Excerpts of current SPD STCs

B. Managed Care Delivery Systems for Seniors and People with Disabilities (SPD) Populations Affected by the Demonstration

If the State chooses to use a managed care delivery system to provide benefits to the SPD population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities) is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. Each of these STCs is in addition to standards established under other provisions of the STCs for this Demonstration, and nothing in this section waives any provision of Part 438 of Title 42 to the Code of Federal Regulations (CFR) and Section 1903(m) of the Social Security Act. Requirements related to tribal members apply to this section. Timelines included for CMS review (and approval as noted) reflect dates identified to the "Critical Path for SPD Enrollment" (See Attachment A). These STCS apply to the counties indicated in Attachment O – County Listing for SPD Enrollment.

81. Mandatory Enrollment of SPDs

a. Enrollment. The State may mandatorily enroll SPDs into Medi-Cal managed care programs to receive benefits in the counties specified in Attachment O and apply to the transition of SPDs that occurred from June 2011 through May 2012 based on birth month and on December 1, 2014 in the Regional and Imperial Model Counties, herein called RIMC. This does not include individuals who are eligible for full benefits in both the Medicare and Medicaid programs, or dual-eligible individuals, who are excluded from mandatory enrollment in a Medi-Cal managed care plan unless the same plan operates as a Medi-Cal and Medicare Advantage plan in the county that the dual eligible resides in. The mandatory enrollment of SPD individuals will apply to new or existing Medi-Cal in the counties specified in Attachment O when the plan or plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State will provide updates through its regular meetings with CMS and submit regular documentation requested of its Readiness Review status.

i. SPDs residing in Sacramento county will not be mandatorily enrolled into the Sacramento County dental program. SPDs will have the option to voluntarily enroll into the dental program.

b. Choice. For RIMC, pursuant to Welfare and Institution Code, §14087.98(b) and authorized under AB 1467, and or counties that do not operate a County Organized Health

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Systems (COHS), the State will ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 plans meeting all readiness requirements from which to choose. For counties that operate a COHS, the State need not ensure any choice of plans.

c. Notice Requirement for a Change in Network. The State will provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State may not mandatorily enroll the SPD population into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

d. Enrollment and Contracting. The State will not begin mandatory enrollment of the SPD population into a managed care plan prior to obtaining contract approval from CMS. The State will utilize appropriate risk adjustment in the development of its capitation payments and will set forth expectations for plans to ensure sufficient access, quality of care, and care coordination for beneficiaries. By April 1 2011 or with at least 60 days notice, prior to their effective date the State will submit contracts to CMS for approval. For RIMC, by October 1, 2014, or with at least 60 days notice, prior to their effective date the State will submit contracts to CMS for approval.

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e. Advisory Committee. The State will maintain for the duration of the Demonstration a managed care advisory group comprised of individuals and interested parties impacted by Medi-Cal managed care, regarding the impact, effective implementation, and quality of care provided to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of newly mandatorily enrolled individuals. The Advisory Committee will meet at least quarterly during the Demonstration's implementation and minutes related to the Advisory Committee's activity will be submitted to CMS with the State's quarterly report as per STC 23.

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f. The specific geographic areas where SPDs are mandatorily enrolled in managed care are detailed in Attachment O. SPDs will initially be voluntarily enrolled through an "opt-in" process in the 20 counties implementing the non-COHS delivery system model as part of the 2013 managed care expansion described in STC 52.g. and may not be mandatorily enrolled without CMS approval of an amendment to the demonstration's special terms and conditions. For RIMC, SPDs will become mandatory effective December 1, 2014. SPDs in San Benito County will remain voluntary

82. **SPD Benefit Package**

a. SPDs mandatorily enrolled in any managed care program within the State will receive from the managed care program the benefits as identified in Attachment N – Capitated Services

List/Managed Care Benefit Package. The attachment must also indicate the services excluded from the benefit package; those services will be available outside of the managed care program. As noted in plan readiness and contract requirements, the State will assure that enrolled individuals shall have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package.

b. Any addition or subtraction in Medicaid program benefits not reflected in the state plan, such as home and community based services (HCBS), for any specific population added to the established benefit package will require an amendment to the Demonstration. The state may submit technical updates to Attachment N without submitting an amendment for benefit changes that are reflected in the state plan as a result of an approved state plan amendment.

