment. If you are a clinic working with 10 payers, [providers] have to go through 10 different programs and referral patterns."

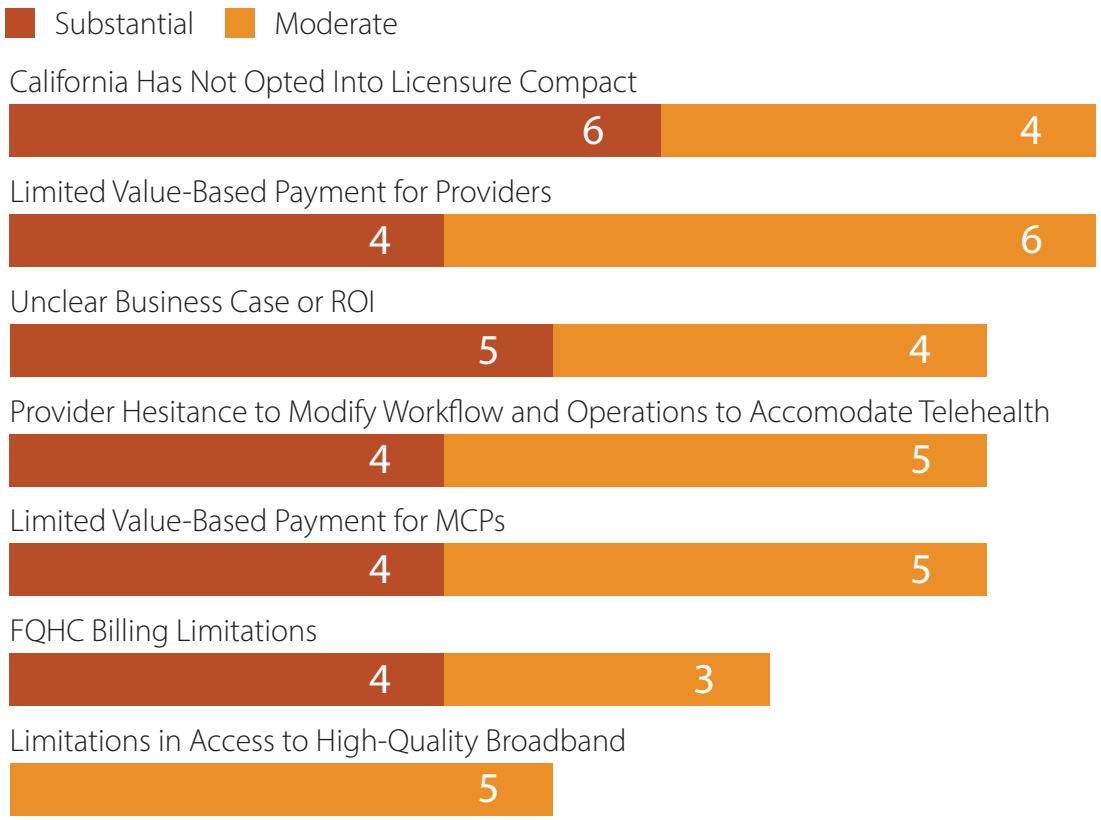
Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

There are similarly many barriers to the broader use of provider-to-provider eConsults.

MCPs rank inconsistent payer support high, given that eConsults are highly platform dependent and many MCP-led models exist. For example, when an MCP supports FQHC adoption of eConsult for only its members, the FQHC providers must use other platforms or practice without this service for other patients.

Lack of Access to Broadband and FQHC Billing Restrictions Least Likely to Impede eConsult

Number of MCPs reporting that the following are substantial or moderate barriers to the broader use of eConsult.



"Value-based care and telehealth will be a huge part of us remodeling care to find efficiencies."

MCPs identified a number of other potential barriers to eConsult.

Limited value-based purchasing programs for MCPs and providers reflects that most eConsult programs are reimbursed under the fee-for-service model.

Source: BluePath Health 2019 survey of Medi-Cal managed care plans. See "Methods" section for details.

Discussion: Opportunities to Improve Enrollee Access to Telehealth

This report's findings reveal MCP interest in using telehealth to realize a myriad of member needs and outcomes, and MCPs are investing human and financial resources to expand programs. The findings also show that policy and business practice barriers stand in the way of telehealth adoption. These include issues that are not necessarily exclusive to telehealth but that may pose unique considerations, including the MCP rate-setting process, network adequacy approval, the delegation model, and Medi-Cal provider enrollment.

While some of the barriers may have been addressed by urgent action taken by state officials in response to COVID-19, it's unclear which of these policies and practices will remain in place after the crisis has ended. This discussion and the policy recommendations that follow assume DHCS will return to business as usual. That would be a missed opportunity.

