DHCS
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Department of Health Care Services

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GOVERNOR

March 1, 2016

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ANNUAL PROGRESS REPORT FOR THE REPORTING PERIOD OF 07/01/2014 THROUGH 10/31/2015 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Mr. Fishman, Ms. Hossain, Ms. Ross, and Ms. Dillon:

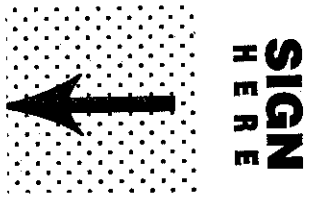
Enclosed is the Annual Progress Report required by Section 25 of the Special Terms and Conditions of California's Section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the annual progress report for Demonstration Year Ten, which covers the period from July 1, 2014 through October 31, 2015.

If you or your staff have any questions or need additional information regarding this report, please contact Angeli Lee at (916) 324-0184.

Sincerely,

[redacted]

Ms. Mari Cantwell
Chief Deputy Director
Health Care Programs



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TITLE:

California Bridge to Reform Demonstration (11-W-00193/9)

Section 1115 Annual Report

REPORTING PERIOD:

Demonstration Year: Ten (07/01/14-10/31/15)

INTRODUCTION:

The Department of Health Care Services (DHCS) submits this Annual Report for Demonstration Year (DY) 10 to the Centers for Medicare & Medicaid Services (CMS) in accordance with Item 25 of the Special Terms and Conditions (STCs) in California's section 1115 Bridge to Reform Demonstration (11-W-00193/9). The report addresses the following areas of operations for the various Demonstration programs during the Demonstration Year:

- Accomplishments
- Project Status
- Quantitative findings
- Qualitative and case study findings
- Utilization data
- Policy and administrative issues

AB 342 (Perez, Chapter 723, Statutes of 2010) authorized the Low Income Health Program (LIHP) to provide health care services to uninsured adults, ages 19 to 64, who are not otherwise eligible for Medi-Cal, with incomes up to 133 percent of the Federal Poverty Level (FPL). Further, to the extent Federal Financial Participation (FFP) is available. LIHP services may be made available to individuals with incomes between 134%-200% of the FPL.

SB 208 (Steinberg/Alquist, Chapter 714, Statutes of 2010) authorized DHCS to implement changes to the federal Section 1115 (a) Comprehensive Demonstration Project Waiver titled, *Medi-Cal Hospital/Uninsured Care Demonstration (MCH/UCD),* which expired on August 31, 2010. The bill covered implementation of all Section 1115 Waiver provisions except those sections addressing the LIHP projects, which are included in AB 342.

ABX4 6 (Evans, Chapter 6, Statutes of 2009) required the State to apply for a new Section 1115 Waiver or Demonstration Project, to be approved no later than the conclusion of the MCH/UCD, and to include a provision for enrolling beneficiaries in mandatory managed care. Department of Health Care Services 2

On June 3, 2010, California submitted a section 1115 Demonstration waiver as a bridge toward full health care reform implementation in 2014. The State's waiver will:

- Create coordinated systems of care for Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans
- Identify the model or models of health care delivery for the California Children Services (CCS) population that would result in achieving desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness
- Phase in coverage in individual counties through LIHP for the Medicaid Coverage Expansion (MCE) population—adults aged 19-64 with incomes at or below 133 percent of the FPL who are eligible under the new Affordable Care Act State option
- Phase and coverage in individual counties through LIHP for the Health Care Coverage Initiative (HCCI) population—adults between 133 percent to 200 percent of the FPL who are not otherwise eligible for Medicaid
- Expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers
- Implement a series of infrastructure improvements through a new funding sub-pool called the Delivery System Reform Incentive Pool (DSRIP) that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care
    - Note: Reporting to CMS for DSRIP is done on a semi-annual and annual aggregate reporting basis and will not be contained in these progress reports.

On January 10, 2012, the State submitted an amendment to the Demonstration, approved March 31, 2012, to provide Community Based Adult Services (CBAS) — outpatient, facility-based program that delivers skilled-nursing care, social services, therapies, personal care, family/caregiver training and support, means, and transportation—to eligible Medi-Cal beneficiaries enrolled in a managed care organization. Beneficiaries who previously received Adult Day Health Care Services (ADHC), and will not qualify for CBAS services, will receive a more limited Enhanced Case Management (ECM) benefit.

On June 28, 2012, CMS approved an amendment to the Demonstration to:

- Increase authorized funding for the Safety Net Care Uncompensated Care Pool in DY 7 by the amount of authorized but unspent funding for HCCI and the Designated State Health Programs in DY 6.
- Reallocate authorized funding for the HCCI to the Safety Net Care Uncompensated Pool for DY 7.

- Establish an HIV Transition Program within the DSRIP for “Category 5” HIV transition projects to develop programs of activity that support efforts to provide continuity of quality and coverage transition for LIHP enrollees with HIV.

Beginning January 1, 2013 the Healthy Families Program beneficiaries were transitioned into Medi-Cal’s Optional Targeted Low-Income Children’s (OTLIC) Program, where they will continue to receive health, dental, and vision benefits. The OTLIC Program covers children with family incomes up to and including 250 percent of the federal poverty level.

Effective April 2013 an amendment was approved which allows (DHCS to make supplemental payments to Indian Health Service (IHS) and tribal facilities for uncompensated care costs. Qualifying uncompensated encounters include primary care encounters furnished to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a LIHP.

On August 29, 2013 DHCS received approval to expand Medi-Cal Managed Care into 20 additional counties, with phased-in enrollment beginning in September 2013. Subsequently, in November 2014, CMS approved the mandatory enrollment of SPDs into managed care in 19 of these rural counties effective December 1, 2014.

Over the course of the Waiver, the Department also sought federal approval to roll over unexpended HCCI funding (a component of the LIHP that funded coverage expansion for individuals between 133% and 200% of FPL) to the Safety Net Care Pool-Uncompensated Care in subsequent demonstration years so that the State and designated public hospitals could access those federal funds.

Effective January 1, 2014 individuals newly eligible for Medi-Cal based on expanded income eligibility criteria under the ACA’s Optional Expansion (up to 138% of FPL) were added to the managed care delivery system under Waiver authority. The waiver amendment allowed for a seamless transition of the Medi-Cal Expansion (MCE) LIHP program into Medi-Cal managed care. This amendment also contains approval for an expansion of the current Medi-Cal managed care benefits to include outpatient mental health services.

In March 2014 DHCS received approval of an amendment to begin coverage under the Coordinated Care Initiative (CCI), no sooner than April 1, 2014. The goal of CCI is to offer integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community. The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. This amendment also allows for the operation of a Program of All-Inclusive Care for the Elderly (PACE) in Humboldt County alongside the Humboldt County-Organized Health System (COHS) plan.

On July 31, 2015, DHCS received approval of a waiver amendment to expand full-scope coverage to pregnant women 109%-138% of the federal poverty limit. Pregnant women with incomes up to and including 138% of the FPL are also required to enroll in a Medi-Cal managed care health plan in the counties in which such plans are available. In addition, DHCS received CMS approval on August 13, 2015 for the Drug Medi-Cal Organized Delivery System waiver amendment. This amendment authorizes the state to launch a pilot program and to provide a continuum of care for Medi-Cal beneficiaries with substance use disorders.

TIME PERIODS:

Demonstration Year

The periods for each Demonstration Year will consist of 12 months, with the exception of DY 6, which will be 8 months, and DY 10, which will be 16 months. The periods are:

- DY 6: November 1, 2010 through June 30, 2011
- DY 7: July 1, 2011 through June 30, 2012
- DY 8: July 1, 2012 through June 30, 2013
- DY 9: July 1, 2013 through June 30, 2014
- DY 10: July 1, 2014 through October 31, 2015

Annual Report

This report covers the period from July 1, 2014 through October 31, 2015.

I. General Reporting Requirements

- **Item 7 of the Special Terms and Conditions – Amendment Process**

  Behavioral Health Therapy for Children Under the Age of 21, Technical Change

  On September 29, 2014, the Department of Health Care Services (DHCS) submitted an amendment to the 1115 Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS) to allow for the addition of behavioral health therapy (BHT) to the list of covered benefits available to children under the age of 21 who have a diagnosis of autism spectrum disorder. These technical changes clarify that BHT services for children under 21 to treat autism spectrum disorder are consistent with those services articulated in the state plan. This amendment was approved by CMS on October 16, 2014.

  Full Scope Medi-Cal for Pregnant Women 109-138% of the Federal Poverty Level

  On September 3, 2014, DHCS submitted an amendment to the 1115

Demonstration Waiver to CMS to allow DHCS to expand full-scope Medi-Cal benefits to qualified low-income pregnant women with incomes up to and including 138 percent of the Federal Poverty Level (FPL). This amendment was approved by CMS on July 31, 2015.

Drug Medi-Cal Organized Delivery System (DMC-ODS)

In November 2014, the Department of Health Care Services (DHCS) submitted an amendment to the 1115 Bridge to Reform demonstration waiver for Substance Use Disorder services. DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a SUD. On August 13, 2015, the Centers for Medicare and Medicaid Services (CMS) approved California's Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.

- **Item 14 of the Special Terms and Conditions – Public Notice, Tribal Consultation and Consultation with Interested Parties**

  BHT Amendment

  Public Notice:

  This amendment was shared publically as follows:
  - Stakeholder meetings were held on September 4, October 16, November 18, and December 19, 2014 and January 22, April 23, May 22, June 18, July 7, and July 17, 2015.
  - On August 15, 2014, the public notice announcing the amendment to add BHT was released.
  - Draft State Plan Amendment (SPA) pages were released on December 19, 2014.
  - On June 18, 2015, the final 60-day and 30-day managed care transition notices were released.

  All stakeholder meetings, agendas, and frequently asked questions are available on the DHCS website at: http://www.dhcs.ca.gov/services/medi-cal/Pages/BehavioralHealthTreatment.aspx.

  Tribal Notice:

  DHCS provided the tribal notice on this amendment on August 19, 2014. DHCS' responses to questions were posted on October 1, 2014 on the DHCS Indian Health Program's website at: http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx.

  Full Scope Medi-Cal for Pregnant Women 109-138% FPL Amendment

Public Notice:

This amendment was shared publically as follows:

- Fiscal year 2014-15, public state budget process as analyzed by legislative staff, and discussed in several public hearings conducted by the health program and budget committees in the Assembly and Senate of the California Legislature.
- On July 25, 2014, DHCS began monthly stakeholder meetings with Covered California and contracting Medi-Cal managed care health plans (MCPs) and insurers, and other stakeholders regarding the provisions of Senate Bill 857. These meetings were scheduled through April 2015, and are conducted through in-person meetings, webinars, and teleconferences.
- The Public Notice is available at: http://www.dhcs.ca.gov/services/medi-cal/Documents/Pregnant_full-scope_JvR_English.pdf.

All stakeholder meetings, agendas, and frequently asked questions are available on the DHCS website at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Affordability-and-Benefit-Program.aspx.

Tribal Notice:

DHCS provided tribal notice on this amendment on July 28, 2014. DHCS issued a tribal notice to tribal organizations and presented the Waiver amendment at the quarterly tribal webinar on August 29, 2014. Questions and responses were posted on October 1, 2014. Additional information can be found on the DHCS Indian Health Program's website at: http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx.

DMC-ODS

- March 2nd 2015 Region 1 Meeting
- October 22nd 2015 DHCS hosted DMC-ODS Stakeholder Webinar
- October 27th 2015 Substance Use Disorder Statewide Conference
- October 28th 2015 Region 2 Implementation Meeting
- December 8th 2015 Follow up Region 2 implementation Meeting

- **Item 21 of the Special Terms and Conditions – Contractor Reviews**

California Children's Services (CCS)

In the course of Demonstration Year (DY) 10, Department of Health Care Services (DHCS) completed a financial review of Health Plan San Mateo's

(HPSM's) California Children's Services' (CCS) Demonstration Project (DP) quarterly reports; specifically, their Administrative Costs, Profit Margin, and Medical Loss Ratio reports. Please refer to Attachment #1, Department of Health Care Services – Health Plan of San Mateo: Plan Analysis.

DMC-ODS

No data to report.

- **Item 23 of the Special Terms and Conditions – Demonstration Quarterly Reports**

  The quarterly progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, stakeholder outreach, as well as consumer operating issues. Five reports for DY 10 were submitted to CMS electronically on the following dates:

  - Quarter 1 (7/1/14-9/30/14) – Submitted December 9, 2014
  - Quarter 2 (10/1/14-12/31/14) – Submitted February 27, 2015
  - Quarter 3 (1/1/15-3/31/15) – Submitted May 29, 2015
  - Quarter 4 (4/1/15-6/30/15) – Submitted August 21, 2015
  - Quarter 5 (7/1/15-10/31/15) – Submitted December 24, 2015

- **Item 24 of the Special Terms and Conditions – SPD Specific Progress Reports**

  DHCS submits SPD specific progress reports in the quarterly waiver reports.

- **Item 26 of the Special Terms and Conditions – Transition Plan and Implementation Milestones**

  Delivery System Reform Incentive Pool (DSRIP) Evaluation Plan

  On September 30, 2014 UCLA submitted to the state their interim evaluation findings. This report was reviewed by the state and submitted to CMS on October 1, 2014 as required by the STCs. UCLA is currently on track for providing their final evaluation findings 120 days after the end of the demonstration which is at the end of February. The state has remained in contact with UCLA throughout their evaluation process to ensure they had the technical assistance needed to execute their research properly. We will continue to provide this support and partnership throughout the duration of their analysis.

  Behavioral Health Services Plan Implementation

On July 21st, DHCS launched its statewide stakeholder initiative, the Behavioral Health Forum, thereby initiating the first in a series of quarterly meetings during which DHCS staff provides updates to stakeholders regarding key policy and program issues impacting public mental health and substance use disorder services (MHSUDS). The Forum is an opportunity for stakeholders to learn about the status of more than 100 program and policy issues identified in the DHCS Business Plan, as well as from other sources (e.g., the California Mental Health and Substance Use System Needs Assessment and Service Plan), which have been organized into a grid format and assigned to four Forum committees (Strengthen Specialty Mental Health and Drug Medi-Cal County Programs and Delivery Systems; Coordinated and Integrated Systems of Care for MHSUDS and Medical Care; Coordinated and Useful Data Collection, Utilization, and Evaluation of Outcomes, and Cost Effective and Simplified Fiscal Models). The Forum provides an opportunity to report back to stakeholders across the state and to solicit additional input from interested parties. Meeting information and materials, including a grid summarizing issues identified thus far, may be downloaded from the DHCS website. Anyone who is interested in participating in one or all of the Forum's committees, and/or the consumer and family member "open to all" forum, may contact DHCS at MHSUDStakeholderInput@dhcs.ca.gov.

- **Item 28 & 29 of the Special Terms and Conditions – Evaluation Design and Implementation**

  Due to the diversity of the waiver programs and the varied timing of the roll out of each of them, DHCS determined that it was most effective and appropriate to focus specific demonstration evaluations related to certain initiatives and their impact on target populations and Delivery System Reform Incentive Program (DSRIP) initiatives.

  An interim evaluation report provided an individual evaluation and program specific hypotheses and measures as appropriate for each of the following targeted programs:

  - DSRIP;
  - Low Income Health Program (LIHP);
  - Indian Health Services (IHS) Uncompensated Care Pool; and
  - Healthy Families Program Transition to Medi-Cal.

  Appendix C, Bridge to Reform Evaluation Reports for the above programs can be found at the following link: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal-Official-Submission.aspx.

  Evaluations on some of the more recent waiver initiatives that became active during or after 2013 and the implementation of health care reform were not included in the

interim report. Because the evaluations for the following programs are still under development or in process, DHCS provided operational reports in the interim report for SPDs, California Children's Service pilots, and Coordinated Care Initiative. These operational findings can be found in the Medi-Cal 2020, Key Concepts for Renewal, Appendix A, Bridge to Reform Evaluation Interim Evaluation, at the following link: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MC2020KCFR_032715.pdf.