83. Consumer Assistance

a. Initial Outreach and Communication Strategy. By December 2010 and October 1, 2014 for RIMC, the State shall develop, and CMS shall review, an outreach and education strategy to explain the changes to individuals to be impacted by mandatory enrollment. The strategy shall describe the State's planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific population. The strategy will further articulate the State's efforts to ensure that the individuals have access to information and human assistance to understand the new system and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for implementation. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review throughout the Demonstration.

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b. CMS Review of Enrollee Communication. The State will submit to CMS any written communication from the State to enrollees for review, before they are sent to beneficiaries. Ongoing.

c. Stakeholder Review of Enrollee Communication. The State will submit to stakeholders any written communication to enrollees for review, before they are sent to beneficiaries.

d. Ongoing Outreach and Communication Strategy. The State shall provide to CMS by March 1, 2011and October 1, 2014 for RIMC, the State's communication strategy that reiterates options and articulates the rights of individuals impacted by mandatory enrollment as required by

Excerpts of current SPD STCs

42 CFR 438.The State shall submit its strategy describing the State's methodology for advising individuals utilizing an array of outreach techniques to meet the wide spectrum of needs identified within the population. The strategy will further articulate the State's efforts to ensure that the individuals have access to human assistance to understand the new system and their choices, their opportunities to select a health plan or particular provider and to achieve continuity of care and care coordination. On an ongoing basis the State will assure that enrollees be notified of changes that will have a major impact on their benefits or access no less than 30 days prior to the change.

e. Sensitivity Training. The State shall submit to CMS for review and approval, the State-proposed draft SPD Sensitivity Training curriculum, including anticipated target audience, by November 1, 2010 and October 1, 2014 for RIMC. Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.

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i. All appropriate plan and State staff shall be trained using the SPD Sensitivity Training Curriculum by March 2011 and October 1, 2014 for RIMC.

f. Informing/Education Materials. The State shall develop, and submit for CMS review informational and educational materials that meet the requirements of 42 CFR 438 by November 1, 2010 and August 15, 2014 for RIMC to explain the changes in service delivery. Such materials must comport with 42 CFR 438., and be developed in collaboration with stakeholders. These materials must be sent to the CMS Regional Office for review in advance of mailings to beneficiaries. Information should include information on timeframes, enrollment choice options and types and availability of assistance.

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The State shall submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents. Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.

g. Offers of individual assistance should be prevalent in documentation developed by the State and the plans including information on how to obtain in-person individual assistance through various means in an effort to minimize default assignments (e.g., assistance through enrollment broker, availability of a toll-free number, etc.).

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i. CMS Review. The State will submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents.

Excerpts of current SPD STCs

Updates or modifications to the curriculum will be submitted to CMS throughout the Demonstration.

ii. Communication Follow-up. Offers of individual assistance should be prevalent in documentation developed by the State and the plans.

h. Readability and Accessibility. All education materials, mail or electronic, should be available in languages, in formats, and at reading levels that will substantially meet the needs of the individuals impacted by the mandatory enrollment.

i. Community Presentation. The State shall submit to CMS, for review, the State's proposed "Community Presentation" by February 1, 2011 and September 1, 2014 for RIMC and complete all "Community Presentations" by May, 2011 and November 1, 2014 for RIMC. Forums or locations for these Presentations will be determined in collaboration with stakeholder groups.

i. Collaboration with Community Organizations- Since transition of a large number of high needs beneficiaries will impact the organizational structure and resources of health plans, clinics and community-based organizations that serve SPD, the State will ensure health plans are partnering with community organizations in an ongoing effort to improve resource utilization, training, and communication for members.

