State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
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December 9, 2014

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 07-01-2014 THROUGH 09/30/2014 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Mr. Pellanda, Ms. Hossain, and Ms. Lee:

Enclosed is the Quarterly Progress Report required by Paragraph 20 and Attachment I of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the first quarterly progress report for Demonstration Year Ten, which covers the period from July 1, 2014 through September 30, 2014.

If you or your staff have any questions or need additional information regarding this report, please contact Danielle Stumpf at (916) 324-9457.

Sincerely,

[redacted]

Toby Douglas
Director

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TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Nine (07/01/13-06/30/14)
Fourth Quarter Reporting Period: 04/01/2014-06/30/2014

INTRODUCTION:

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 the Department of Health Care Services (DHCS) to implement changes to the federal Section 1115 (a) Comprehensive Demonstration Project Waiver titled, *Medi-Cal Hospital/Uninsured Care Demonstration (MCH/UCD)* that 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.

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 in 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 quarterly 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.

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.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

Seniors and Persons with Disabilities (SPD) are persons who derive their eligibility from the Medicaid State Plan and are either: aged, blind, or disabled.

According to the Special Terms and Conditions of this Demonstration, DHCS may mandatorily enroll SPDs into Medi-Cal managed care programs to receive benefits. This does not include individuals who are:

- Eligible for full benefits in both Medicare and Medicaid (dual-eligible individuals)
- Foster Children
- Identified as Long Term Care (LTC)
- Those who are required to pay a "share of cost" each month as a condition of Medi-Cal coverage

Starting June 1, 2011, the following counties began a 12-month period in which approximately 380,000 SPDs were transitioned from fee-for-service systems into managed care plans: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

The State will ensure that the Managed Care plan or plans in a geographic area meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS.

The SPD transition is part of DHCS's continuing efforts to fulfill the aims of the Patient Protection and Affordable Care Act (ACA). Medi-Cal's goals for the transition of SPDs to an organized system of care are to: ensure beneficiaries receive appropriate and medically necessary care in the most suitable setting, achieve better health outcomes for beneficiaries, and realize cost efficiencies. Managed care will allow DHCS to provide beneficiaries with supports necessary to enable SPDs to live in their community instead of in institutional care settings, reduce costly and avoidable emergency department visits, as well as prevent duplication of services.

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 4.27 million Medi-Cal beneficiaries in 27 counties. DHCS provides three types of managed care models:

1. Two-Plan, which operates in 14 counties.
2. County Organized Health System (COHS), which operates in 11 counties.
3. Geographic Managed Care (GMC), which operates in two counties.

DHCS also contracts with one prepaid health plan in one additional county and with two specialty health plans.

Enrollment information:

The “mandatory SPD population” consists of Medi-Cal-only beneficiaries with certain aid codes who reside in all counties operating under the Two-Plan Model (Two-Plan) and Geographic Managed Care (GMC) models of managed care. The “existing SPD population” consists of beneficiaries with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Dual Eligibles and other voluntary SPD populations with certain aid codes in all counties operating under the Two-Plan and GMC models of managed care.

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
July 2014 – September 2014

County	Total Member Months
Alameda	91,780
Contra Costa	50,314
Fresno	70,170
Kern	56,555
Kings	7,811
Los Angeles	595,701
Madera	7,475
Riverside	95,061
San Bernardino	111,417
San Francisco	52,838
San Joaquin	51,323
Santa Clara	70,154
Stanislaus	37,171
Tulare	33,287
Sacramento	115,488
San Diego	120,045
Total	**1,566,590**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2014 – September 2014