CCS

DHCS collected "baseline" data for the annual Member Satisfaction Phone survey (Member Survey), which was developed and implemented during the months of July through September 2014 for HPSM's CCS DP. Of the 855 HPSM families DHCS attempted to contact by telephone, 379 families participated in the survey (44%). On April 1, 2015, DHCS shared the results of the Member Survey with HPSM.

DMC-ODS

Through an existing contract DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care.

UCLA holds monthly conference call with updates, activities, and meetings.

On October 12th, 2015, UCLA sent the Evaluation Design contract to CMS; subsequently, CMS sent feedback to DHCS on February 2, 2016.

- **Item 30 of the Special Terms and Conditions – Revision of the State Quality Strategy**

On behalf of DHCS, the Office of the Medical Director is overseeing the annual revision to the *DHCS Strategy for Quality Improvement in Health Care* (*Quality Strategy*). All Divisions and Offices have been asked to update their respective quality improvement projects. In addition, new projects are being outlined. The *Quality Strategy* serves as a blueprint, outlining specific programs and policies the Department is undertaking to improve clinical quality and to advance population health among the members, patients, and families we serve. The 2016 *Quality Strategy* will be released in February 2016. It will be the fourth version of the blueprint to be distributed by the Department.

- **Item 32 of the Special Terms and Conditions – Cooperation with Federal Evaluators**

  Nothing to report.

- **Item 39(b)(i) of the Special Terms and Conditions – SNCP Uncompensated Care**

  On February 8, 2016, CMS approved the State's request to move $3,042,000 ($327,000 for Demonstration Year 7 and $2,715,000 for Demonstration Year 8) in unused Delivery System Reform Incentive Pool federal funds to fund uncompensated care.

- **Item 39(b)(ii) of the Special Terms and Conditions – SNCP DSHP**

  There are no new DSHP amendments or STC revisions to report under this item. An update to the DSHP program is provided in the "Program Updates" section below.

- **Item 40 of the Special Terms and Conditions – General Finding and Reimbursement Protocol for SNCP Expenditures**

  Safety Net Care Uncompensated Care Pool

  On December 30, 2014, CMS approved the extension of Indian Health Services (IHS) supplemental payments for the period covering January 2014 through October 2015. IHS payments are for services provided by IHS and tribal 638 facilities to IHS eligible individuals for optional benefits that were eliminated under State Plan Amendment 09-001.

  Designated State Health Programs (DSHP)

  An update to the DSHP program is provided in the "Program Updates" section below.

- **Item 47 of the Special Terms and Conditions – LIHP Cost Claiming Protocols**

  The updates for STC 47 are provided below under "Project Status." CMS denied the county specific protocols for Alameda and San Bernardino, and the capitated rate methodology laid out in Attachment G – Supplement 2. More detail is included below under "Project Status."

- **Item 48 of the Special Terms and Conditions – LIHP Maintenance of Efforts (MOE)**

DHCS completed the annual MOE determination for LIHP's compliance with the annual MOE Statewide amounts for each DY. The baseline MOE amount for the ten legacy counties under the prior Health Care Coverage Initiative program under California's Medi-Cal Hospital Uninsured Care 1115 Medicaid waiver was $893,508,895 MOE based on State Fiscal Year (SFY) 2006/2007 level. The legacy counties continued or increased their baseline from the SFY 2006/2007 level. The new local LIHPs based their MOE baseline amount on SFY 2009/2010. The required MOE baseline amounts varied in DY 7, 8, and 9 due to the staggered implementation of the local LIHPs during the first two years of the program and the end of the program midway through DY 9. The MOE baseline amount for DY 7 increased to $1,017,607,901 with ten local LIHPs in the first half of the year and fifteen local LIHPs in the last half of the year. By the end of DY 8, all nineteen local LIHPs had implemented their programs. The non-Federal expenditures exceeded the required statewide baseline each year from $500-900 million as shown in the table below.

DY	SFY	Baseline	Non-Federal Funds Expended	Amount Above Baseline
7	11/12	$1,012,424,216	$1,894,170,078	$881,745,862
8	12/13	$1,162,289,395	$2,151,507,675	$989,218,280
9	13/14	$589,492,495	$1,098,056,156	$508,563,661

- **Item 49 of the Special Terms and Conditions – Prior Approval of Claiming Mechanisms**

  On February 27, 2015, CMS approved the revised Low Income Health Program Administrative Costs Claiming Protocol Implementation Plan. More detail is included below under "Accomplishments."

- **Item 51 of the Special Terms and Conditions – HCCI Allocations**

  The State is beginning to complete final reconciliations for the Health Care Coverage Initiative (HCCI) program for all demonstration years and will ensure the Department stays within the annual HCCI limit of $360 million Total Computable ($180 million FFP).

- **Item 55 of the Special Terms and Conditions – Encounter Data Validation Study for New Health Plans**

  Managed Care Quality and Monitoring Division (MCQMD)

  During DY10, DHCS contracted with an External Quality Review Organization (EQRO) to conduct a validation of encounter data reported by MCPs.

The study was administered as a plan survey focusing the operational and infrastructure changes implemented by MCPs in support of the transition to DHCS's new Post Adjudicated Claims and Encounters System, national standard formats for data reporting, and the implementation of new data reporting requirements. Specifically, the EQRO sought to determine whether the changes applied by the MCPs support the creation, processing, and submission of complete, accurate, reasonable, and timely encounter data to DHCS.

The EQRO produced an internal report that summarized statewide and MCP-specific results and provided findings along with recommendations to DHCS for continued quality improvement efforts with MCPs. DHCS is assessing and considering the findings and highlights in order to find ways to improve future implementation efforts.

CCS

Nothing to report.

- **Item 60 of the Special Terms and Conditions – Network Adequacy (CCS, SPD, 1915(b) Waiver Populations, Managed Care Expansion Population, and New Adult Group)**

  SPD/1915(b) Waiver Populations/Managed Care Expansion Population/New Adult Group

  MCQMD requires all MCPs to submit quarterly reports that include network adequacy data and notice of significant changes. Data summaries are included with quarterly waiver reports to CMS. The Managed Care Operations Division (MCOD) contract managers actively work with MCPs to resolve any concerns identified.

  During DY 10, in collaboration with California Department of Managed Health Care (DMHC), DHCS closely monitored all MCP provider networks. MCQMD reviewed and analyzed the quarterly and monthly network adequacy data. Data analysis and inquiries are incorporated in DMHC/DHCS joint review letters and sent to the MCPs quarterly for responses and necessary resolutions. MCPs then provide responses to the identified deficiencies, which DMHC/DHCS evaluate during the next quarterly review. Network adequacy indicators that are monitored include, but are not limited to, the following:

  - Primary care provider (PCP)-to-member ratios;
  - Physician-to-member ratios;
  - PCP time and distance standards;
  - Reasonable geographical access to specialists;
  - Availability of PCPs and specialists;

- Timely access to PCPs and specialists;
- Out of network requests/approvals/denials;
- Grievances regarding geographical access and timely access to PCPs, specialists, and hospitals;
- PCPs accepting new patients or not;
- Hospital admitting privileges; and
- Hospital geographical access.

The monitoring activities are ongoing.

CCS

During Demonstration Year (DY) 8, HPSM contract was executed with an April 1, 2013 effective date. On March 22, 2013, DHCS sent a letter to the Federal Centers for Medicare and Medicaid Services (CMS), certifying HPSM met the network certification requirements in the Special Terms and Conditions (STCs).

II. Waiver Demonstration Program Updates

LOW INCOME HEALTH PROGRAM (LIHP)

Low Income Health Program (LIHP) is a county-based elective program that included two components, the Medicaid Coverage Expansion (MCE) and HCCI. MCE enrollees had family incomes at or below 133 percent of the federal poverty level (FPL). HCCI enrollees had family incomes above 133 through 200 percent of the FPL. The MCE was not subject to a cap on federal funding, and provided a broader range of medical assistance than the HCCI. LIHP ended on December 31, 2013; effective January 1, 2014, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California, pursuant to the Affordable Care Act.

ACCOMPLISHMENTS:

DHCS continued collaboration with the University of California, Los Angeles (UCLA), Center for Health Policy Research, the independent evaluator for the LIHP, to produce data reports used to measure the effectiveness of the local LIHPs and aid in the evaluation project.

DHCS continued to work on the implementation of the primary care provider (PCP) increased payment claiming process by working with the local LIHPs to calculate the amount of eligible expenditures for specific evaluation, management, and vaccine administration services for which enhanced payments are required per Title 42, Part 447 of the Code of Federal Regulations (CFR). On February 4, 2015, DHCS provided data from the State online registry to local LIHPs for their use in determining eligible PCPs.

DHCS continued LIHP transition to Medi-Cal activities. Specific tasks and activities included, but were not limited to:

- DHCS monitored transition data to determine status of the LIHP transition and any remaining issues.
- DHCS developed and provided LIHP Transition Reports to the local LIHPs and county social services agencies to aid in monitoring the transition of LIHP enrollees and provided data on cases that needed investigation to correct eligibility status and transition issues.

On February 27, 2015, CMS approved the revised LIHP Administrative Costs Claiming Protocol Implementation Plan which corrected the calculation error in the percentage of reallocated activities allowable for claiming. After this protocol was approved, DHCS began to process these administrative claims.

DHCS continued the process to initiate the receipt of funds for reimbursement of costs that the Department has incurred related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

DHCS continued to provide guidance to, and solicit feedback from, stakeholders and local LIHP staff through the LIHP e-mail inbox and telephone discussions. The Department updated communication processes with local LIHPs and with other stakeholders during program close-out activities.

PROJECT STATUS:

DHCS continued working to obtain CMS approval for the revised county specific cost claiming protocols submitted by Alameda and San Bernardino LIHPs under Attachment G Supplement 1, Section K, titled "Total Fund Expenditures of Other Governmental Entity." The revisions to these protocols added other entities that could provide CPEs for claiming purposes.

DHCS also continued working to obtain CMS approval for the revised Attachment G - Supplement 2, titled "Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health program-Claims Based on Capitation."

On January 7, 2015, CMS notified DHCS that Attachment G - Supplement 1 and 2 was not approved. On February 13, 2015, DHCS requested that CMS reconsider their denial of Attachment G - Supplement 2. On February 26, 2015, DHCS requested that CMS reconsider their denial of the revisions to the two county specific cost claiming protocols.

Since the approval of the revised LIHP Costs Claiming Protocol Implementation Plan on February 7, 2015, DHCS has worked with the counties to review and complete the time study survey and to process LIHP administrative claims.

On August 31, 2015, CMS denied the Department's appeal requests that were submitted in February 2015 for the Alameda and San Bernardino cost claiming protocol revisions and the capitation payments.

DHCS is working with local LIHPs to obtain final costs for all LIHP costs for all demonstration years in order to begin processing final reconciliations.

QUANTITATIVE FINDINGS:

The following table illustrates Certified Public Expenditures (CPE), Intergovernmental Transfers (IGT), Federal Financial Participation (FFP), and Total Funds paid.

Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
Counties & CDCR					
DY10 CDCR	$470,723	$0	$941,446	DY 7	$470,723
	$2,823,062	$0	$5,646,124	DY 8	$2,823,062
	$9,636,723	$0	$19,273,445	DY 9	$9,636,723
DY10 Health Care	$21,048,394	$21,048,394	$0	DY 7	$42,096,788
	$681,536	$681,536	$0	DY 9	$13,63,072
	$77,442,710	$0	$154,885,419	DY 7	$77,442,710
	$215,285,198	$0	$430,570,395	DY 8	$215,285,198
	$19,382,859	$0	$38,765,717	DY 9	$19,382,859
DY10 Administrative	$15,703,906	$0	$31,407,811	DY 7	$15,703,906
	$37,014,884	$0	$74,029,770	DY 8	$37,014,884
	$24,825,652	$0	$49,651,303	DY 9	$24,825,652
Total	$424,315,647	$21,729,930	$805,171,430		$444,682,505

QUALITATIVE FINDINGS:

Nothing to report.

UTILIZATION DATA

Due to the claim lags, utilization data for DY 9 was not available for the DY 9 annual report, but it is now available to be included in this DY 10 annual report. The data tables, including enrollment data, will be in the next page.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Nothing to report.

		LIHP Year 9 (July 1, 2013 - December 2013) Enrollment Data											
		Monthly Enrollees						Total Member Months			Cumulative Unduplicated Enrollees		
	Aid Code	Jul. '13	Aug. '13	Sep. '13	Oct. '13	Nov. '13	Dec. '13	Quarter 1	Quarter 2	Program to Date	Quarter 1	Quarter 2	Program to Date
Alameda*	MCE New	36,828	36,887	37,225	38,510	39,722	41,998	110,940	120,230	929,049	40,166	42,197	64,562
	MCE Existing	2,682	2,651	2,634	2,650	2,645	2,670	7,967	7,965	94,043	2,764	2,708	4,593
	HCCI New	6,723	6,732	6,739	6,749	6,762	6,660	20,194	20,171	174,624	7,303	7,198	12,114
	HCCI Existing	434	428	428	415	404	397	1,290	1,216	16,076	445	420	800
	Total	**46,667**	**46,698**	**47,026**	**48,324**	**49,533**	**51,725**	**140,391**	**149,582**	**1,213,792**	**50,678**	**52,523**	**82,069**
CMSP	MCE New	63,740	64,607	65,629	66,451	65,066	65,936	193,976	197,453	1,389,765	74,978	73,135	143,264
	Total	**63,740**	**64,607**	**65,629**	**66,451**	**65,066**	**65,936**	**193,976**	**197,453**	**1,389,765**	**74,978**	**73,135**	**143,264**
Contra Costa*	MCE New	9,090	9,339	9,541	9,799	10,389	10,759	27,970	30,947	234,114	10,446	10,901	19,014
	MCE Existing	1,319	1,248	1,193	1,152	1,154	1,147	3,758	3,453	81,139	1,336	1,163	6,502
	HCCI New	2,153	2,154	2,144	2,109	2,122	2,072	6,451	6,303	52,160	2,493	2,326	5,209
	HCCI Existing	224	211	204	192	178	171	639	541	14,380	246	194	1,462
	Total	**12,786**	**12,950**	**13,082**	**13,252**	**13,843**	**14,149**	**38,818**	**41,244**	**381,793**	**14,279**	**14,438**	**27,740**
Kern	MCE New	6,663	7,056	7,393	7,953	8,466	9,076	21,112	25,495	142,693	7,893	9,164	13,496
	MCE Existing	1,841	1,843	1,817	1,821	1,853	1,914	5,501	5,588	63,196	1,955	1,941	4,312
	HCCI New	17	17	17	18	18	19	51	55	1,251	17	19	122
	HCCI Existing	364	360	333	317	314	301	1,057	932	13,918	371	320	1,074
	Total	**8,885**	**9,276**	**9,560**	**10,109**	**10,651**	**11,310**	**27,721**	**32,070**	**221,058**	**10,222**	**11,429**	**18,301**
Los Angeles	MCE New	282,767	290,317	299,977	302,053	311,765	317,948	873,061	931,766	6,225,402	311,281	326,229	437,025
	MCE Existing	4,251	4,127	4,080	3,979	3,964	3,797	12,458	11,740	408,547	4,284	4,015	28,975
	Total	**287,018**	**294,444**	**304,057**	**306,032**	**315,729**	**321,745**	**885,519**	**943,506**	**6,633,949**	**315,561**	**330,244**	**460,854**
Monterey	MCE New	991	1,185	1,324	1,777	2,260	2,862	3,500	6,899	12,307	1,349	2,915	2,983
	Total	**991**	**1,185**	**1,324**	**1,777**	**2,260**	**2,862**	**3,500**	**6,899**	**12,307**	**1,349**	**2,915**	**2,983**
Orange*	MCE New	26,047	26,996	28,035	30,196	32,994	34,101	81,078	97,291	607,575	29,752	34,403	50,256
	MCE Existing	12,584	12,383	12,245	11,922	11,948	12,036	37,212	35,906	422,166	12,867	12,165	22,668
	HCCI New	8,077	8,293	8,486	8,711	9,069	9,168	24,856	26,948	191,983	8,938	9,280	15,256
	HCCI Existing	3,123	3,115	3,098	3,029	3,038	3,062	9,336	9,129	109,892	3,213	3,088	7,318
	Total	**49,831**	**50,787**	**51,864**	**53,858**	**57,049**	**58,367**	152,482	169,274	**1,331,616**	54,587	58,692	**88,580**
Placer	MCE New	3,368	3,473	3,640	3,824	3,906	4,017	10,481	11,747	48,070	3,843	4,239	4,902
	Total	**3,368**	**3,473**	**3,640**	**3,824**	**3,906**	**4,017**	**10,481**	**11,747**	**48,070**	**3,843**	**4,239**	**4,902**
Riverside	MCE New	28,843	29,255	30,865	31,868	33,536	35,781	88,963	101,185	587,881	32,495	35,935	49,250
	Total	**28,843**	**29,255**	**30,865**	**31,868**	**33,536**	**35,781**	**88,963**	**101,185**	**587,881**	**32,495**	**35,935**	**49,250**
Sacramento	MCE New	12,764	12,960	12,912	13,066	13,493	13,936	38,636	40,495	151,734	14,233	14,515	18,293
	Total	**12,764**	**12,960**	**12,912**	**13,066**	**13,493**	**13,936**	**38,636**	**40,495**	**151,734**	**14,233**	**14,515**	**18,293**
San Bernardino	MCE New	32,381	33,055	33,664	35,122	36,773	38,776	99,100	110,671	609,308	36,641	40,148	55,759
	Total	**32,381**	**33,055**	**33,664**	**35,122**	**36,773**	**38,776**	99,100	110,671	**609,308**	36,641	40,148	**55,759**