84. Transition into Mandatory Managed Care and Enrollment Strategies

a. Approaches to Affirmative Choices. The State will implement mandatory managed care for all SPD populations affected by the Demonstration:

i. Any non- County Organized Health System (COHS) participating county by assuring that at least 2 plans are meeting the readiness requirements by June 1, 2011 and December 1, 2014 for RIMC.

ii. Any new non-COHS county cannot implement mandatory managed care for SPDs until the designated plan meets the same readiness requirements as described in paragraph 85

e. Beginning June 1, 2011, SPD individuals in each county will be enrolled on a rolling basis over a 12 month period based on the date of their birth. The State may propose for CMS review and approval a plan for the enrollment of individuals living in Los Angeles County on a basis other than enrollment by the date of birth. For RIMC, all SPD's will transition on December 1, 2014.

f. Through the outreach, enrollment and education strategy the State will articulate and establish clear methods for affirmative choice for individuals (e.g., online, in person, in writing, verbal with signature confirmation, by proxy or surrogate decision-maker, etc.). By January 1, 2011, these methods will be available for review by CMS and October 1, 2014 for RIMC.

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Excerpts of current SPD STCs

b. Approaches to Default

i. For individuals who do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data to make a default selection into a plan based on usual and known sources of care, including previous providers, and utilization history, including use of particular specialty providers data. Default enrollees will have the opportunity to see their existing providers for a period of 12 months after enrollment as described in paragraph 81.f. iii. The default shall not occur until education and outreach efforts are conducted (in person as needed) as noted above. The State must submit its default process rationale and design to CMS prior to initial enrollment. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.

ii. By April 2011 and October, 2014 for RIMC, the State will provide documentation and assurances for CMS review, that the infrastructure is in place at the State level, and across the plans, to effectively manage the default selection process prior to June 1, 2011 and December 1, 2014 for RIMC.

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iii. The State shall submit to CMS for review and approval the enrollment broker protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to SPD default. Such protocol should, in circumstances where available data and utilization is insufficient to provide a clear, reasonable default selection, provide for pre-default assessment to determine individual needs. November 1, 2010 and October, 2014 for RIMC.

iv. The State shall inform individuals of their opportunity to change plans at any time.

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c. Efforts to Ensure Seamless Transitions

i. The State will provide CMS with its methodology for providing plans with a maximum of available data on Medi-Cal service utilization and provider utilization for SPD enrollee. This includes Medi-Cal administered services that are administered through sister agencies and takes into account the use of electronic health records (EHR) and Health Information Exchange as a source of clinical data on SPD enrollees as it becomes available. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

ii. By April 2010 and October, 2014 for RIMC, the State shall provide documentation that information technology systems and infrastructure are in place and can effectively manage the data exchange expectations set forth in this section to support smooth transition on June 1, 2011 and December 1, 2014 for RIMC.

Excerpts of current SPD STCs

A. iii. At least 30 days prior to enrollment, the State shall provide plans with up to one year of utilization and Treatment Authorization Request data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees upon assignment or enrollment. ,

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iv. The State will work with CMS to establish a mechanism within its Money Follows the Person (MFP) Demonstration, "California Community Transitions," to increase opportunities for eligible individuals to access HCBS upon discharge from hospitals and nursing facilities as an alternative to institutional services.

85. Plan Readiness and Contracts

a. Plan Readiness – Initial and Ongoing

i. The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the mandatorily enrolled SPDs that ensures compliance with 42 CFR 438 and the Knox Keene Act. The final methodology will be developed in consultation with CMS and will include such items as specialist to beneficiary ratios based on data from the COHS, geo-mapping of FFS providers versus network providers, minimum standards regarding access to specialty providers and their capacity to serve individuals, physical and programmatic accessibility of the plan (including completion of facility site reviews before readiness) or other strategies to ensure adequate network resources to meet the needs of the individuals to be served. December 1, 2010 and October 1, 2014 for RIMC.

ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation.

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iii. The State will complete network certifications for each county. Each county network certification will be done across the geographic area covered by the county. March 1, 2011 and October 1, 2014 for RIMC.

iv. The State will submit any updates to the network adequacy procedures upon changes.Ongoing.

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b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply. Ongoing.

c. The State will submit to CMS for review and approval a list of deliverables/submissions for readiness that is being requested from plans (presently and on regular intervals), and a

description of State approach to analysis and verification. November 1, 2010 and October , 2014 for RIMC.

d. The State shall submit to CMS its plan for ongoing monitoring of plans. Beginning in year one of mandatory enrollment, monitoring must occur quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter until the quarter ending , and December 31, 2015 for RIMC.