County	Total Member Months
Alameda	45,422
Contra Costa	18,239
Fresno	23,634
Kern	15,489
Kings	2,292
Los Angeles	333,948
Madera	2,273
Marin	18,919
Mendocino	17,547
Merced	47,313
Monterey	46,617
Napa	13,973
Orange	340,491
Riverside	60,802
Sacramento	42,371
San Bernardino	60,277
San Diego	89,879
San Francisco	26,897
San Joaquin	16,145
San Luis Obispo	25,234
San Mateo	69,752
Santa Barbara	44,687
Santa Clara	42,379
Santa Cruz	30,125
Solano	57,570
Sonoma	51,939
Stanislaus	7,728
Tulare	11,138
Ventura	80,517
Yolo	25,320
Total	**1,668,917**

Enrollment (July 2014 – September 2014)

During the quarter, mandatory SPDs had an average choice rate of 64.5%, an auto-assignment default rate of 12.53%, a passive enrollment rate of 0.01%, a prior-plan default rate of 0.55%, and a transfer rate of 22.41%. In September, overall

SPD enrollment in Two-Plan and GMC counties was 516,527 (point-in-time), a 0.01% decrease from June's enrollment of 516,483. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY10-Q1 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

The Medi-Cal Managed Care Division (MMCD) continues to update and improve the MMCD Performance Dashboard for the Medi-Cal Managed Care program. On August 18, 2014, the MMCD released the third edition of the MMCD Dashboard. The dashboard assists DHCS and its stakeholders to identify trends and better observe and understand MCP activities on all levels: statewide, by managed care model (i.e., COHS, GMC, Two-Plan, and Rural Expansion), and within an individual MCP. It includes metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, MCP finances, care coordination, and continuity of care. It also stratifies reported data by beneficiary populations including Medi-Cal-only SPDs, dual eligibles, and children transitioned from the Healthy Families Program into Medi-Cal Managed Care.

MMCD posted the third edition of the dashboard on the DHCS website with a release date of August 18, 2014. The fourth edition of the MMCD Dashboard will be released in November 2014 and MMCD will conduct a webinar with stakeholders to discuss the Dashboard.

The MMCD Dashboard was originally developed with funding from the California HealthCare Foundation (CHCF).

Operational/Policy Issues:

Network Adequacy
Between July 2014 and September 2014, the Department of Managed Health Care (DMHC) completed a provider network review of all Two-Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provide DHCS with an updated list of providers SPDs may contact to receive care. DMHC conducted a thorough review of each MCP's provider networks and identified no access-to-care issues.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee
On September 11, 2014, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no specific discussions relating to the SPD Implementation. Full documentation from the meeting is available at: http://www.dhcs.ca.gov/Pages/SAC-9-11-Meeting-Materials.aspx.

Office of the Ombudsman (July 2014 – September 2014)

MMCD's Office of the Ombudsman experienced an overall increase in customer calls between the periods April-June 2014 (DY9-Q4) and July-September 2014 (DY10-Q1). During DY10-Q1, the Ombudsman received 45,367 total calls, of which 14,490 concerned mandatory enrollment and 2,471 were from SPDs. During DY9-Q4, the Ombudsman received 40,172 total calls, of which 13,591 concerned mandatory enrollment and 2,685 were from SPDs. This represents a 12.93% increase in total calls, a 3.86% increase in calls regarding mandatory enrollment, and a 7.97% decrease in calls regarding mandatory enrollment from SPDs.

For DY10-Q1, 0.13% of SPD and 0.05% of non-SPD calls concerned access issues. This is a small decrease in SPD and non-SPD calls from DY9-Q4, during which 0.34% of SPD calls and 0.06% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) increased for overall measures, but dropped slightly for SPD measures. Total SHRs increased from 631 DY9-Q4 to 733 in DY10-Q1. The percentage of SHRs from SPDs dropped from 44% to 37%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs increased slightly from 155 DY9-Q4 to 214 in DY10-Q1. The percentage of those requests from SPDs decreased slightly from 39% to 27%. There were no SHRs related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachments "DY10 Q1 Ombudsman Report" and "DY10 Q1 State Hearing Report."

Medical Exemption Requests (July 2014 – September 2014)

The number of MERs/EDERs during this quarter remained relatively unchanged from the previous quarter. The automation of the MER process has kept the number of outstanding MERs to a minimum and EDERs continued to be processed on a daily basis.