	Aid Code	Monthly Enrollees						Total Member Months			Cumulative Unduplicated Enrollees		
		Jul. '13	Aug. '13	Sep. '13	Oct. '13	Nov. '13	Dec. '13	Quarter 1	Quarter 2	Program to Date	Quarter 1	Quarter 2	Program to Date
San Diego	MCE New	38,012	38,713	39,427	40,717	43,071	45,513	116,152	129,301	879,786	43,151	46,308	72,811
	MCE Existing	1,186	1,170	1,147	1,121	1,123	1,119	3,503	3,363	46,036	1,207	1,139	2,030
	HCCI New	28	30	30	28	29	27	88	84	2,949	30	30	397
	HCCI Existing	50	46	44	45	43	41	140	129	3,859	50	45	248
	Total	**39,276**	**39,959**	**40,648**	**41,911**	**44,266**	**46,700**	**119,883**	**132,877**	**932,630**	**44,438**	**47,522**	**75,052**
San Francisco	MCE New	7,710	8,188	11,470	11,976	12,483	12,253	27,368	36,712	225,984	12,155	12,551	18,961
	MCE Existing	1,689	1,475	1,357	1,345	1,326	1,294	4,521	3,965	73,111	1,689	1,348	5,979
	HCCI New	347	380	414	427	433	425	1,141	1,285	17,094	432	437	1,155
	HCCI Existing	393	351	307	286	281	276	1,051	843	14,644	398	286	1,111
	Total	**10,139**	**10,394**	**13,548**	**14,034**	**14,523**	**14,248**	**34,081**	**42,805**	**330,833**	**14,453**	**14,609**	**24,891**
San Joaquin	MCE New	3,428	3,594	3,809	4,086	4,370	4,564	10,831	13,020	49,249	3,809	4,564	4,564
	Total	**3,428**	**3,594**	**3,809**	**4,086**	**4,370**	**4,564**	**10,831**	**13,020**	**49,249**	**3,809**	**4,564**	**4,564**
San Mateo	MCE New	7,407	7,475	7,545	7,662	8,050	8,477	22,427	24,189	181,580	8,247	8,566	14,145
	MCE Existing	1,587	1,552	1,516	1,459	1,464	1,468	4,655	4,391	67,248	1,611	1,491	4,540
	HCCI New	24	24	22	22	22	15	70	59	2,867	24	23	300
	HCCI Existing	69	69	62	57	46	38	200	141	6,311	69	57	648
	Total	**9,087**	**9,120**	**9,145**	**9,200**	**9,582**	**9,998**	27,352	28,780	**258,006**	9,950	10,128	**18,376**
Santa Clara	MCE New	13,986	14,361	14,638	15,171	15,975	17,007	42,985	48,153	250,332	15,577	17,110	21,729
	MCE Existing	3,210	3,165	3,128	3,091	3,096	3,108	9,503	9,295	109,680	3,300	3,154	5,592
	HCCI Existing	504	474	450	433	425	418	1,428	1,276	22,157	530	433	1,573
	Total	**17,700**	**18,000**	**18,216**	**18,695**	**19,496**	**20,533**	53,916	58,724	**382,184**	19,345	20,692	**27,902**
Santa Cruz	MCE New	1,262	1,170	1,097	1,058	1,051	1,040	3,529	3,149	37,304	1,263	1,058	2,441
	Total	**1,262**	**1,170**	**1,097**	**1,058**	**1,051**	**1,040**	**3,529**	**3,149**	**37,304**	**1,263**	**1,058**	**2,441**
Tulare	MCE New	3,758	4,141	4,055	3,958	3,835	3,713	11,954	11,506	31,722	4,246	3,960	4,371
	Total	**3,758**	**4,141**	**4,055**	**3,958**	**3,835**	**3,713**	**11,954**	**11,506**	**31,722**	**4,246**	**3,960**	**4,371**
Ventura*	MCE New	7,171	7,155	7,228	7,263	7,542	7,795	21,554	22,600	175,367	7,880	7,859	12,956
	MCE Existing	1,693	1,647	1,583	1,549	1,547	1,536	4,923	4,632	67,352	1,737	1,554	3,768
	HCCI New	2,259	2,205	2,171	2,096	2,128	2,124	6,635	6,348	56,987	2,469	2,166	4,586
	HCCI Existing	659	648	605	565	561	555	1,912	1,681	24,548	697	566	1,720
	Total	**11,782**	**11,655**	**11,587**	**11,473**	**11,778**	**12,010**	**35,024**	**35,261**	**324,254**	**12,569**	**12,121**	**20,549**
All LIHPs	MCE New	586,216	599,927	619,474	632,510	654,747	675,552	1,805,617	1,962,809	12,769,222	659,405	695,757	1,010,782
	MCE Existing	32,042	31,259	30,700	30,089	30,120	30,089	94,001	90,298	1,432,518	32,750	30,678	88,959
	HCCI New	19,628	19,835	20,023	20,160	20,583	20,510	59,486	61,253	499,915	21,706	21,479	39,139
	HCCI Existing	5,820	5,702	5,531	5,339	5,290	5,259	17,053	15,888	225,785	6,019	5,409	15,954
	Total	643,706	656,723	675,728	688,098	710,740	731,410	1,976,157	2,130,248	14,927,455	718,939	752,867	1,130,141

Notes:
(1) County Inmates are included in the MCE enrollment numbers; State Inmates are excluded.
(2) Enrollment estimates are continuously updated to reflect retroactive changes to enrollment status, and may not match monthly aggregate enrollment data reported by
(3) The total number of member months can be interpreted as the number of months of enrollee-time contributed by all enrollees together during the reporting period. Each
(4) Data for Los Angeles are self-reported.
(5) Light grey shaded areas denote counties were not operational during that time period. Reflects lack of Existing Enrollees and no HCCI component.
(*) Four counties are currently operating the HCCI component of LIHP.

LIHP Year 9 (July 1, 2013 - December 31, 2013) Utilization Data

Physical Health Care, by Units of Service

Physical Health Care Services	Inpatient Hospital		Outpatient Hospital		Clinic Visits		Physician Services		FY 9 (13/14) Year-to-Date Totals 7/1 - 12/31			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	Inpatient Hospital	Outpatient Hospital	Clinic Visits	Physician Services
Alameda	2,441	1,929	13,760	16,700	29,030	28,626	20	2	**4,370**	**30,460**	**57,656**	**22**
CMSP	9,331	6,200	87,218	63,903	59,366	47,358	67,336	53,261	**15,531**	**151,121**	**106,724**	**120,597**
Contra Costa	2,422	1,852	2,077	1,787	266	213	22,560	23,380	**4,274**	**3,864**	**479**	**45,940**
Kern	2,418	1,232	11,478	6,570	7,209	7,659	0	0	**3,650**	**18,048**	**14,868**	**0**
Los Angeles	13,666	10,871	101,231	98,411	40,269	112	2,821	2,135	**24,537**	**199,642**	**40,381**	**4,956**
Monterey	349	443	2,151	2,105	1,449	1,520	405	554	**792**	**4,256**	**2,969**	**959**
Orange	12,948	11,280	21,594	22,502	3,528	3,632	68,149	67,247	**24,228**	**44,096**	**7,160**	**135,396**
Placer	446	204	1,716	905	1,501	1,432	2,587	1,597	**650**	**2,621**	**2,933**	**4,184**
Riverside	5,007	4,309	27,352	24,919	12,646	14,076	13	0	**9,316**	**52,271**	**26,722**	**13**
Sacramento	8,621	2,969	25,380	4,159	2,726	2,399	4,780	3,701	**11,590**	**29,539**	**5,125**	**8,481**
San Bernardino	14,269	7,136	12,978	9,646	1	1	62,736	55,731	**21,405**	**22,624**	**2**	**118,467**
San Diego	1,598	1,565	14,004	15,074	16,698	18,515			**3,163**	**29,078**	**35,213**	
San Francisco	185	336	3,532	4,403	397	58	242	309	**521**	**7,935**	**455**	**551**
San Joaquin	888	480	2,970	2,599	28	63	3,830	2,976	**1,368**	**5,569**	**91**	**6,806**
San Mateo	2,443	2,159	25,047	29,632	51	1,315	13,563	13,243	**4,602**	**54,679**	**1,366**	**26,806**
Santa Clara	119	118	404	228	1,409	1,190	1,045	792	**237**	**632**	**2,599**	**1,837**
Santa Cruz	5,049	2,991	3,861	3,333	3,319	2,285	19,170	16,069	**8,040**	**7,194**	**5,604**	**35,239**
Tulare	865	549	2,624	1,565	19	23	6,995	6,004	**1,414**	**4,189**	**42**	**12,999**
Ventura	1,115	891	14,160	15,486	6,628	7,224	124	34	**2,006**	**29,646**	**13,852**	**158**
Total	**84,180**	**57,514**	**373,537**	**323,927**	**186,540**	**137,701**	**276,376**	**247,035**	**141,694**	**697,464**	**324,241**	**523,411**

= services not provided

LIHP Year 9 (July 1, 2013 - December 31, 2013) Utilization Data

Table 3.1: Mental Health Services, by Units of Service

Mental Health Care Services	Inpatient Hospital		Outpatient Hospital		Outpatient Clinic		Physician Services		FY 9 (13/14) Year-to-Date Totals 7/1 - 12/31			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	**Inpatient Hospital**	**Outpatient Hospital**	**Outpatient Clinic**	**Physician Services**
Alameda	914	946	32	10	11,693	12,981			**1,860**	**42**	**24,674**	
CMSP	997	237	22	38	1,234	594	510	275	**1,234**	**60**	**1,828**	**785**
Contra Costa	835	773	2,033	3,527	59	103			**1,608**	**5,560**	**162**	
Kern	188	137	58	29	299	77			**325**	**87**	**376**	
Los Angeles	5,505	5,494			105,751	94,725			**10,999**		**200,476**	
Monterey	19				2,360	2,325			**19**		**4,685**	
Orange	826	1,004	131	174	4,931	5,348			**1,830**	**305**	**10,279**	
Placer	252	342			1,742	1,815			**594**		**3,557**	
Riverside	796	904			8,972	11,454			**1,700**		**20,426**	
Sacramento	313	548			0	0			**861**	**0**	**0**	
San Bernardino	1,757	1,687	3,708	3,482	6,874	6,949	3,583	3,618	**3,444**	**7,190**	**13,823**	**7,201**
San Diego	1,124	527			1,888	855			**1,651**			
San Francisco	164	170			782	560			**334**			
San Joaquin					1,827	2,135			**0**			
San Mateo	223	118	9	3	910	602	2,457	1,701	**341**	**12**	**1,512**	**4,158**
Santa Clara	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**0**
Santa Cruz	45	60			289	309			**105**			
Tulare	5	15	1	0	675	294	239	0	**20**	**1**	**969**	**239**
Ventura	0	0	0	0	3,298	2,910			**0**			
Total	**13,963**	**12,962**	**5,994**	**7,263**	**153,584**	**144,036**	**6,789**	**5,594**	**26,925**	**13,257**	**282,767**	**12,383**

= **services not provided**

LIHP Year 9 (July 1, 2013 - December 31, 2013) Utilization Data

Table 3.2: Substance Use Services, by Units of Service

Substance Use Services	Inpatient Hospital		Outpatient Hospital		Outpatient Clinic		Physician Services		FY 9 (13/14) Year-to-Date Totals 7/1 - 12/31			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	**Inpatient Hospital**	**Outpatient Hospital**	**Outpatient Clinic**	**Physician Services**
Alameda												
CMSP	0	0	258	156	1	2	343	89	**0**	**414**	**3**	**432**
Contra Costa												
Kern	0	0	12	0	32	27			**0**	**12**	**59**	
Los Angeles												
Monterey												
Orange												
Placer												
Riverside												
Sacramento												
San Bernardino												
San Diego												
San Francisco	0	0	1	0	445	1,008			**0**	**1**	**1,453**	
San Joaquin												
San Mateo	2,949	5,502	3,732	4,640	86,724	85,381			**8,451**	**8,372**	**172,105**	
Santa Clara	0	0	0	0	0	0	0	0	**0**	**0**	**0**	**0**
Santa Cruz					35	39			**0**		**74**	
Tulare												
Ventura												
Total (All LIHPs)	**2,949**	**5,502**	**4,003**	**4,796**	**87,237**	**86,457**	**343**	**89**	**8,451**	**8,799**	**173,694**	**432**

= **services not provided**

LIHP Year 9 (July 1, 2013 - December 31, 2013) Utilization Data

Table 3.3: Emergency Services, by Units of Service

Emergency Services	Out of Network Emergency Visits		Out of Network Post-Stabilization Services		In Network Emergency Services Visits		FY 9 (13/14) Year-to-Date Totals 7/1 - 12/31		
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	Out Network Emergency	Post - Stabilization	In Network Emergency
Alameda	524	557	3,900	4,245	5,057	4,226	**1,081**	**8,145**	**9,283**
CMSP	2,468	1,657	15,398	10,532	28,285	18,702	**4,125**	**25,930**	**46,987**
Contra Costa	0	0	0	0	2,658	3,269	**0**	**0**	**5,927**
Kern	532	389	145	77	1,866	1,223	**921**	**222**	**3,089**
Los Angeles	18,996	8,217	2,286	677	14,870	15,207	**27,213**	**2,963**	**30,077**
Monterey	9	8	1	0	522	530	**17**	**1**	**1,052**
Orange	0	1	8	13	7,790	8,705	**1**	**21**	**16,495**
Placer	16	5	2	20	414	487	**21**	**22**	**901**
Riverside	2,113	1,973	1,962	255	3,477	3,256	**4,086**	**2,217**	**6,733**
Sacramento	33	13	222	200	517	468	**46**	**422**	**985**
San Bernardino	867	1,863	703	808	6,548	6,117	**2,730**	**1,511**	**12,665**
San Diego	68	49			9,401	6,391	**117**		**15,792**
San Francisco	26	0	19	0	1,894	2,131	**26**	**19**	**4,025**
San Joaquin	69	136	11	3	402	548	**205**	**14**	**950**
San Mateo	492	438			1,881	1,743	**930**		**3,624**
Santa Clara	163	144	25	18	4,056	2,777	**307**	**43**	**6,833**
Santa Cruz	7	0	1	1	239	167	**7**	**2**	**406**
Tulare	25	21	0	0	805	270	**46**	**0**	**1,075**
Ventura	26	0	4	1	0	0	**26**	**5**	**0**
Total	**26,434**	**15,471**	**24,687**	**16,850**	**90,682**	**76,217**	**41,905**	**41,537**	**166,899**

= services not provided

SENIORS AND PERSONS WITH DISABILITIES (SPD)

SPDs are persons who derive their eligibility from the Medicaid State Plan and are aged, blind, or disabled.