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e. By April 1, 2011 and November 1, 2014 for RIMC the State will submit to CMS for review the State's contingency plan for addressing insufficient network issues.

f. Items Necessary for plan readiness:

i. Care Coordination. The State shall submit to CMS their procedures for ensuring that each plan has sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SPD population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network. March 1, 2011 and October 1, 2014 for RIMC.ii. Standardized Assessments. The State shall provide detailed information regarding the process to conduct health risk assessments for individuals at risk based on FFS data. April 1, 2011 and November 1, 2014 for RIMC.

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The State shall direct the plans to engage in a preliminary assessment/screen of needs of enrolled individuals within 44 days of enrollment. Ongoing.

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments. Ongoing.

iii. Care Continuity. Initial and Ongoing - The State shall ensure that the plans have mechanisms to provide continuity of care to SPD enrolled individuals in order to furnish seamless care with existing providers for a period of up to 12 months after enrollment and established procedures to bring providers into network.

Excerpts of current SPD STCs

The State shall submit to CMS the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended period of care continuity for individuals with significant, complex or chronic medical conditions. May 1, 2011 and October 1, 2014 for RIMC

iv. Person-Centered Planning and Service Design. The State ensures that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee by the end of the first year of the Demonstration. While definitions and models of person-centered planning vary, the protocols shall, at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

v. Specialty Healthcare Sufficient Provider Pool. The State shall ensure that each plan has a sufficient supply and continuum of providers to meet the unique needs of the population to be served as required by 42 CFR 438.206-207, the Knox Keene Act and other applicable state law and regulation. Such adequacy analysis can be based upon COHS plans data. For RIMC, the State will utilize current Fee-for-Service utilization data for matching against each health plans network to assure an adequate network is in place to continue to provide all medically necessary care, with minimal disruption to the member.

vi. Geographic Accessibility. The State shall ensure that each plan has an accessible network (including specialty providers) with reasonable geographic proximity to the individuals enrolled as required by State statute and regulations, including the Knox Keene Act, taking into account the location of FFS providers, means of transportation ordinarily used by SPD enrollees, and taking into consideration community standards as necessary, including time and distance standards.

vii. Physical Accessibility. The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or

condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

viii. Interpreter Services - Information Technology. The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.

ix. Transportation – Specialized. The State will ensure that each plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.

x. Fiscal Solvency (SPD-specific considerations). The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis.

xi. The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c).

xii. Transparency. The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to SPDs.

The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.

xiii. Timing. The State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

xiv. Access to non-network specialty providers. The State shall ensure that plans provide enrolled members timely access to non-network specialty providers as required by 42 CFR 438, State statute and regulations and the Knox Keene Act.

Submit final plan readiness specifications to CMS for Review and Approval beginning in November, 2010 and October 2014 for RIMC.

86. Contract Requirements. Each of the elements noted in 85 above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains:

a. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:

i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and

ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution. The State will encourage statewide use of a uniform discharge planning checklist (see Attachment B).

b. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using claims data and/or other available data sources, such as electronic health records (EHRs) and Health Information Exchange (HIE) as a source of clinical data on SPD enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements (including mechanisms for regular monitoring).

c. Expectations regarding plan obligation to link individuals to services outside of plan benefit packages.

d. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.

e. Each plan shall be required to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012.

f. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.

g. The State must ensure that a uniform Grievance System is in place and monitored by the State for enrolled individuals in each plan that includes a grievance process, an appeal process

and access to the State's hearing process as defined in the Medicaid statutory and regulatory requirements per 42 CFR 438 subpart F. This includes, but is not limited to the following:

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i. Protocols for receiving, tracking and resolving grievances (complaints)

ii. Protocols for what to include in a Notice of Action when a service request is denied or reduced

iii. Protocols for receiving tracking and responding to Member Appeals including Notice of Decision including State Fair Hearing Request instructions

h. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable.

i. SPDs will be substantially involved in plan advisory groups and committees.

j. Provisions outlining when out-of-network care be provided.

k. Comprehensive health assessments for SPDs.

l. Coordination of carved out services based on FFS data.