Several opportunities exist for MCPs, their provider partners, DMHC, DHCS, and other stakeholders to collaborate and create clearer guidelines for how telehealth is operationalized, measured, and acknowledged. Key considerations include:

- **Modifying MCP capitation-rate development and expanding reimbursement.** DHCS should review the feasibility of acknowledging telehealth encounters that are currently not billable in the Medi-Cal program and related MCP financial investments in the process of setting capitation rates. Various models for capturing financial investments exist, and MCPs can leverage the opportunity to improve rate setting through ongoing discussions with DHCS as the department pursues reprocurement in the coming year.[6] MCPs can additionally look to use telehealth to provide "in lieu of services" should the Centers for Medicare & Medicaid Services (CMS) approve DHCS's proposal to allow for MCP flexibility in providing benefits. DHCS may also consider expanding existing telehealth reimbursement to include remote patient monitoring.[7] At the same time, Federally Qualified Health Center (FQHC) billing limitations may be mitigated by clarifying billing rules that many perceive as inhibiting FQHC use of telehealth, and by exploring novel ways to promote FQHC participation in telehealth programs, including through MCP-FQHC partnerships for telehealth services not paid for at FQHCs' full prospective payment system rate.[8]
- **Improving Medi-Cal provider enrollment.** DHCS should consider taking steps for processing Medi-Cal provider enrollment applications more expeditiously, even sooner than the 180-day statutorily imposed timeframe.[9] Dedicating additional resources and/or prioritizing provider enrollment based on need may help to smooth the process that MCPs and vendors face in staffing remote panels of providers for telehealth programs.[10]

Several opportunities exist for MCPs, their provider partners, DMHC, DHCS, and other stakeholders to collaborate and create clearer guidelines for how telehealth is operationalized, measured, and acknowledged.

Discussion: Opportunities to Improve Enrollee Access to Telehealth (continued)

- **Developing a new approach to network adequacy.** DHCS and DMHC should coordinate to create a formal method for considering telehealth in the approval of MCP provider networks. Work has initiated with DMHC to account for telehealth-only providers in network reporting, but DHCS has yet to engage in this work.[11] DHCS and DMHC should consider working with stakeholders, including MCPs and consumer advocates, to develop a framework for considering telehealth for compliance with network adequacy standards like timely access, and time and distance standards.
- **Creating standards for contracting.** MCPs, their provider partners, and telehealth vendors should create and disseminate best practices for telehealth billing, contracting, and delegation in Medi-Cal managed care.[12] Outreach to providers and a thoughtful assessment of their current telehealth programs, needs, and challenges related to telehealth may contribute to the strengthening of these contracting practices and policies. Once best practices are identified and in place, MCPs and provider partners can develop targeted technical assistance or grant programs to increase provider participation in telehealth programs.
- **Facilitating payer collaboration to uncover insights that inform strategies and expansion.** MCPs should leverage existing forums or create a new multi-MCP collaborative to share telehealth program lessons and to develop new strategies for expansion.[13] MCPs acknowledge they would benefit from focused discussion around business and regulatory considerations identified in the findings, including consistent data and provider network capture policies, evaluation metrics, incentive programs, and provider and member engagement strategies that can be deployed and reported to state agencies. Other key topics may include education on Medi-Cal reimbursement policies and privacy concerns to demystify any perceived legal or policy barriers to telehealth expansion.

DHCS and DMHC should consider working with stakeholders, including MCPs and consumer advocates, to develop a framework for considering telehealth for compliance with network adequacy standards like timely access, and time and distance standards.

" Is anyone willing to discuss best practices? We don't know what other plans are doing."

Conclusion

This first snapshot of telehealth policies and practices among Medi-Cal managed care plans, conducted months before the outbreak of COVID-19, reveals that many MCPs are taking steps to expand availability and use of telehealth to improve access to care, quality of care, and member and provider satisfaction. They are also seeking ways to better measure the value of telehealth solutions and, for some, to collaborate with other MCPs to identify and share best practices.

Policy changes enacted in 2019, particularly revisions by DHCS to the telehealth chapter of the Medi-Cal Provider Manual and state legislation requiring payment parity for telehealth in commercial health plan contracting, signal positive changes for continued adoption and greater use of telehealth services. Additional policy changes enacted in 2020 in response to COVID-19 are also important and demonstrate that state officials understand how telehealth can improve access to care. However, some of these shifts may be temporary, and any shifts will take time to mature and require stakeholder oversight and collaboration with DMHC and DHCS to ensure sound policy implementation.

With persistent gaps in access to care for many Medi-Cal enrollees, wide regional and ethnic disparities, and slow progress on quality improvement, the urgency is great, even after COVID-19 is behind us. With the California Advancing and Innovating Medi-Cal (CalAIM) Initiative taking shape and managed care procurement about to launch, the window of opportunity to create and maintain a more coordinated and collaborative regulatory and clinical practice environment for telehealth in Medi-Cal managed care is now.