Pursuant to the Special Terms and Conditions of the waiver, DHCS mandatorily enrolled SPDs into Medi-Cal managed care in non-County Organized Health System (COHS) counties, with the exception of San Benito County, which remains voluntary. This did not include individuals who are:

- Eligible for full benefits in both Medicare and Medicaid (dual-eligible individuals);
- Foster children;
- Eligible for Long term Care (LTC);
- Required to pay a "share of cost" each month as a condition of Medi-Cal coverage.

Prior to implementation, DHCS ensured that MCP(s) in each geographic area met certain readiness and network requirements. DHCS continues to require MCPs to ensure sufficient access, quality of care, and care coordination for beneficiaries as established by the State, required by Title 42, Code of Federal Regulations Section 438, and approved by CMS.

The SPD transition was part of DHCS's continuing efforts to fulfill the aims of the Patient Protection and Affordable Care Act. The goal of the transition was to ensure beneficiaries are able to receive appropriate and medically necessary care in the most suitable setting, achieve better health outcomes, and realize cost efficiencies. DHCS, through managed care, provides SPDs with the supports necessary to enable them to live in the community instead of in institutional care settings, reduces costly and avoidable emergency department visits, as well as prevents duplication of services.

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 10 million Medi-Cal beneficiaries in 58 counties through various managed care models:

- Two-Plan, which operates in 14 counties.
- COHS, which operates in 22 counties.
- Geographic Managed Care (GMC), which operates in two counties.
- Regional Model, which operates in 18 counties.
- Imperial Model, which operates in one county.
- San Benito Model, which operates in one county.

ACCOMPLISHMENTS:

Nothing to report.

PROJECT STATUS:

Nothing to report.

QUANTITATIVE FINDINGS:

Enrollment (July 2014 through October 2015)

Managed care enrollment in Two-Plan, GMC, Regional, Imperial, and San Benito models increased from 6,047,636 beneficiaries in July 2014 to 7,886,856 in October 2015, representing a 23 percent increase. Total SPD enrollment was 531,000 beneficiaries in July 2014, and then decreased to 529,839 beneficiaries in October 2015, representing a 0.22 percent decrease. Since the SPD population shrank slightly, the percentage of the total population also decreased. In July 2014, SPDs represented 8.78 percent of the population, while in October 2015, SPDs represented 6.72 percent of the population. Prior to the SPD transition, all beneficiaries, including SPDs, were already required to mandatorily enroll in COHS plans. As a result, a waiver amendment was not necessary to facilitate mandatory SPD enrollment in these counties. Therefore, these enrollment numbers relative to the SPD transition do not include COHS.

There were 27,970 instances of SPDs who disenrolled from MCPs during this period. The average percentage of SPDs who disenrolled out of all SPDs enrolled each month was 0.32 percent. The stated reasons for 96.39 percent of the disenrollments were due to issues regarding beneficiary choice (i.e., the beneficiary could not choose the doctor he/she wanted, the MCP did not meet beneficiary needs, doctors did not meet beneficiary needs, or the location was too far away from the beneficiary). The other 3.6 percent of disenrollments were due to several reasons that often varied month to month (i.e., the beneficiary was receiving Indian health coverage, was granted a medical exemption, was receiving LTC, the beneficiary was moving out of the county).

Continuity of Care (July 2014 through September 2015)

There were a total of 5,869 extended continuity of care requests submitted to MCPs between July 2014 and September 2015 (*October 2015 data is not available at this time, as the results are reported quarterly). Seventy-three percent or 4,287 of these requests were approved, 198 were in process at the time of reporting, and 1,384 (24 percent) were denied. For those denied, 856 were because the provider refused to work with the MCP, 46 were because the provider and MCP could not agree to a reimbursement rate, 24 were due to a lack of linkage between the SPD and provider, 19 were due to quality of care issues, and 439 were due to other specific reasons that the MCPs identified.

Medical Exemption Requests (July 2014 through October 2015)

For July 2014 through October 2015, 23,317 unique SPDs submitted 27,575 Medical Exemption Requests (MERs) indicating an average of 1.18 MERs submitted per unique SPD who submitted a MER. Out of 12 diagnosis codes, the top diagnosis code was "Complex," with 3,946 MERs (14.31 percent) between July 2014 and October 2015. There are several other codes, such as Dialysis, HIV, and Surgery, for example.

Of the MERs received, 17,130 (62.12 percent) were approved, 156 (0.57 percent) were incomplete, and 10,289 (37.31 percent) were denied.

Risk Data (April 2014 through June 2014*)

*Due to a data lag, the April to June 2014 data was not reported in the DY 9 annual waiver report. As a result, the numbers below include April 2014 through June 2015 data. The July through October 2015 data is still being analyzed.

Through a risk stratification process, MCPs identified 56,504 SPDs as high risk and identified 71,658 SPDs as low risk. There were 12,682 SPDs who did not participate in the stratification process because they were added late and were not enrolled at the beginning of the month. Approximately 82 percent (115,212 SPDs) of the 140,844 total SPDs were successfully contacted by MCPs to participate in a risk assessment survey. The survey asks health questions that further assist MCPs in assessing the needs of a beneficiary and to ensure that beneficiaries are seen by appropriate providers. 38,798 SPDs completed the risk assessment survey (28 percent of SPDs that were determined as high or low risk). As a result of the risk assessment survey, 12 percent of SPDs (17,555 of respondents) were determined to belong in a different risk category than what was determined through the stratification process.

Ombudsman Data (July 2014 through October 2015)

There were 9,110 calls regarding mandatory SPD enrollment into managed care (5.24 percent of total calls to the DHCS Office of the Ombudsman). There were 17 SPD calls (0.14 percent of total SPD calls) compared to 30 calls from other members (0.03 percent of total other member calls) regarding access issues.

Plan Grievances (July 2014 through October 2015)

There were a total of 19,157 SPD grievances. Approximately 16 percent of SPD grievances, or 2,985, were related to access issues. The remaining percentage was due to a variety of non-access issues, such as out-of-network.

QUALITATIVE FINDINGS:

Nothing new to report.

UTILIZATION DATA:

Enrollment of SPDs grew from 529,523 in the third quarter of 2013 to 548,181 in the third quarter of 2014. For this time period, of the SPD population, approximately 68 percent had pharmacy claims, 50 percent had outpatient visits, 14 percent had emergency room visits, 6 percent had hospital admissions, and 5 percent had inpatient visits.

On average, each SPD who utilized the services had 6.73 outpatient visits, 3.68 inpatient visits, 14.98 pharmacy claims, 1.99 hospital admissions, and 1.74 emergency room visits.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

DHCS evaluated the SPD transition and identified several lessons learned and strategies for improvement as follows:

- Lesson Learned #1: Collaboration across entities and settings improves plan and provider readiness.
    - DHCS strategies/improvement:
        - Discuss readiness and outreach opportunities with the plans on a bi-weekly basis.
        - Work with plans on establishing town hall meetings to increase outreach to providers and beneficiaries in the community.
        - Emphasize the importance of high completion percentages for the Health Risk Assessments (HRAs).
    - Plan strategies/improvement:
        - Participate in town hall meetings and other outreach opportunities.
        - Utilize all available resources to increase HRA return rates.

- Lesson Learned #2: Plans need timely access to beneficiary data to improve plan readiness and care coordination.
    - DHCS Strategies/Improvement:
        - Provide utilization data and Treatment Authorization Request (TAR) data for new members to plans 30 days prior to enrollment.
        - Utilize a linkage process for plan assignment for those beneficiaries that do not make an active plan choice.
        - Provide technical assistance to refine the process for data sharing.

        - Mail choice packets to beneficiaries 75 days prior to enrollment which will allow more time for beneficiaries to make a plan choice and have any questions they have addressed.

- Lesson Learned #3: Developing adequate provider networks to prepare for an expansion was both a challenge and an opportunity.
    - DHCS strategies/improvement:
        - Provide payment increases for the SPD population.
        - Provide plans with rendering and billing provider information to identify specialists who are being accessed in the area.
        - Work with the Department of Managed Health Care to expand network adequacy reviews.
        - Engage with providers on outreach efforts.
        - Hold regularly scheduled meetings with the plans to discuss network issues.
    - Plan strategies/improvement:
        - Offer incentive programs for providers, including paying higher amounts for the SPD population.
        - Encourage plans to continually seek opportunities to expand their networks through various organizations.

- Lesson Learned #4: The transition impacted the organizational structure and resources of those who served the SPD population.
    - DHCS strategies/improvement:
        - Incorporate provisions that require plans to provide specialized training to staff working with SPDs.
        - Incorporate contract provisions to address linguistic and cultural competencies, SPD sensitivity training, and case management.
        - Include oversight of these contract provisions in the health plan readiness reviews.
        - Provide utilization, TAR, and demographic data to plans that identify high utilizers and those needing specialty services.
        - Update member notices to add language on Medical Exemption Requests (MERs) and Continuity of Care.
        - Require plans to honor fee-for-service (FFS) TARs for up to 60 days or until a new authorization is completed by the plan to minimize care disruption.
        - Work with plans on provider outreach materials.
    - Plan strategies/improvement:
        - Regularly conduct provider trainings.
        - Provide specialized outreach to particular provider types, if needed.
        - Look to partner with community organizations to improve resource utilization and communication.

        - Make MER and Continuity of Care information available in their Evidence of Coverage and Member Services Departments.

- Lesson Learned #5: The transition generated an even greater need for care coordination.
    - DHCS strategies/improvement:
        - Review the plans' policies and procedures for care coordination to ensure processes are in place.
        - Work with the plans to address any deficiencies.
        - Require the plans to correct any deficiencies prior to implementation.
        - Monitor the plans' administrative readiness, including staffing, training and education.
        - Hold bi-weekly meetings with the plans to discuss care coordination, among other topics.
    - Plan strategies/improvement:
        - Provide ongoing specialized staff training.
        - Ensure medical contacts are available 24 hours a day to coordinate services.

- Lesson Learned #6: Capitalize on improving beneficiary experience during the transition.
    - DHCS strategies/improvement:
        - Notification and informing materials to include the benefits of managed care, timing of the transition, how the change affects the beneficiary and key contact information for questions and information.
        - Notices to include information on how a beneficiaries can remain on FFS through the MER process, if they qualify.
        - Development of a Continuity of Care website.
    - Plan strategies/improvement:
        - Improve beneficiary informing materials.
        - Help beneficiaries navigate their plan options, find doctors in the network, and educate on medication changes.
        - Using FFS utilization data, link beneficiaries to a primary care doctor, if possible.

Nothing new to report for DY10.

2013 MANAGED CARE EXPANSION

Medi-Cal managed care provides high quality, accessible, and cost-effective health care through managed care delivery systems.

DHCS contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. MCPs are a cost-effective use of health care resources that improve health care access and ensure quality of care.

Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), the health omnibus budget trailer bill, authorized DHCS to expand Medi-Cal managed care to Medi-Cal beneficiaries residing in the following 28 rural FFS counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba. This statewide expansion was part of Governor Brown's 2012-2013 Budget.

In preparation for this statewide expansion, in March 2012, DHCS issued a Request for Information to solicit health plan interest in providing health care services to Medi-Cal beneficiaries in these rural counties. In November 2012, DHCS issued a Request for Application (RFA) inviting interested health plans to submit formal applications to DHCS.

On February 27, 2013, DHCS released an administrative bulletin excluding the following seven counties from the RFA: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Pursuant to Welfare and Institutions Code Section 14087.98(b) and authorized under AB 1467, DHCS chose to enter into an exclusive health plan contract with an existing COHS, Partnership HealthPlan of California (PHC), for these seven counties. DHCS also chose to enter into an exclusive health plan contract with the same COHS to include Lake County, which was not part of the original RFA.

Also on February 27, 2013, DHCS announced Anthem Blue Cross and California Health and Wellness Plan (CHWP) as the selected plans in the following 18 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. Final health plan contracts were contingent upon all the plans' completion of state and federal plan readiness activities. Additionally, DHCS contracted with Kaiser Foundation Health Plan in three of these counties (Amador, El Dorado and Placer) to ensure continuity of care for beneficiaries given Kaiser's staff model for delivery of care was already in place.

DHCS, in collaboration with the Imperial County Public Health Department, participated in a community meeting for stakeholders in Imperial County on December 6, 2012. Local providers and MCPs attended and participated in the meeting. The purpose of this meeting was to discuss the managed care model options with stakeholders and to

answer questions and obtain information about the geography of Imperial County's desert landscape and how it affects access to services. Based upon CMS and DHCS collaboration, DHCS contracted with two plans in Imperial County: CHWP and Molina Healthcare.

San Benito County, which originally planned to join an existing COHS plan (Central California Alliance for Health), instead operates as a single plan model (Anthem Blue Cross).

As of October 2015, which is the end of the reporting period, approximately 10 million Medi-Cal beneficiaries in all 58 California counties were enrolled in Medi-Cal managed care and received their health care through the following models of managed care:

1. Two-Plan, which operates in 14 counties.
2. COHS, which operates in 22 counties.
3. GMC, which operates in two counties.
4. Regional Model, which operates in 18 counties.
5. Imperial Model, which operates in one county.
6. San Benito Model, which operates in one county.

ACCOMPLISHMENTS:

On September 1, 2013, DHCS successfully completed the expansion of Medi-Cal managed care in the eight rural FFS counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

On November 1, 2013, DHCS successfully completed the expansion into the remaining 20 rural FFS counties of: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

Nothing new to report for DY 10.

PROJECT STATUS:

Noted in "Accomplishments" above.

QUANTITATIVE FINDINGS:

Enrollment (July 2014 through October 2015)

In July 2014, the enrollment in the rural COHS counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity was approximately 150,984. In October 2015, enrollment was 182,662, which is a 17 percent increase.

In July 2014, the enrollment in the rural Regional, Imperial, and San Benito Model counties of: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba was approximately 265,793. In October 2015, enrollment increased to approximately 370,750 which is a 28 percent increase.

Continuity of Care (July 2014 through September 2015*)

A total of 732 extended continuity of care requests were submitted to MCPs between July 2014 and September 2015 (*October 2015 data is not available at this time, as the results are reported quarterly). Ninety-four percent, or 689, of these requests were approved, 0 (0 percent) were in process at the time of reporting, and 42 (6 percent) were denied. For those denied, one was because the provider would not accept the reimbursement rate; three were because the provider refused to work with managed care and 37 were due to various other reasons that were identified by the MCPs.

Medical Exemption Requests (September 2013 through April 2014)

For July 2014 through October 2015, a total of 15,541 MERs were received, 10,154 (65.34 percent) were approved and 5,370 (34.55 percent) were denied.

Risk Data (July 2014 through October 2015)

Nothing to report for DY 10.

Ombudsman Data (July 2014 through October 2015)

The Office of Ombudsman resolved 5,287 cases in the 28 rural expansion counties. The top four counties with the most cases were Placer County with 1,847 cases, Imperial County with 776 cases, Shasta County with 460 cases, and Sutter County with 444 cases. Seventy-seven percent of the cases were enrollment and disenrollment issues; 14.6 percent of the cases were eligibility and education/outreach issues; 3.8 percent were miscellaneous issues; 1.7 percent were MCP issues; one percent was quality of care issues; 0.8 percent were other health care coverage issues; and the remaining 1.1 percent were issues related to: billing, medical exemption requests, plan subcontractor issues, continuity of care, FFS, address changes/updates, LTC and Intermediate Care Facility Program/Developmentally Disabled, and aid codes.