Submit draft contract modification language for existing plans and newly contracting plans to CMS. November 1, 2010 and October 1, 2014 for RIMC.

87. Information Technology. The State will submit to a plan to CMS to ensure that the State has information technology available and operational that can meet all requirements set forth in these SPD STCs. April 1 2011 and October 1, 2014 for RIMC.

88. Health Home Service Delivery Model. The State will ensure that any health home delivery model developed through the Demonstration will comport with Section 1945 of the Social Security Act (the Act), and any applicable Federal future regulation or guidance on its implementation.

Enhanced FMAP for health home services will only be available through the Demonstration, including for the Low Income Health Program, if the program design meets all applicable requirements of Section 1945 of the Act.

Excerpts of current SPD STCs

The State will assure a mechanism for tracking appropriate health home services to receive the enhanced FMAP.

The State will submit detailed information on health home program design in a manner specified by CMS for approval prior to the State's implementation of the design.

89. Participant Rights and Safeguards

a. Information - All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

b. Disenrollment - Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities regularly and in a manner consistent with 42 CFR 438 and other requirements set forth in the Demonstration terms and conditions.

90. Quality Oversight and Monitoring. In addition to all quality requirements set forth in 42 CFR 438, the State will ensure the following:

a. Encounter Data - The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by seniors and persons with disabilities, in a manner that enables the State to assess performance by plan, by county, and Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data on SPDs from each plan is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012. The State will provide summaries of this data

in its regular meetings with CMS regarding the implementation of the Demonstration. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

b. Measurement Activities - The State will collect data and information on the following measures to ensure ongoing monitoring of individual wellbeing and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

The State will submit a plan for developing and implementing additional HEDIS and QIP measures specific to the SPD population (as opposed to the general HEDIS and QIP measures). The plan must be submitted to CMS for approval and must include the timelines for developing and implementing such measures). April 1, 2011 and October 1, 2014 for RIMC.

c. In addition to HEDIS and Existing CAHPS tools currently utilized, the State will consider the use of OASIS measures or other measures. The State shall also require the mandatory utilization of measures related to:

i. Avoidable Hospitalizations

ii. Hospital Readmissions

iii. Emergency Room Utilization

iv. Outcome measures related to person-centered care planning and delivery

Initial performance measurement requirement changes relevant to the new mandatory SPDs will be added to the State's existing requirements to be effective in January 2012 and further changes will be made annually in subsequent years. The State will continue to collect and report performance measurement results for all managed care plan members and begin reporting statistically significant stratified results for mandatory SPDs once these members have had one year of continuous enrollment in managed care.

d. Stratification and Analysis by County and Plan - For all data collected from MCOs, and COHS the State will be able to stratify information by population, plan, and county. The State

must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the counties and the plans.

91. Notice of Change in Implementation Timeline. The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified above and in the "Critical Path" document below

92. Withholding Approval. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

93. Applicability to Existing COHS Plans. The State will ensure that COHS Plans formerly operating under 1915(b) authority prior to approval of this Demonstration or those COHS plans expanding in 2011 (Ventura, Marin and Mendocino counties) will meet the requirements in these STCs within a 2-year period after approval of this Demonstration or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

94. Applicability to Future COHS Expansions. The State will ensure that the 2013 managed care COHS expansion and any new COHS expansions that are implemented subsequent to this Demonstration with the exception of those COHS plans (Ventura, Marin and Mendocino counties)will meet the terms in this Section (B), or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

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Attachment L – Managed Care Enrollment Requirements