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Methods

In July 2019, BluePath Health sent an online survey to all 24 Medi-Cal MCPs about their perspectives on and experience with telehealth. Over a three-month period, 17 MCPs completed the survey, and 14 MCPs agreed to participate in follow-up interviews to elaborate on their responses and to share additional insights. MCPs that completed the questionnaire represent over 88% of Medi-Cal managed care enrollees and include four of the six County Organized Health Systems, six of the nine local initiative health plans, and seven of nine commercial MCPs. MCPs were asked to include only their Medi-Cal business line when answering the questionnaire. One MCP responded by including all lines of business, as they are unable to report Medi-Cal-specific data. All survey responses were self-reported, and none were independently verified.

Survey respondents representing the following MCPs by type:

Commercial Health Plans

- Anthem Blue Cross Partnership Plan
- Blue Shield Promise Health Plan
- California Health & Wellness
- Health Net
- Kaiser Foundation Health Plan
- Molina Healthcare of California
- UnitedHealthcare Community Plan

County-Organized Health Systems

- CalOptima
- Central California Alliance for Health
- Gold Coast Health Plan
- Partnership HealthPlan of California

Local Initiative Health Plans

- CalViva Health
- Health Plan of San Joaquin
- Inland Empire Health Plan
- Kern Family Health Care
- L.A. Care Health Plan
- San Francisco Health Plan

About the Authors

BluePath Health provides consulting services to payers, providers, and government agencies to adopt new ways to deliver quality health care and see through successful technology transitions. In addition, we support our clients in preparing for policy and technology change, assessing organizational readiness for implementation, and managing vendor relationships.

BluePath Health has a track record of bringing together diverse stakeholders to work together to achieve common goals. BluePath Health facilitates the California-based E-Consult Workgroup representing a wide range of stakeholders to share program accomplishments, disseminate research, and track policy advancements. BluePath Health also works with the Center for Connected Health Policy to facilitate the California Telehealth Policy Coalition and works with its payer, patient advocacy, and provider organizations to advance telehealth policy in California.

About CHCF

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system. For more information, visit www.chcf.org.

California
Health Care
Foundation

Endnotes

1. *California Mandated Report: Telehealth Services and the Medicare Program*, Medicare Payment Advisory Commission, March 2018, www.medpac.gov/docs (PDF); M. L. Bennett et al., "Los Angeles Safety-Net Program eConsult System Was Rapidly Adopted and Decreased Wait Times to See Specialists," *Health Affairs* 36, no. 3 (2017): 492–99, doi:10.1377/hlthaff.2016.1283; and Roseanne M. Fairchild et al., "Telehealth Decreases Rural Emergency Department Wait Times for Behavioral Health Patients in a Group of Critical Access Hospitals," *Telemedicine and e-Health* 25, no. 12 (Feb. 8, 2019): 1154–64, doi:10.1089/tmj.2018.0227. MedPAC's review of telehealth research shows that telehealth can improve access to care, convenience, and cost savings. Bennett el at. found decreased wait times and that 25% of e-consults were resolved without a follow-up specialist visits, reducing wait times. Fairchild et al. found that tele-behavioral health access in the ED resulted in decreased wait times.
2. Health Interview Survey, 2016.
3. For an overview of these Medi-Cal changes, see *State Telehealth Laws & Reimbursement Policies, Spring 2019*, Center for Connected Health Policy (CCHP), n.d., www.cchpca.org (PDF).
4. *Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)*, Department of Health Care Services, March 24, 2020, www.dhcs.ca.gov (PDF).
5. For an overview of Medi-Cal Managed Care Plan models, see Margaret Tatar and Athena Chapman, *Medi-Cal Explained: The Medi-Cal Program — An Overview*, California Health Care Foundation (CHCF), February 2019, www.chcf.org.
6. For more information on novel models for Medi-Cal Managed Care rate setting, see *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*, CHCF, March 2018, www.chcf.org.
7. *State Telehealth Medicaid Fee-For-Service Policy: A Historical Analysis of Telehealth: 2013-2019*, CCHP, January 2020, www.cchpca.org (PDF). CCHP notes that 14 state Medicaid programs now cover at least some applications of remote patient monitoring, up from 6 in 2013, based on historical legislation and policy tracking.
8. *Medi-Cal Telehealth Updated Policy,* CCHP, August 2019, www.cchpca.org (PDF). CCHP notes that FQHCs face added requirements for telehealth billing, including establishing a patient with a clinic and limitations to billing at their PPS rates.
9. Cal. Welf. & Inst. Code § 14043.26. State law requires that DHCS either gives providers notice of their enrollment determination within 180 days of application submission or grants provisional status.
10. *2017–18 Access Assessment: Final Report*, DHCS, October 2019, www.dhcs.ca.gov (PDF). The report notes that rural areas face greater issues around access to care, and that large gaps exist across specialties. The authors identify telehealth as an opportunity to close access gaps in rural regions.
11. This work has been spearheaded by the E-Consult Workgroup. More information is available at https://econsulttoolkit.com/.
12. Various groups have developed considerations for developing best practices. For example, the California Telehealth Resource Center has developed a list of considerations for FQHC billing practices, available at www.caltrc.org.
13. For more information on the DHCS Medi-Cal Managed Care Advisory Group, see www.dhcs.ca.gov.