Plan Grievances (July 2014 through October 2015)

From July 1, 2014 to October 31, 2015, the five MCPs operating in the rural expansion counties provided grievance data to DHCS that fell within five categories: quality of care/service; miscellaneous reasons; benefits and coverage issues; accessibility issues; and referral issues. MCPs reported a total of 1,456 grievances. Of that total, 45 percent were due to quality of care/service; 28 percent were due to miscellaneous reasons; 16 percent were due to benefits and coverage issues; 8.1 percent were due to accessibility issues; and 2.4 percent were due to referral issues.

QUALITATIVE FINDINGS:

Nothing to report for DY 10.

UTILIZATION DATA:

The following utilization data is reported in a manner consistent with the Medi-Cal Managed Care Performance Dashboard, which is a monitoring tool used to display data quarterly. Due to a lag time in receiving data from MCPs, the most recent complete utilization rates available for the 28 rural expansion counties are for the third quarter of 2014 (July through September) and the fourth quarter of 2014 (October through December). The numbers below indicate the number of services that were paid for by Medi-Cal. The Optional Targeted Low Income Children's Program (OTLICP) is the former Healthy Families Program (HFP). The results are listed below:

Rural Expansion Utilization Rate Per 1000 Member Months

Q3 2014	All	SPDs	Dual-Eligibles	OTLICP
ER Visits	63	122	121	22
ER Visits w/IP Admits	3	11	7	0
Inpatient Admits	30	68	207	2
Outpatient Visits	898	2057	1714	457
Pharmacy Claims	770	3211	391	183

Q4 2014	All	SPDs	Dual-Eligibles	OTLICP
ER Visits	68	124	147	25
ER Visits w/IP Admits	4	14	8	1
Inpatient Admits	28	59	203	2
Outpatient Visits	931	2194	1684	500
Pharmacy Claims	731	2913	276	201

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Nothing new to report for DY10.

DESIGNATED STATE HEALTH PROGRAMS (DSHP)

The Special Terms and Conditions of California's Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) allow the State to claim Federal Financial Participation (FFP) using the certified public expenditures (CPE) of approved Designated State Health Programs (DSHP). The annual FFP limit the State may claim for DSHPs during each Demonstration Year is $400 million for a five-year total of $2 billion.

ACCOMPLISHMENTS:

In DY 10, DHCS completed the following DY 5 and 6 final reconciliations for Safety Net Care Pool Designated State Health Programs (DSHP).

- CMSP

In DY 10, DHCS completed the following DY 7 final reconciliations for Safety Net Care Pool Designated State Health Programs (DSHP).

- Prostate Cancer Treatment Program (PCTP)
- Song Brown HealthCare Workforce Training
- Mental Health Loan Assumption (MHLAP)
- Steven M. Thompson Physician Corp. Loan Repayment Program (STLRP)

In DY 10, DHCS completed the following DY 8 final reconciliations for Safety Net Care Pool Designated State Health Programs (DSHP).

- Medically Indigent Adult Long-Term Care (MIA/LTC)
- Breast & Cervical Cancer Treatment Program (BCCTP)
- Department of Developmental Services (DDS)

PROJECT STATUS:

Assembly Bill 1467 gave the Department the statutory authority to use excess Designated Public Hospital CPEs to claim against the $400 million annual DSHP limit, to the extent that program expenditures were not sufficient to claim up to this amount. DHCS is developing a methodology to claim excess CPEs in order to reach our annual limit.

QUANTITATIVE FINDINGS:

As of January 2016, DHCS has claimed a total of $359,533,370 for DSHPs in DY 10. The table below lists the claim detail for each program:

State Only Medical Programs	
California Children Services (CCS)	**$64,328,391**
Genetically Handicapped Persons Program (GHPP)	**$49,727,423**
Medically Indigent Adult Long-Term Care (MIA/LTC)	**$18,932,000**
Breast & Cervical Cancer Treatment Program (BCCTP)	**$1,307,441**
AIDS Drug Assistance Program (ADAP)	**$68,721,155**
County Mental Health Services Program	**$62,060,677**
Department of Developmental Services (DDS)	**$84,951,797**
Every Woman Count (EWC)	$0
Prostate Cancer Treatment Program (PCTP)	**$1,208,913**
State Only Medical Programs Total	**$351,237,797**
Workforce Development Programs	
Song Brown HealthCare Workforce Training	$3,685,381
Steven M. Thompson Physician Corp. Loan Repayment Program	$1,464,646
Mental Health Loan Assumption	$3,145,546
Workforce Development Programs Total	**$8,295,573**
Grand Total for DSHPs	**$359,533,370**

QUALITATIVE FINDINGS:

Not applicable.

UTILIZATION DATA:

Not applicable.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Not applicable.

COMMUNITY BASED ADULT SERVICES (CBAS)

On July 1, 2011, Assembly Bill 97 (Chapter 3, Statues of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas,* challenged the elimination of ADHC services and a settlement agreement was reached to eliminate ADHC services under the Medi-Cal program effective March 31, 2012 and replace it with CBAS effective April 1, 2012. The Department of Health Care Services (DHCS) amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR Waiver) to include CBAS. On March 30, 2012, CMS approved this amendment which made CBAS operational under the BTR Waiver for the period of April 1, 2012, through August 31, 2014.
DHCS and California Department of Aging (CDA) conducted extensive stakeholder input regarding the continuation of CBAS in anticipation of the CBAS BTR Waiver end period of August 2014. CMS approved an amendment to the CBAS BTR Waiver which extended CBAS for the length of the overall BTR Waiver, with an effective date of December 1, 2014. The end date for Demonstration Year (DY) 10 reporting period is October 31, 2015. CBAS continues as a CMS approved benefit under the Medi-Cal 2020 Demonstration Waiver effective November 1, 2015.

PROGRAM REQUIREMENTS:

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal members that meet CBAS criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the BTR Demonstration Waiver; and 4) exhibit ongoing compliance with above requirements.
Eligibility for CBAS benefit is determined initially through a face-to-face review by a managed care plan registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. When a managed care plan determines that the receipt of CBAS is clinically appropriate based on information that the plan possesses, an initial face-to-face review is not required. Ongoing eligibility for CBAS benefit is determined at least every six months or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate. Denial in services or reduction in the requested number of days for services requires a face-to-face review by a CBAS Center representative.

PROJECT STATUS:

Enrollment and Assessment Information

Enrollment for CBAS remained steady during its continuation as a managed care benefit in 26 counties. Of the almost 29,000 participants statewide, approximately 280 remain in Fee-for-Service (FFS) CBAS.
The annual preliminary CBAS Enrollment data is broken down Quarterly (Table 1 in the Enclosures/Attachments section) for both managed care plan and FFS members in each county of participation. The Annual Report is consistent with all previous reported quarterly data from the managed care plans, along with claims data for FFS enrollment.

Table 1: FFS and MCP Enrollment Data															
	DY10 Q1 Jul - Sept 2014			DY10 Q2 Oct - Dec 2014			DY10 Q3 Jan - Mar 2015			DY10 Q4 Apr - June 2015			DY10 Q5 Jul - Sept 2015		
County	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used
Alameda	8	431	73%	5	490	82%	1	458	76%	0	466	83%	0	24	4%
Butte	32	0	31%	1	42	42%	0	31	31%	0	26	26%	0	0	0%
Contra Costa	6	194	62%	4	201	64%	3	194	61%	2	200	63%	2	206	65%
Fresno	5	661	69%	11	625	66%	6	563	59%	3	619	64%	3	522	54%
Humboldt	113	0	29%	0	105	27%	0	206	53%	0	98	25%	1	106	28%
Imperial	367	0	66%	10	351	65%	0	340	61%	0	177	32%	0	81	14%
Kern	0	110	32%	0	92	27%	0	91	27%	0	96	28%	0	50	15%
Los Angeles	941	16,707	57%	744	17,270	58%	558	17,991	60%	261	18,173	60%	340	18,744	62%
Merced	0	96	52%	0	89	48%	0	90	49%	0	86	47%	0	96	52%
Monterey	0	75	40%	0	83	45%	0	87	47%	0	86	46%	0	78	42%
Orange	6	2,313	70%	1	2,248	68%	3	2,194	66%	1	2,248	68%	0	2,248	68%
Riverside	13	383	37%	14	377	36%	9	392	37%	7	390	37%	7	389	37%
Sacramento	20	544	63%	31	561	66%	17	553	64%	17	575	66%	26	622	72%
San Bernardino	16	456	87%	16	498	95%	6	526	98%	4	539	100%	3	549	102%
San Diego	29	1,873	60%	32	1,530	49%	11	1,453	41%	3	1,762	50%	5	1,776	56%
San Francisco	61	664	49%	63	686	51%	55	657	49%	49	657	48%	56	664	49%
San Mateo	0	151	66%	0	148	65%	0	127	56%	0	155	68%	0	154	67%
Santa Barbara	0	4	4%	0	2	2%	0	3	3%	0	3	3%	0	4	4%
Santa Clara	1	544	39%	5	576	41%	2	500	36%	1	548	39%	1	643	46%
Santa Cruz	0	107	70%	0	112	73%	0	107	70%	0	94	62%	0	96	63%
Shasta	44	0	31%	1	42	30%	1	45	32%	0	44	31%	1	40	28%
Ventura	1	940	65%	9	907	64%	6	899	63%	2	899	63%	0	915	63%
Yolo	1	280	74%	1	274	72%	1	288	76%	0	72	19%	0	81	21%
Marin, Napa, Solano**	0	177	35%	51	94	29%	51	90	28%	0	179	36%	0	158	32%
Total	1,664	26,727	**57%**	**999**	**27,403**	**57%**	**730**	**27,885**	**58%**	**350**	**28,192**	**52%**	**445**	**28,246**	**58%**
Combined Totals	28,391			**28,402**			**28,615**			**28,542**			**28,691**		
										DHCS / CDA Enrollment Data 9/2015					

** Counties with CBAS Center Closure where only one CBAS facility was in the county area; Participants may be served at CBAS Center in another local county

Note: Los Angeles data is an estimate based on previously reported by the managed care plan. It will be reflected on the next quarter's report. Information for October 2015 is currently unavailable due to a delay in the availability of data.

OUTREACH/INNOVATIVE ACTIVITIES:

Stakeholder Process

DHCS and CDA hosted three meetings/webinars in February, March, and April 2015 focused on developing the CBAS Home Community Based Settings transition plan, released a CBAS HCB Settings Transition Plan for public comment in May 2015, and presented the comments and CBAS Plan revisions in July 2015 for incorporation into California's Statewide Transition Plan. DHCS submitted the amended Statewide Transition Plan, including the CBAS Plan, on August 14, 2015 to the Centers for Medicare and Medicaid Services (CMS).[1]

Based on stakeholder input and milestones identified in the CBAS amendment of the BTR Waiver, DHCS and CDA convened two workgroups beginning in July 2015 to develop a CBAS quality strategy and to revise the current CBAS Individual Plan of Care (IPC) emphasizing person-centered planning. The workgroups are comprised of managed care plans, CBAS providers, advocates, and state staff, which are scheduled to meet every other month through June 2016.

OPERATIONAL AND POLICY DEVELOPMENT/ISSUES:

DHCS and CDA continue to work with CBAS providers and managed care plans to provide clarification regarding the CBAS benefit, operational, and policy issues.

Accomplishments

- As of December 1, 2014 Medi-Cal FFS benefits were only available for CBAS members who have an approved medical exemption from enrolling into managed care.

- In December of 2014 the final four rural counties of Shasta, Humboldt, Butte, and Imperial were transitioned to managed care plans that could provide CBAS benefits.

QUANTITATIVE FINDINGS:

Consumer Issues

Complaints:

DHCS regularly monitors and responds to concerns and questions in writing or by telephone. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Issues that generate CBAS complaints are minimal from both members and providers.

[1] Updates and progress on the HCB Settings Transition plan for CBAS can be found at www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB_Settings_Stakeholder_Process

Complaints are collected via telephone and emails directed to CDA (CBAS@dhcs.ca.gov) at an email address provided by DHCS. Data regarding complaints received is summarized in Table 2 and Table 3 below.

Table 2: Data on CBAS Complaints			
Demo Year 10 Quarters	**Member Complaints**	**Provider Complaints**	**Total Complaints**
DY10 - Qrt 1 (Jul 1 - Sep 30)	12	3	15
DY10 - Qrt 2 (Oct 1 - Dec 30)	5	10	15
DY10 - Qrt 3 (Jan 1 - Mar 31)	5	5	10
DY10 - Qrt 4 (Apr 1 - Jun 30)	5	5	10
DY11 - Qrt 1 (Jul 1 - Sep 30)	19	3	22

Note: Information for October 2015 is currently unavailable due to a delay in the availability of data.

Table 3: Data on CBAS Managed Care Plan Complaints			
Demo Year 10 Quarters	**Member Complaints**	**Provider Complaints**	**Total Complaints**
DY10 - Qrt 1 (Jul 1 - Sep 30)	13	3	16
DY10 - Qrt 2 (Oct 1 - Dec 30)	18	2	20
DY10 - Qrt 3 (Jan 1 - Mar 31)	28	1	29
DY10 - Qrt 4 (Apr 1 - Jun 30)	16	2	18
DY10 - Qrt 5 (Jul 1 - Sep 30)	19	3	22

Note: Information for October 2015 is currently unavailable due to a delay in the availability of data.

Grievances and Appeals:

For DY10, CBAS grievances filed with managed care plans were minimal. Per information reported during DY 10, there were a total of eight grievances filed and resolved.

State Fair Hearings are held through the normal State Hearing process, with the California Department of Social Services Administrative Law Judges presiding over all cases filed. As of DY 10, there were nine cases related to Managed Care filed/heard throughout the state. Hearings have typically been related to misunderstandings with Managed Care enrollment.

Quality Assurance/Monitoring Activity

As required under the BTR Waiver, DHCS continues to monitor CBAS Center locations, accessibility, and capacity for access. The data in Table 4 below demonstrates the current CBAS capacity is adequate to service Medi-Cal members in counties with CBAS centers.

County	Table 4: CBAS Centers Licensed Capacity						
	DY10-Q1 Jul-Sep 2014	DY10-Q2 Oct-Dec 2014	DY10-Q3 Jan-Mar 2015	DY10-Q4 Apr-Jun 2015	DY10-Q5 Jul-Sept 2015	Percent Change Between Last Two Quarters	Capacity Used
Alameda	355	355	355	330	**330**	0%	73%
Butte	60	60	60	60	**60**	0%	31%
Contra Costa	190	190	190	190	**190**	0%	62%
Fresno	572	572	572	572	**572**	0%	69%
Humboldt	229	229	229	229	**229**	0%	29%
Imperial	330	330	330	330	**330**	0%	66%
Kern	200	200	200	200	**200**	0%	32%
Los Angeles *	18,284	18,284	18,180	18,238	**18,502**	1%	57%
Marin	75	75	75	75	**75**	0%	22%
Merced	109	109	109	109	**109**	0%	52%
Monterey	110	110	110	110	**110**	0%	40%
Napa	100	100	100	100	**100**	0%	53%
Orange	1,960	1960	1960	1960	**1960**	0%	70%
Riverside	640	640	640	640	**640**	0%	37%
Sacramento	529	529	529	529	**529**	0%	63%
San Bernardino	320	320	320	320	**320**	0%	87%
San Diego	1,873	1,873	2,117	2,068	**2,233**	8%	60%
San Francisco	866	866	866	866	**866**	0%	49%
San Mateo	135	135	135	135	**135**	0%	66%
Santa Barbara	55	55	60	60	**60**	0%	4%
Santa Clara	830	830	830	830	**830**	0%	39%
Santa Cruz	90	90	90	90	**90**	0%	70%
Shasta	85	85	85	85	**85**	0%	31%
Solano	120	120	120	120	**120**	0%	26%
Ventura	851	851	851	851	**851**	0%	65%
Yolo	224	224	224	224	**224**	0%	74%
SUM =	29,192	29,192	30,412	30,396	30,825	0%	57%

CDDA Licenced Capacity as of 09/2015

Note: Data for Los Angeles County is an estimate based on September 2015 data provided the managed care plans. Information for October 2015 is currently unavailable due to a delay in the availability of data.