Prior authority/ 1115 transition group	County Included	Included State Plan Populations								
		Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP [a]	BCCPT * Program	Children with accelerated eligibility
HIO Waiver 1915(b)	Santa Cruz	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Monterey	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Merced	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Orange	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Solano	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Napa	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Sonoma	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Yolo	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
HPSM 1915(b)	San Mateo	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
SBSLORHA 1915(b)	Santa Barbara	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
	San Luis Obispo	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
Two-Plan/GMC Waiver 1915(b)	Alameda	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Contra Costa	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Fresno	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kern	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kings	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Los Angeles	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Madera	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Riverside	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Sacramento	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Bernardino	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Diego	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Francisco	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Joaquin	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Santa Clara	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Stanislaus	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Tulare	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
2011 Managed Care Expansions	Marin	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Mendocino	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Ventura	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
2013 Managed Care Expansion County Organized Health System (COHS) Health Insuring Organization (HIO)±	Del Norte	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Humboldt	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lake	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lassen	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Modoc	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Shasta	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Siskiyou	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Trinity	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]

Attachment L – Managed Care Enrollment Requirements

Prior authority/ 1115 transition group	County Included	Included State Plan Populations: Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP[a]	BCCPT * Program	Children with accelerated eligibility
2013 managed care expansion Regional[z]	**Alpine**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Amador	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Butte	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Calaveras	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Colusa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	El Dorado	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Glenn	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Inyo	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mariposa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mono	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Nevada	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Placer	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Plumas	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sierra	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sutter	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tehama	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tuolumne	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Yuba	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion Imperial[z]	**Imperial**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion San Benito[z]	**San Benito**	Vol					Vol	Vol	Vol	Vol[b]

Notes:
Vol=Voluntary
Req=Required

[a] Required CHIP enrollment is subject to the transition requirements of STC 105 and all other requirements in section VIII. E of the demonstration's STCs.
[b] New eligible children after January 1, 2013 that meet CHIP and enrollment requirements as set forth by above designation [a]

* BCCPT - Breast and Cervical Cancer Prevention Treatment Program

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013
[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

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Attachment L – Managed Care Enrollment Requirements

		Populations that may be excluded from enrollment in managed care									
Prior authority/ 1115 transition group	**County Included**	Dual Eligibles	Preg. Women	Other Insurance	Nursing Facility or ICF/MR Resident	Enrolled in Another Managed Care Program	Less than 3 Months Eligibility	HCBS Waiver-enrolled	Special Needs Children (State Defined)	CHIP Title XXI	Retro Eligibility
HIO Waiver 1915(b)	**Santa Cruz**					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM 1915(b)	**San Mateo**					X				X[h]	
SBSLORHA 1915(b)	**Santa Barbara**					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver 1915(b)	**Alameda**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera**	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
2011 Managed Care Expansion	**Marin**					X				X[h]	
	Mendocino					X				X[h]	
	Ventura					X				X[h]	
2013 Managed Care Expansion **County Organized Health System (COHS) Health Insuring Organization (HIO)±**	**Del Norte**					X				X[h]	
	Humboldt					X				X[h]	
	Lake					X				X[h]	
	Lassen					X				X[h]	
	Modoc					X				X[h]	
	Shasta					X				X[h]	
	Siskiyou					X				X[h]	
	Trinity					X				X[h]	

Attachment L – Managed Care Enrollment Requirements

2013 Managed Care Expansion **Regional[z]**	**Alpine**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Amador	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Butte	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Calaveras	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Colusa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	El Dorado	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Glenn	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Inyo	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mariposa	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mono	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Nevada	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Placer	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Plumas	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sierra	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sutter	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tehama	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tuolumne	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Yuba	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion **Imperial,[z]**	**Imperial**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion **San Benito[z]**	**San Benito**	X[c]	X[d]	X[e,f]	X	X[g]	X			X[i]	

Notes:

[c] State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;

[d] These beneficiaries receive pregnancy related services only;

[e] State excludes individuals that have a share of cost or are ineligible for full-scope services;

[f] State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;

[g] Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program

[h] State only Healthy Families;

[i] Except for non-Healthy Families children in the Percent of Poverty program.

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013

[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment M – Geographic Distribution and Delivery System Model

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Prior authority/ 1115 transition group	Counties Included	Delivery System Model	Managed Care Organizations Participating
HIO Waiver 1915(b)	Santa Cruz	MCO/HIO	Central Coast Alliance
	Monterey	MCO/HIO	Central Coast Alliance
	Merced	MCO/HIO	Central Coast Alliance
	Orange	MCO/HIO	CalOPTIMA
	Solano	MCO/HIO	Partnership HealthPlan of California
	Napa	MCO/HIO	Partnership HealthPlan of California
	Sonoma	MCO/HIO	Partnership HealthPlan of California
	Yolo	MCO/HIO	Partnership HealthPlan of California
HPSM 1915(b)	San Mateo	MCO	Health Plan of San Mateo
SBSLORHA 1915(b)	Santa Barbara	MCO/HIO	CenCal
	San Luis Obispo	MCO/HIO	CenCal
Two-Plan/ GMC Waiver 1915(b)	Alameda	MCO	Alameda Alliance for Health , Anthem Blue Cross Partnership Plan
	Contra Costa	MCO	Contra Costa Health Plan, Anthem Blue Cross Partnership Plan
	Fresno	MCO	Health Net Community Solutions, Anthem Blue Cross Partnership Plan
	Kern	MCO	Kern Family Health, Health Net Community Solutions
	Kings**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Los Angeles *	MCO	L.A. Care Health Plan, Health Net Community Solutions
	Madera**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Riverside *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	Sacramento	MCO; medical PAHP; dental	Anthem Blue Cross, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Bernardino *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	San Diego	MCO	Care First, Community Health Group, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Francisco	MCO	San Francisco Health Plan, Anthem Blue Cross Partnership Plan
	San Joaquin	MCO	Health Plan of San Joaquin, Health Net
	Santa Clara	MCO	Santa Clara Family Health Plan, Anthem Blue Cross Partnership Plan
	Stanislaus	MCO	Health Plan of San Joaquin, , Health Net Community Solutions
	Tulare	MCO	Anthem Blue Cross Partnership Plan, Health Net Community Solutions
2011 Managed Care Expansions	Kings	MCO	Anthem Blue Cross, CalViva
	Madera	MCO	Anthem Blue Cross, CalViva
	Marin	MCO/HIO	Partnership HealthPlan of California
	Mendocino	MCO/HIO	Partnership HealthPlan of California
	Ventura	MCO/HIO	Gold Coast Health Plan
2013 Managed Care Expansion County	Del Norte	MCO/HIO	Partnership HealthPlan of California
	Humboldt	MCO/HIO	Partnership HealthPlan of California
	Lake	MCO/HIO	Partnership HealthPlan of California
	Lassen	MCO/HIO	Partnership HealthPlan of California
	Modoc	MCO/HIO	Partnership HealthPlan of California

Attachment M – Geographic Distribution and Delivery System Model

Organized Health System (COHS) Health Insuring Organization (HIO)±	**Shasta**	MCO/HIO	Partnership HealthPlan of California
	Siskiyou	MCO/HIO	Partnership HealthPlan of California
	Trinity	MCO/HIO	Partnership Health Plan of California
2013 Managed Care Expansion Regional±	**Alpine**	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Amador	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Butte	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Calaveras	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Colusa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	El Dorado	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Glenn	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Inyo	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mariposa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mono	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Nevada	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Placer	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Plumas	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sierra	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sutter	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tehama	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tuolumne	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Yuba	MCO	Anthem Blue Cross, California Health and Wellness Plan
2013 Managed Care Expansion Imperial±	**Imperial**	MCO	California Health and Wellness Plan, Molina Healthcare
2013 Managed Care Expansion San Benito±	**San Benito**	MCO	Anthem Blue Cross (Note: beneficiaries in this county will also have a choice of FFS because only one plan is available)

Note:
* These counties allow beneficiaries in certain zip codes to enroll on a voluntary basis
Planned Expansions:

- **In March 2011, Kings and Madera County, Two Plan Expansion - authority as approved by the Tri-Country 1915b approval
- ***In July, 2011, Marin, Mendocino and Ventura counties plan to begin operation using an HIO model

± Part of the 2013 Managed Care Regional Expansion effective September 1, 2013 for COHS counties and November 1, 2013 for non-COHS counties.