Table 4 illustrates each county's licensed capacity since the CBAS program became part of the BTR Waiver benefit in April 2012. The table also illustrates that on average, licensed capacity by Medi-Cal and non-Medi-Cal members is 57% statewide. Overall, all of the CBAS Centers have not operated at full capacity. This allows for the CBAS Centers to enroll more managed care and FFS members should the need arise.

STCs 99(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider capacity per county. Since there was no drop in provider capacity of 5% or more in any Quarter, an analysis is not needed.

Unbundled Services

DHCS continues to review any possible impact on participants by CBAS Center closures. Prior to any Center closure, the CBAS Center is required to notify CDA on their planned closure date and to conduct discharge planning for all their CBAS participants. While most CBAS Centers would notify CDA and connect the participants with other local CBAS Centers or community resources, not all CBAS Centers follow this process. Occasionally, Centers will close, shutting their doors without any notification to participants, vendors, or CDA. Unfortunately, CDA finds out too late about the sudden Center closure from CBAS participants or other CBAS Centers in the community.

If there is a CBAS Center closure and CBAS participants are unable to attend another local CBAS Center or if there is insufficient CBAS Center capacity to satisfy the demand, participants can receive unbundled CBAS. These services are typically delivered outside of centers with a similar objective of supporting participants, allowing them to remain in the community. Unbundled services include local senior centers to engage participants in social/recreational activities and group programs, home health nursing and/or therapy visits to monitor health status and provide skilled care, and In-Home Supportive Services (IHSS) through Medi-Cal FFS; or if the member resides in a Coordinated Care Initiative (CCI) County, through the participants Medi-Cal managed care plan.

QUALITATIVE FINDINGS:

DHCS and CDA recently engaged managed care plans and CBAS providers regarding the development of an application process for prospective new CBAS providers. The managed care plan and provider input have been instrumental to the development of a high quality application and certification process for new centers. CDA has begun working with several interested applicants and anticipates receiving applications for new centers in 2016.

UTILIZATION DATA:

DHCS continues to monitor the opening and closing of CBAS centers since April 2012 when CBAS became operational. Nine CBAS Centers closed and six opened between July 2014 and October 2015. For DY 10, CDA had 242 CBAS Centers open and operating in California. Table 5 illustrates the total number of operational CBAS Centers since July 2014 and the number of centers that have been opened and closed since that time.

Table 5: CBAS Center History					
Month	**Operating Centers**	**Closures**	**Openings**	**Net Gain/Loss**	**Total Centers**
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245

While STC 99(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider capacity per county with an analysis that addresses such variance, there was no drop in any DY 10 Quarters to require this analysis.

FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT/ISSUES:

Nothing to report.

CALIFORNIA CHILDREN SERVICES (CCS)

The CCS Program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, and traumatic injuries.

The CCS Program is administered as a partnership between local CCS county programs and the DHCS. Approximately 75 percent of CCS-eligible children are Medi-Cal eligible.

The pilot project under the 1115 Bridge to Reform Waiver focused on improving care provided to children in the CCS Program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction and greater cost effectiveness, by integrating care for the whole child under one accountable entity. The positive results of the project could lead to improved care for all 185,000 children enrolled in CCS.

The project is a component of the Bridge to Reform's goal to strengthen the state's health care delivery system for children with special health care needs. The pilot projects will be evaluated to measure effectiveness of a system of care that treats the whole child, not just the CCS condition. Results of the evaluation may be used for CCS program improvements statewide or in specific counties.

Under a competitive bid contracting process utilizing a Request for Proposals (RFP) document, DHCS with the input of the CCS stakeholder community solicited submission of proposals to test four specific health care delivery models for the CCS Program. These included an existing Medi-Cal Managed Care Organization (MCO); a Specialty Health Care Plan (SHCP); an Enhanced Primary Care Case Management Program (E-PCCM); and an Accountable Care Organization (ACO). DHCS received five proposals. There have been significant challenges with implementation in three of the five pilot projects, which did not have a start date at the end of DY 10. These challenges are discussed in detail later in this report. In addition to HPSM, it is anticipated DHCS will contract with Rady Children's Hospital of San Diego (RCHSD), an Accountable Care Organization.

ACCOMPLISHMENTS:

Program Timeline

Date	HPSM Pilot Action Items
April 2014 (bi-weekly) – Ongoing	DHCS and HPSM conduct bi-weekly conference calls to discuss various issues in the CCS DP operational phase (i.e. financial/accounting, information technology, and other deliverables)
July 2014 – September 2014	DHCS implemented the annual Member Survey
October 17, 2014	DHCS performed an in-person facility site visit with both HPSM and San Mateo County (SM County) to satisfy the operational review component
November 25, 2014	HPSM began to enroll children into the pilot with eligibility codes 7U, 7W, and K1
March 19, 2015	HPSM received an executed Contract Amendment A01 from DHCS; addressed retroactive rate adjustments, carve-out of specific coagulation factor products; redefined definition of other health coverage; and correction of contract term
May 7, 2015	HPSM executed an updated Memorandum of Understanding (MOU) with SM County
July – August 2015	HPSM initiated a Youth Committee within the Demonstration Project Advisory Committee (DPAC)
July 2015 – Pending	Drafted Contract Amendment A02, which includes; exercise of one year option to extend contract per Request for Proposal and increase the total budget to compensate the Contractor for continuing to perform services for an additional year. Contract amendment is anticipated to be finalized during DY11
Date	**RCHSD Pilot Action Items**
July 2013 – October 31, 2015	DHCS reviewed 63 RCHSD deliverables [Policies and Procedures (P&Ps)]. Rate setting and contract language in development
March 13, 2014 – Ongoing	DHCS and RCHSD participated in weekly conference calls to discuss and resolve contract, P&Ps, and various other issues

November 4, 2014	DHCS and RCHSD held an in-person meeting in San Diego
November 6, 2014	DHCS developed and sent RCHSD another Data Library Confidentiality Data Use Agreement (DUA) which allowed DHCS to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
November 25, 2014	RCHSD returned a signed and dated DUA
December 11, 2014	DHCS returned to RCHSD a fully executed DUA
December 30, 2014	DHCS and RCHSD held an in-person meeting in San Diego
March 18, 2015; April 27, 2015	DHCS released initial and revised cost utilization data to RCHSD for analysis and rate discussion
July 2015 – Pending	Financial – Rates by DHCS's Capitated Rates Development Division (CRDD) for RCHSD CCS DP are in development
September 2015 – Pending	RCHSD in preliminary stages of contracting with a pharmaceuticals benefits manager (PBM) to process claims
Anticipated Winter 2016	RCHSD CCS DP to be operational, pending approval from CMS of rates and contract
Committees / Advisory Groups / Stakeholders Meetings	
September 2014 – October 2015 (Quarterly)	CCS Executive Committee Meetings
September 11, 2014; February 11, 2015; May 20, 2015; July 22, 2015; and October 14, 2015	DHCS 1115 Waiver Stakeholder Advisory Committee (SAC) Meetings
July 25, 2014 (Kick-Off Webinar); August 8, 2014 (Stakeholder Process); September 26, 2014 (Webinar); December 2, 2014; January 23, 2015; March 20, 2015; May 29, 2015 (Webinar); June 22, 2015; and July 17, 2015	CCS Redesign Stakeholder Advisory Board (RSAB) Meetings

October 21, 2015	CCS Advisory Group (AG) Meeting

The milestones listed below were achieved during DY 10 (July 1, 2014 through October 31, 2015).

HPSM CCS DP

- July 2014 – September 2014: DHCS implemented a Member Survey for DHCS's use to improve services provided to CCS clients and to determine how the CCS DP is functioning for CCS clients. DHCS contacted 385 HPSM families.

- October 17, 2014: DHCS performed an in-person facility site visit with both HPSM and SM County to satisfy the operational review component.

- March 19, 2015: HPSM received an executed contract amendment to address retroactive rate adjustments, carve-out of specific coagulation factor products; redefined definition of other health coverage; and correction of contract term.

- May 7, 2015: HPSM executed a revised MOU with SM County.

- July 2015 – August 2015: HPSM implemented a Youth Committee within the CCS Demonstration Project Advisory Committee (DPAC) to gain a greater understanding of issues that are important to youth and young adults.

- October 1, 2015: 9D Aid Code activated for CCS-Only population for proposed HPSM CCS DP enrollment.

RCHSD CCS DP

- November 4, 2014: DHCS and RCHSD held an in-person meeting in San Diego.

- November 6, 2014: DHCS developed and sent RCHSD another Data Library Confidentiality Data Use Agreement (DUA) which allows DHCS to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements.

- November 25, 2014: RCHSD returned to DHCS a signed DUA that allows DHCS to release cost utilization data to the Demonstration contractor.

- December 11, 2014: DHCS fully executed a DUA that allows DHCS to release cost utilization data to the Demonstration contractor.

- December 30, 2014: DHCS and RCHSD held an in-person meeting in San Diego.

- March 18, 2015: DHCS released cost utilization data to RCHSD for analysis and rate discussion.

- April 27, 2015: DHCS released additional cost utilization data to RCHSD for analysis and rate discussion.

- June 2015: DHCS informed RCHSD that they would be required to cover and process all pharmaceuticals claims for the CCS DP.

- November 2014 - September 2015: DHCS and RCHSD were in discussions regarding appropriate evaluation metrics during operations of the CCS DP.

- September 2015: RCHSD in preliminary stage of contracting with a PBM.

- July 2014 - September 2015: DHCS continued to negotiate and finalize contract language.

- July 2014 - September 2015: DHCS continued a comprehensive review, analysis, and evaluation of RCHSD ability to implement services to proposed members of the CCS DP.

PROJECT STATUS:

HPSM - Evaluation Design and Implementation

During DY10/Q2, DHCS analyzed the results from the Member Survey that was administered to HPSM CCS DP families. On April 1, 2015, DHCS shared the results of the Member Survey with HPSM. HPSM responded to DHCS on April 17, 2015, with feedback regarding the results of the Member Survey. Feedback from HPSM consisted of the following:

- Commendable that the Member Survey obtained 379 participants. Participation could have been higher if the Member Survey did not coincide at the same time the Title V Needs Assessment survey was also conducted.

- Concern regarding a question, "Were you ever contacted by the HPSM or someone else to let you know about having a case manager?" HPSM believes the low response rate is due to CCS members knowing their case manager as their "nurse" and that the inclusion of the word "nurse" would provide a higher "Yes" response.

- Another concern was the high proportion of respondents stating they had not received the member handbook (MH) from HPSM. HPSM stated they would explore ways to increase awareness of the MH and the information contained within it.

HPSM – Contract Amendments

Contract amendment A01 was executed on March 19, 2015. The amendment addressed the following: retroactive capitated rate adjustments, carve-out of a specific coagulation factor products; redefined definition of other health coverage; and correction of contract term to a period of three (3) years with two (2) one-year (1-year) options to extend the term. The rates adjustment covered the time periods from April 1, 2013 through June 30, 2015 and reflects the following: Elimination of the inpatient provider payment reduction, AB 1422, AB 78, ACA 1202, mental health benefits, increased case management costs, and Hepatitis C payments.

HPSM contract amendment A02 is in process during DY10/Q5. This amendment is to extend the contract one year as allowed by Request for Proposal #11-88024; and to increase the total budget to compensate the Contractor for continuing to perform services for an additional year.

HPSM contract amendment A03 is being drafted to adjust Fiscal Year (FY) 2015/2016 rate and revise FY 2014/2015 rate due to overestimated assumptions, add CCS State-only population and is pending recommended HPSM contract changes. The contract amendment is estimated to be finalized Spring 2016.

Executed MOU – HPSM and SM County

HPSM executed a MOU with SM County on May 7, 2015 and forwarded a copy to DHCS on May 28, 2015. The MOU between HPSM and SM County was not updated prior to HPSM CCS DP operational date April 1, 2013.

HPSM – Utilization Management

HPSM has improved access to care by eliminating pre-authorization of routine CCS and non-CCS services for Lucile Packard Children's Hospital, which provides medical services to approximately 80% of CCS DP members; unburdening the SM County staff's time which can be redirected to focusing on a member's care coordination.

HPSM – Department Communications

DHCS and HPSM conduct bi-weekly scheduled conference calls to discuss various issues, inclusive to those related to financials, information technology, and deliverable reporting.

On October 17, 2014, DHCS conducted site visits with HPSM and SM County for a review of the CCS DP. This site review addressed the main goals of the CCS DP, which focused on care coordination, medical home, and family-centered care.

Discussions focused on what was working well and what were challenges with the CCS DP. Overall the program was working well.

RCHSD CCS DP

RCHSD – Performance Measurement

On November 6, 2014, RCHSD submitted proposed evaluation metrics that included initial outcomes, clinical measures, and interventions to identify baseline data. On January 15, 2015, RCHSD provided a draft of clinical measures proposed to be evaluated during the course of the demonstration. Clinical measures will include two specific measures for each of the five conditions upon which eligibility is based. On September 21, 2015, RCHSD provided additional feedback and recommendations to the requirements. These are currently being reviewed by DHCS.

RCHSD – Weekly Conference Calls

DHCS and RCHSD continue to participate in weekly conference calls. Since March 13, 2014, DHCS has been collaborating with RCHSD and the local CCS Program regarding implementing the RCHSD CCS DP. Discussions have taken place around contract documents (SOW, reporting requirements, etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination, and transition of the CCS population from a fee-for-service based system to a capitated model.

RCHSD - Capitation Rates

Since July 2015, DHCS's CRDD continued to work with actuaries on rate development and risk corridor contract language. Concerns that affect rate derivation regarding drug pricing and pharmacy access have been resolved, and data discrepancies have been validated. Updated rates are being prepared and are expected to be shared with RCHSD in early November 2015.

RCHSD – Contract

On July 2, 2014, RCHSD returned comments on contract Exhibit A: SOW to DHCS. DHCS proposed revised language to RCHSD on August 21, 2014. On September 18, 2014, RCHSD submitted their comments on contract Exhibits B: Budget Detail and Payment Provisions, D(F): Special Terms and Conditions, E: Additional Provisions, and G: HIPAA Business Associate Addendum (BAA). As of December 2014, contract terms being discussed included: clarification of provisions in Exhibit E such as data certification, appeals process, financial working papers, and Exhibit B for the catastrophic coverage limitation provision. During DY10/Q3, contract discussions continued and included: data certification, appeals process, financial working papers, plan versus provider, and clinical evaluation. DY10/Q4, multiple requests have been received from RCHSD for a number of changes to the contract and Exhibit G. DHCS's Privacy Office (PO) and Information Security Office (ISO) have been consulted to review the requested changes to Exhibit G during the reporting period. On July 13,

2015, DHCS provided to RCHSD a draft contract packet (including SOW, Exhibit B, and Exhibit E). On August 24th, DHCS provided Exhibit G: HIPAA BAA Department standards for RCHSD consideration, which included approved edits by both DHCS's PO and ISO. On August 28th, an updated version of Exhibit E: Additional Provisions were approved/accepted by both DHCS and RCHSD.