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.			X[1]			
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X	X	X	X
California Children Services (CCS)	Service is not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			X[6]			
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provide services within the scope of their practice.	X	X	X	X	X	X
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X	X	X	X

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Child Health and Disability Prevention (CHDP) Program		A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X[4]	X	X	X
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)		A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.						
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	0		X			
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X	X	X	X

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 95.	X	X	X	X	X	X
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X	X	X	X
Dental Services (Covered under Denti-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.						
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.						
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X	X	X	X

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X	X	X	X
Enhanced Case Management (ECM), as defined in paragraph 96		A service consisting of those "Complex Case Management" and "Person-Centered Planning" services including the coordination of beneficiaries' individual needs for needed long-term care services and supports.	X	X	X	X	X	X
Erectile Dysfunction Drugs		FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.						
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.						
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).	X	X	X	X	X	X
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X	X	X	X
Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.						
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X	X	X	X
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X	X	X	X

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Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X	X	X	X
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X	X	X	X
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			X[7]			

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.			X			
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services	.	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X[5]	X[5]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/ID-N) are covered subject to prior authorization by the Department for the ICF/ ID-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/ID-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.						
Long Term Care (LTC)		Care in a facility for longer than the month of admission plus one month. Medically necessary care in a facility covered under managed care health plan contracts	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	X	X	X	X	X	X
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered 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.	X	X	X	X	X	X
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.	X[9]	X[9]	X[9]			
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X	X	X	X
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management	X[2]	X[2]	X[2]	X[2]	X[2]	X[2]
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.						
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.						
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.	X[9]	X[9]	X[9]			
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	X	X	X	X	X
Podiatry Services	Other Practioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Prosthetic and Orthotic Appliances	Prosthetic and Orthodic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X[1,2*]	X[1,2]	X[1,2*]	X[1,2]	X[1,2]	X[1,2]
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			X[8]			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X	X	X	X
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X	X	X	X
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.						
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.						
Skilled Nursing Facility Services,	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X	X	X	X
Specialty Mental health services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.						
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[5]	X[5]	X	X[5]	X[5]	X[5]
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X	X	X	X
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.						
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.						
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	**X**	**X**	**X**	**X**	**X**	**X**
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.						

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[1] Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.

[2] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

[3] Fabrication of optical lenses only covered by CenCal Health.

[4] Not covered by CenCal

[5] Only covered for the month of admission and the following month

[6] Not Covered by CalOptima, Central California Alliance for Health, Partnership HealthPlan of California (Sonoma County Only) and CenCal (San Luis Obispo County Only)

[7] Only covered in Health Plan of San Mateo and CalOptima

[8] Only Only covered in Health Plan of San Mateo

[9] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Alameda, Los Angeles, Orange, San Bernadino, San Diego, San Mateo, Santa Clara, and Riverside

[10] Services covered only when provided by provider in FQHC/RHC

Attachment O – County Listing for SPD Enrollment

County Name	Plan Model						Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	Regional	Imperial	San Benito	
Alameda	X						X
Alpine				X			X
Amador				X			X
Butte				X			X
Calaveras				X			X
Colusa				X			X
Contra Costa	X						X
Del Norte			X				
El Dorado				X			X
Fresno	X						X
Glenn				X			X
Humboldt			X				
Imperial					X		X
Inyo				X			X
Kern	X						X
Kings	X						X
Lake			X				
Lassen			X				
Los Angeles	X						X
Madera	X						X
Marin			X				
Mariposa				X			X
Mendocino			X				
Merced			X				
Modoc			X				
Mono				X			X
Monterey			X				
Napa			X				
Nevada				X			X
Orange			X				
Placer				X			X
Plumas				X			X
Riverside	X						X
Sacramento		X					X
San Benito						X	X
San Bernardino	X						X
San Diego		X					X
San Francisco	X						X
San Joaquin	X						X

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San Luis Obispo			X				
San Mateo			X				
Santa Barbara			X				
Santa Clara	X						X
Santa Cruz			X				
Shasta			X				
Sierra				X			X
Siskiyou			X				
Solano			X				
Sonoma			X				
Stanislaus	X						X
Sutter				X			X
Tehama				X			X
Trinity			X				
Tulare	X						X
Tuolumne				X			X
Ventura			X				
Yolo			X				
Yuba				X			X