RCHSD – 60-Day and 30-Day Notices

DHCS forwarded draft 60- and 30-Day notices (for patients, providers, and the GMC plans) to DHCS for review on September 8, 2015. These notices will be used to communicate the disenrollment of eligible CCS DP clients from five Geographic Managed Care (GMC) plans into RCHSD CCS DP. Content within the notices consist of the following:

- Announcement of the pilot to a CCS Member enrolled in a GMC Plan;
- Pilot coordinates health care services for five medical conditions [Hemophilia, Cystic Fibrosis, Sickle Cell, Diabetes Type I and II (age 1-10 years), and Acute Lymphoblastic Leukemia];
- No changes to member's health, dental, or vision coverage and the choice to retain current medical doctor;
- Enhanced benefits (coordination of health care, community referrals, parenting resources, and education using a family centered approach);
- Date of automatic enrollment and health benefit covers would occur;
- Receipt of an identification card for doctor visits, pharmacy, and hospital; and
- Phone number for questions.
-

The member and provider notice will be coordinated with the Medi-Cal Managed Care Division.

RCHSD Readiness Review Deliverables

On July 2, 2014, RCHSD began submitting, for DHCS's review and approval, their P&Ps as indicated in the Readiness Review document.[2] By September 30, 2014, of the 67 required deliverables, 37 were approved, 20 denied, 9 needed review, and 1 was not submitted. By December 24, 2014, 52 deliverables were approved, 8 denied, and 7 needed review. By October 31, 2015, 63 deliverables had been approved by DHCS.

[2] DHCS developed a Readiness Review Deliverables Matrix (Matrix) tool, which was originally used with the HSPM CCS DP. This Matrix includes both outreach and readiness tools to operationalize RCHSD CCS DP. The Matrix lists deliverables that the RCHSD pilot needs to submit to DHCS prior to going live. These P&Ps ensure that the RCHSD CCS DP has safeguards in place for access to care and family centered care practices. DHCS gave RCHSD the Readiness Review document in Summer/Fall 2013.

RCHSD has pursued partnerships with several PBM firms; however, this was a challenge due to PBMs' reluctance to contract for services with an initial small population size. On September 1, 2015, RCHSD submitted to DHCS MedImpact's provider directory to be reviewed by DHCS's pharmacist. As of September 21, 2015, RCHSD submitted to DHCS a Letter of Intent from MedImpact Healthcare Systems, Inc. (MedImpact) to be their PMB.
DHCS reviewed and provided comments to RCHSD's MH on July 10, 2014. RCHSD submitted to DHCS the revised MH on November 12, 2014. On December 11, 2014, DHCS returned the MH delineating corrective items needed per the SOW requirements. RCHSD submitted three (3) drafts of the MH during DY10/Q3. On June 25, 2015, RCHSD provided DHCS a revised draft (version 7) of the MH and DHCS at the end of July 2015 provided comments. Currently, RCHSD is holding onto the MH until the pharmacy/pharmaceutical component is resolved. It is anticipated the MH will be finalized early 2016.

RCHSD developed their Provider Manual during the months July through December 2014 to satisfy a Readiness Review component. RCHSD submitted to DHCS the Provider Manual during the last week of January 2015 and DHCS provided comment to RCHSD in February 2015. RCHSD continues to develop the Provider Manual and submitted the Provider Manual (version 3) to DHCS on August 12, 2015 for review. In September 2015, DHCS provided some recommended changes to the Provider Manual and on November 2, 2015, DHCS completed the review and supplied additional recommendations. Significant pending items include grievance and appeals process and enhancement of the pharmacy section.

During DY10/Q2, RCHSD continued development of their Site Review Tool to satisfy a Readiness Review component. Discussions within DY10/Q3 decided that RCHSD would collaborate with Healthy San Diego (HSD) Site Review Committee to satisfy the review Readiness Review requirement. As of DY10/Q4, a Memorandum of Agreement (MOA) was drafted for HSD's review. HSD agreed for RCHSD to participate in the review process.

As of July 2015, RCHSD Information Technology (IT) verified they could accept a "test" eligibility member file and ensured the infrastructure worked appropriately. RCHSD requested a modification to the eligibility file, to utilize an existing column in the eligibility table, and to convert into a diagnosis column not currently captured in the eligibility table. Due to system limitations this request was denied, however San Diego County CCS staff (SD County) agreed to provide a separate report once operations begin and will include the needed data.

<u>RCHSD – Site Visit</u>

On November 4, 2014, DHCS met with RCHSD and SD County representatives. The discussion topics with RCHSD follow: Rates (pharmacy, risk corridor, data for the conditions); County Administration Allocation fund (components of the administration

rate, responsibilities that would remain with SD County, and duties that would transfer to RCHSD under the CCS DP); contract language (letter of credit, disclosure statements for subcontractors); authorization process for carved-out services (pharmacy, mental health, etc); 60 and 30-Day notices; evaluation metrics (review metrics, cohort study time window, patient survey); and catastrophic cases unrelated to CCS conditions. SD County discussion topics included a CCS DP update, administration fee, authorization processes for carve-outs, and clarification of roles (eligibility and enrollment, potential authorizations for pharmacy); metrics/evaluation review; and mini Sickle-Cell pilot.

DHCS met with SD County representatives on December 30, 2014 and discussed the SD County Administration Allocation fund; health plan MOA; San Diego CCS Pre- and Post-Assessment/Evaluation; and CCS Tools [i.e., Frequently Asked Questions (FAQs)].

QUANTITATIVE FINDINGS:

Enrollment

The monthly enrollment for HPSM CCS DP is reflected in the table below. Eligibility data is extracted from the Children's Medical Services Network (CMSNet) utilization management system and is verified by the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to HPSM. HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference Prior Month	Month	HPSM Enrollment Numbers	Difference Prior Month
July 2014	1,472		March 2015	1,302	-1
August 2014	1,457	-15	April 2015	1,276	-26
September 2014	1,435	-22	May 2014	1,250	-26
October 2014	1,413	-22	June 2015	1,199	-51
November 2014	1,405	-8	July 2015	1,158	-41
December 2014	1,421	16	August 2015	1,125	-33
January 2015	1,364	-57	September 2015	1,086	-39
February 2015	1,303	-61	October 2015	1,050	-36

Aid Codes

Effective August 1, 2014, 27 additional enrollment aid codes[3] were available for HPSM's use in the enrollment of children into the CCS DP. HPSM CCS DP began enrolling children into the pilot with "foster care" eligibility codes 7U, 7W, and K1. The effective date for these codes was November 25, 2014.

Financial/Budget

DHCS implemented an aid code which will allow CCS State-Only children to enroll in the CCS DPs. This will permit all CCS eligible children in the health plan's catchment area to enroll in the CCS demonstration in SM County. Enrollment in the CCS demonstration is expected in 2016. The 9D aid code for "CCS State-Only beneficiaries" was activated October 1, 2015.

QUALITATIVE FINDINGS:

CCS Redesign Stakeholder Advisory Board

DHCS implemented a stakeholder process to investigate potential improvements or changes to the CCS Program. A CCS Redesign Stakeholder Advisory Board (RSAB) composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for children with special health care needs, was assembled to lead this process. The CCS RSAB process was completed in July 2015. The CCS Program Redesign website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.aspx
RSAB meeting dates and topics follow:

- July 25, 2014, a "Kick-off" Webinar and focused on the Medi-Cal 1115 Waiver Renewal and CCS Program improvements.
- December 2, 2014, first meeting and the focus was on: Developing a Roadmap for the CCS Redesign Process; Current Trends in CCS; and Existing Models of Care in CCS.
- January 23, 2015, second meeting and the focus was on the "Formation of Technical Workgroups".
- March 20, 2015, third meeting and the focus was on the "CCS Models of Care".
- May 29, 2015, RSAB held a webinar and the focus was on the "CCS Program Improvement Process and Technical Workgroups Updates".
- June 22, 2015, fourth meeting and the focus was on "Whole-Child Model".
- July 17, 2015, final meeting and the focus was on "Whole-Child Model".

[3] As of January 1, 2014, a list of new Affordable Care Act (ACA) aid codes became available for HPSM's use in the enrollment of children into the CCS DP.

Technical workgroups (TWG) were identified to address key programmatic issues such financing, county interface, health care delivery option development, quality of care measures, etc. TWG conference calls were held for the following:

- County / State Roles and Responsibilities TWG – March 25, 2015
- Data TWG – February 20, 2015; March 17, 2015; May 8, 2015
- Eligibility / Health Conditions TWG – March 12, 2015
- Health Homes / Care Coordination / Transitions TWG – March 26, 2015
- Outcomes TWG – April 10, 2015; May 7, 2015
- Provider Access and Provider Network TWG – March 18, 2015

Materials from the TWGs are available at the website links below:

- http://www.dhcs.ca.gov/services/ccs/Pages/DataTechnicalWorkgroup.aspx
- http://www.dhcs.ca.gov/services/ccs/Pages/EligibilityandHealthCondition.aspx
- http://www.dhcs.ca.gov/services/ccs/Pages/OutcomeMeasures.aspx
- http://www.dhcs.ca.gov/services/ccs/Pages/ProviderAccess.aspx
- http://www.dhcs.ca.gov/services/ccs/Pages/CountyStateRoles.aspx
- http://www.dhcs.ca.gov/services/ccs/Pages/HealthHomeCare.aspx

CCS Advisory Group

DHCS continued stakeholder discussions on CCS Program improvements by transitioning the RSAB group to an ongoing CCS Advisory Group (AG). The CCS AG was formed to continue DHCS's commitment to engaging stakeholders in program changes and improvements, including improvement of the delivery of health care to CCS children and their families through an organized health care delivery system. DHCS developed a "Whole-Child Model" to be implemented in specified counties, no sooner than January 2017.

The CCS AG meets quarterly in Sacramento; in addition to the AG, three topic-specific TWGs have been formed.

The CCS AG website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

The CCS AG held its first meeting on October 21, 2015 and was comprised of the following topics:

- Follow-Up from Previous Meeting, Key Updates, AB 187, and Future Meetings' Topics/Goals;
- Care Coordination / Medical Home / Provider Access Technical Workgroup Update;
- Los Angeles County Update on Case Management Redesign;
- Partnership HealthPlan of California Care Coordination; and

- Data & Quality Measures Technical Workgroup Update, Available Statewide Data, and County CCS Measures.
-

Meeting materials link:
http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsOct21.aspx

Materials from the TWGs are available at the website links below:

- Data and Quality Measures TWG – September 29, 2015; http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsSep.aspx

- Care Coordination / Medical Home / Provider Access TWG – October 9, 2015 http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsOct.aspx

UTILIZATION DATA:

On August 14, 2014, DHCS performed a utilization snapshot for RCHSD which included conditions by identifying the ICD-9 codes. On August 21, 2014, aggregate cost information was given to RCHSD per their request from DHCS, the number of claims, number of hospitalizations and number of Emergency Room visits. In addition, DHCS worked on utilization data for RCHSD, which was broken out by "pharmacy" with units and "visits" types. This utilization data was sent to RCHSD on September 8, 2014. RCHSD requested from DHCS a more current Capitation Rate Data Library.[4] DHCS required RCHSD CCS DP to conform to stringent HIPAA security requirements prior to receiving any cost utilization data.[5] On November 6, 2014, DHCS developed and sent RCHSD another Capitation Rate Data Library Confidentiality DUA to be reviewed and signed; which would allow DHCS to release cost utilization data for three (3) FYS, FY 2011 to 2012 through FY 2013 to 2014 for the following conditions: Sickle Cell, Cystic Fibrosis, Hemophilia, and the additions of Acute Lymphoblastic Leukemia (A.L.L.), and Diabetes Type I and II [ages 1-10 yrs. of age (Diabetes)]. The DUA was signed by RCHSD and returned to DHCS on November 25, 2014. DHCS returned to RCHSD an executed DUA on December 11, 2014.

[4] On July 15, 2013, DHCS originally released cost utilization data to RCHSD for analysis and rate discussion for FY 2009–2010 through FY 2011-2012 and the conditions Sickle Cell, Cystic Fibrosis, and Hemophilia.

[5] In March 2013 and June 2013, the Office of HIPAA Compliance requested DHCS develop both a Capitation Rate Data Library Confidentiality DUA (an administrative vehicle required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk) and an Addendum (addressed several items missing from the original DUA).

On March 18, 2015, DHCS released cost utilization data to RCHSD for analysis. Subsequently, on April 27, 2015, DHCS released revised cost utilization data to RCHSD for analysis.

HPSM CCS DP has been submitting to DHCS quarterly report deliverables, entitled "Enrollment and Utilization" Table. Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
4/1/2013 – 6/30/2013	0	1,474	116	1,358	3,951
7/1/2013 – 9/30/2013	1,358	140	130	1,368	4,093
10/1/2013 – 12/31/2013	1,368	241	119	1,490	8,382
1/1/2014 – 3/31/2014	1,490	108	129	1,469	12,786
4/1/2014 – 6/30/2014	1,469	86	115	1,440	17,166
7/1/2014 – 9/30/2014	1,440	198	99	1,539	4,492
10/1/2014 – 12/31/2014	1,539	150	122	1,567	9,080
1/1/2015 – 3/31/2015	1,567	28	67	1,528	13,660
4/1/2015 – 6/30/2015	1,555	176	135	1,596	18,391

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

DHCS continued to collaborate with CCS DP entities relative to issues and challenges specific to each of the model locations. Challenges vary among the demonstration models but include: determination of the target population, determination of disease specific groups, general organizational structure, reporting requirements, rate development, etc.

The following three pilot models will not be implemented:

- Los Angeles Care Health Plan (LA Care)
- Children's Hospital of Orange County (CHOC)
- Alameda County Health Care (Alameda)

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EVALUATION:

During the months of July through September 2014, DHCS developed an administered a Member Survey to HPSM CCS DP families. Of the 855 HPSM families DHCS attempted to contact by telephone, 379 families were reached and participated in the survey (44%). The survey objective was to assess the families' knowledge and satisfaction of the CCS DP, their knowledge and satisfaction with their care coordinator, their access and satisfaction with providers, and their satisfaction with the medical services provided. This Member Survey will help DHCS improve the services provided to CCS clients and to determine how the CCS DP is working for clients enrolled within the CCS DP.

ENCLOSURES/ATTACHMENTS:

Attached enclosures 1) "California Children's Services (CCS) Member Months and Expenditures" consisting of *Number of Member Months in a Quarter, Number of Unique Eligibles Based on the First Month of Eligibility in the Quarter,* and *Expenditures Based on Month of Payment*. 2) "Health Plan of San Mateo: Plan Analysis" consisting of *Administrative Costs, Profit Margin,* and *Medical Loss Ratio*.

FULL-SCOPE PREGNANCY EXPANSION

The full-scope pregnancy expansion was accomplished by a combination of both a State Plan Amendment (SPA) and the 1115 Waiver. The pregnant women covered by this expansion are provided the same coverage and are included in this progress report.

On August 1, 2015, the Department of Health Care Services's Title XIX SPA 14-021 and 1115 Demonstration Waiver were approved by the Centers for Medicare and Medicaid Services (CMS). The SPA 14-021 increased the income limit for full scope Medi-Cal for pregnant women with satisfactory citizenship/immigration status and incomes above 60 percent of the Federal Poverty Level (FPL) up to and including 109 percent of the FPL. The 1115 Demonstration Waiver amendment expanded the full scope Medi-Cal for pregnant women with satisfactory citizenship/immigration status and incomes over 109 percent of the FPL up to and including 138 percent of the FPL.

Expanding the FPL income eligibility of full scope Medi-Cal for pregnant women up to and including 138 percent FPL provided eligibility equitable with the new adult coverage groups under the Affordable Care Act.

ACCOMPLISHMENTS:

An All-County Welfare Directors Letter 15-35 provided guidance to counties on the full scope pregnancy expansion.

The full scope pregnancy expansion was integrated into California's single application ensuring all applicants are assessed for this expanded coverage group.

PROJECT STATUS:

In September of 2015, an informational letter was sent to current beneficiaries in pregnancy-related Medi-Cal with incomes above 60 percent and up to and including 138 percent of the FPL. These beneficiaries were notified that they are now eligible for full-scope Medi-Cal coverage and informed of their choice of coverage options.

QUANTITATIVE FINDINGS:

Enrollment

As of November 2015, over 22,000 pregnant women are enrolled in California's full scope pregnancy Medi-Cal program, which is an increase of approximately 70 percent from the average number (13,000) enrolled prior to the expansion on August 1, 2015.

Financial/Budget Neutrality Development/Issues

California expects this expansion to be budget neutral.

QUALITATIVE FINDINGS:

No significant consumers issued have been identified.

No quality assurance testing has been completed due to the recent CMS approval of this expansion. However, DHCS formed a stakeholder workgroup to support the implementation and monitoring of this expansion.

UTILIZATION DATA:

No data available at this time.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THIS DEMONSTRATION:

Nothing to report.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

DMC-ODS will provide an evidence-based benefit design covering the full continuum of care, requiring providers to meet industry standards of care, a strategy to coordinate and integrate across systems of care, create utilization controls to improve care and efficient use of resources, reporting specific quality measures, ensuring there are the necessary program integrity safeguards and a benefit management strategy. The DMC-ODS; will allow counties to selectively contract with providers in a managed care environment to deliver a full array of services consistent with the American Society of Addiction Medicine (ASAM) Treatment Criteria, including recovery supports and services. As part of their participation in the DMC-ODS, CMS requires all residential providers to meet the ASAM requirements and obtain a DHCS issued ASAM designation. The DMC-ODS waiver includes residential treatment service for all DMC beneficiaries in facilities with no bed limit.

ACCOMPLISHMENTS:

Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on four key areas: access, quality, cost, and integration and coordination of care. The evaluation design report was sent to CMS on October 13, 2015.

On October 22, 2015, DHCS hosted a DMC-ODS stakeholder webinar.

On October 28, 2015, DHCS hosted a Region 2 Implementation Meeting.

On December 8, 2015, DHCS hosted a Follow-up Region 2 Implementation Meeting.

PROJECT STATUS:

The state DMC-ODS implementation is occurring in five phases, (1) Bay Area, (2) Kern and Southern California, (3) Central and Northern California, (4) Northern California and (5) Tribal Partners. The Department of Health Care Services is currently assisting phase two and have received a total of four implementation plans from: San Francisco, San Mateo, Riverside, and Santa Cruz. These four counties' Implementation Plans are currently in review by DHCS and CMS.

The state will monitor the counties at least once per year through the External Quality Review Organizations (EQRO). If significant deficiencies or significant evidence of noncompliance with the terms of this waiver, the county implementation plan or the state/county intergovernmental agreement are found in a county, DHCS will engage the county to determine if there challenges that can be addressed with facilitation and

technical assistance. If the county remains noncompliant, the county must submit a corrective action plan (CAP) to DHCS.

QUANTITATIVE FINDINGS:

Enrollment (Anticipated Number of Medi-Cal Beneficiaries)

- *San Francisco*
  San Francisco Health Network – Behavioral Health Services (SFHN-BHS) estimates that 24,293 Medi-Cal beneficiaries would meet DSM 5 SUD diagnosis/medical necessity criteria for DMC-ODS Pilot treatment services.

- *San Mateo*
  San Mateo Behavioral Health and Recovery Services (BHRS) projects between 16,756 to 12,154 Medi-Cal beneficiaries have a SUD and could benefit from treatment.

- *Riverside*
  The estimated utilization of services by DMC beneficiaries is 7,000 non-duplicated clients across treatment modalities.

- *Santa Cruz*
  The number of Medi-Cal beneficiaries who will seek DMC-ODS services is estimated to range between 1,588 and 2,602, based on two estimation methods, including 1) extrapolating from a 2013 Mercer study on DMC prevalence and penetration rates that was used by the Department of Finance to estimate DMC expansion costs under AB1X; and 2) extrapolating from the DHCS California Mental Health and Substance Abuse Needs Assessment (2012) and the National Survey on Drug Use and Health (NSDUH) (SAMHSA, 2013).

QUALITATIVE FINDINGS:

Nothing to report.

UTILIZATION DATA:

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THIS DEMONSTRATION:

Nothing to report.

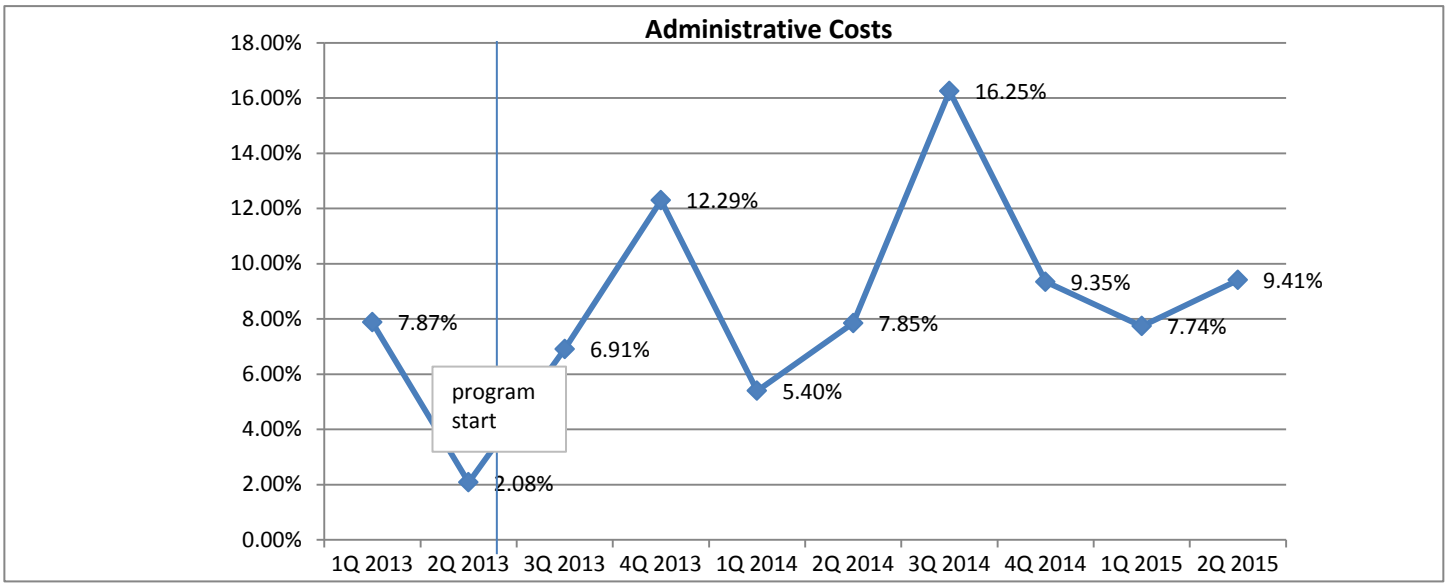
California Department of Health Care Services
California Children's Services (CCS) Member Months and Expenditures
February 18, 2016

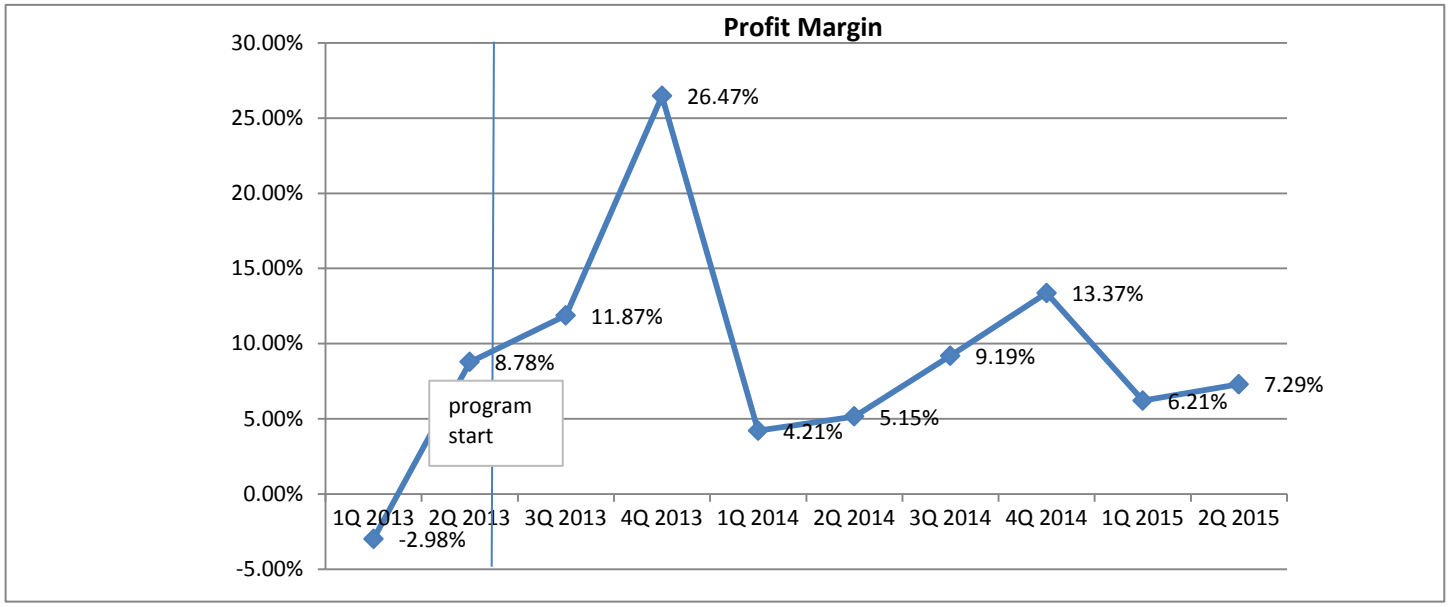
Report Number	Time Period	Number of Member Months in a Quarter	Number of Unique Eligibles Based on the First Month of Eligibility in a Quarter	Expenditures Based on Payment Quarter
DY10, Q1	July – September 2014	475,580	159,907	$502,279,988
DY10, Q2	October – December 2014	464,486	155,234	$532,522,997
DY10, Q3	January – March 2015	464,669	154,707	$538,714,500
DY10, Q4	April – June 2015	468,653	155,614	$559,866,609
DY10, Q5	July – September 2015	474,581	157,258	$522,835,563

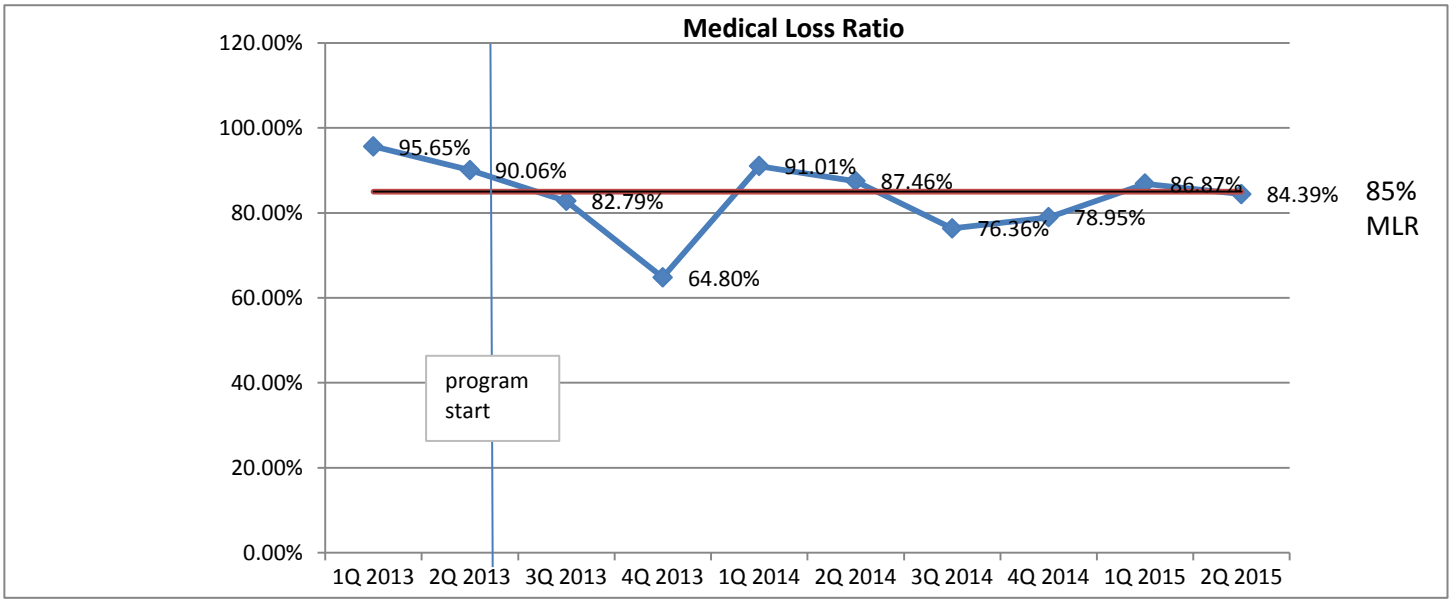
Note: Since payments are based on date of payment, this data cannot be used to calculate cost per member per month.

- California Children Services – Excludes CCS State-Only and CCS Title XXI Individuals
- Expenditures and Eligibles by Specific Time Periods
- Eligibility Sources: CCS/Genetically Handicapped Persons Program (GHPP) Eligibility Table on MIS/DSS for Active CCS Clients with a Medi-Cal Aid Code.
- Expenditure Source: MIS/DSS (Age between 0 and 20, Claim Source Code = 19 EDS Fee-For-Service Medi-Cal)

Department of Health Care Services - Systems of Care Division
Health Plan of San Mateo (Consolidated): Plan Analysis







Department of Health Care Services - Systems of Care Division
Health Plan of San Mateo (Consolidated): Plan Analysis

	March 31, 2013 (1st Qtr. 2013)*	June. 30, 2013 (2nd Qtr. 2013)	Sept. 30, 2013 (3rd Qtr. 2013)	Dec. 31, 2013 (4th Qtr. 2013)	March 31, 2014 (1st Qtr. 2014)	June 30, 2014 (2nd Qtr. 2014)	Sept. 30, 2014 (3rd Qtr. 2014)	Dec. 31, 2014 (4th Qtr. 2014)	March 31, 2015 (1st Qtr. 2015)	June 30, 2015 (2nd Qtr. 2015)
Administrative Costs										
Total Administration Costs	9,266,617	2,069,427	7,214,292	15,812,170	8,127,606	10,505,324	28,678,273	18,605,651	16,944,834	18,308,167
Total Expenses	117,681,157	99,532,752	104,432,238	128,641,718	150,565,318	133,834,502	176,481,329	199,091,784	219,042,683	194,654,760
	7.87%	2.08%	6.91%	12.29%	5.40%	7.85%	16.25%	9.35%	7.74%	9.41%
Profit Margin										
Net Income (Loss)	(3,406,972)	9,581,603	14,065,669	46,312,121	6,616,735	7,270,850	17,858,102	30,714,220	14,497,151	15,314,525
Total Revenue	114,274,185	109,114,355	118,497,907	174,953,838	157,182,053	141,105,352	194,339,432	229,806,004	233,539,834	209,969,285
	-2.98%	8.78%	11.87%	26.47%	4.21%	5.15%	9.19%	13.37%	6.21%	7.29%
Medical Loss Ratio										
Total Medical and Hospital Exp.	108,414,540	97,463,324	97,217,946	112,829,548	142,437,712	123,329,178	147,803,057	180,486,133	202,097,849	176,346,594
Total Revenue (Adjusted) **	113,346,609	108,225,674	117,431,466	174,115,113	156,500,731	141,008,296	193,561,224	228,613,520	232,640,473	208,966,706
	95.65%	90.06%	82.79%	64.80%	91.01%	87.46%	76.36%	78.95%	86.87%	84.39%

*Calculated Amount: Annual less three other quarters (financials not available for this qtr.)

** Total Revenue Minus Interest, Misc. Other Income, and Third Party Administrator Income