Health Risk Assessment Data (January 2014 – March 2014)

According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 38,464 SPDs between January 2014 and March 2014. Of those, MCPs stratified 9,688 (25.19%) as high-risk SPDs and 27,689 (71.99%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 40.78% by phone and 62.72% by mail. Of the total high-risk SPDS, 31.01% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 52.94% by phone and 61.28% by mail. Of the total low-risk SPDS, 24.48% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 2,534 SPDs to be in the other risk category, which is 6.59% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2014 Risk Data."

Continuity of Care Data (April 2014 – June 2014)
According to the data reported by MCPs, operating under the Two-Plan and GMC models, between April and June 2014 SPDs submitted 811 continuity-of-care requests. Of these, MCPs approved 681 requests (83.97% of all requests); held 12 requests 1.48%) in process; and denied 118 requests (14.55%). Of the requests denied, 36.44% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2014 Continuity of Care."

Plan-Reported Grievances (April 2014 – June 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 2,724 grievances between April and June 2014. Of these grievances, 0.40% were related to physical accessibility, 8.63% were related to access to primary care, 3.49% were related to access to specialists, 1.69% were related to out-of-network services, and 85.79% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2014 SPD Grievance."

MERs Data (April 2014 – June 2014)
During 2014, from April through June, 4,263 SPDs submitted 5,079 MERs, an average of 1.19 MERs per SPD who submitted a MER. MMCD approved 3,462 MERs, denied 1,294, and found 323 to be incomplete. The top five MER diagnoses were Complex (672), Cancer (254), Transplant (155), Neurological (137), and Dialysis (69). Summary data is available in the attachment "Q2 2014 MERs Data."

Health Plan Network Changes (April 2014 – June 2014)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 1,072 primary care physicians (PCPs) and removed 2,315 PCPs across all networks, resulting in a total PCP count of 26,695. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2014 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (July 2014 – September 2014)
DHCS is currently finalizing an evaluation proposal to be submitted to CMS pertaining to the SPD demonstration program. The time period for the evaluation will be 12 months with the start date being June 1, 2012. DHCS identified policy questions in five areas: eligibility and enrollment processes, coverage, access to care, quality of care and value based care (costs associated with the services provided to enrollees in the SPD program as compared to FFS costs). A minimum of three sources of data will be used for the evaluation: (1) Management Information Systems/Decision Support Section (MIS/DSS) claims data; (2) encounter data; and (3) a comprehensive survey study,

conducted by UC Berkeley and funded by the California Health Care Foundation, focusing on satisfaction and enrollees experience. DHCS is currently finalizing the methodology to be used to evaluate each of the aforementioned five focus areas.

During 2013 and 2014, SPD Medi-Cal only beneficiaries will be mandatorily transferred from fee-for-service to managed care plans in 27 rural counties, due to the managed care expansion in those areas. (SPD beneficiaries' enrollment into managed care plans will remain voluntary in San Benito since only one managed health plan is operating there). DHCS proposes to conduct, at a later date, a similar evaluation as described above for the SPD demonstration program in those rural counties.

Encounter Data (July 2014 – September 2014)

DHCS initiated the Encounter Data Improvement Project (EDIP) in late 2012, with the goal of improving DHCS' encounter data quality and establishing the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP, currently under development, is DHCS' plan for measuring encounter data, tracking it from submission to its final destination in DHCS's data warehouse, and reporting data quality to internal and external stakeholders.

During the reporting period, the Encounter Data Quality Unit (EDQU), established under the EDIP, continued its efforts to implement and maintain the EDQMRP. EDQU continued to develop metrics that will objectively measure the quality of future encounter data in the dimensions of completeness, accuracy, reasonability and timeliness. EDQU also continued to develop an encounter data monitoring database that will determine an Encounter Data Quality Grade for each Medi-Cal MCP based on these metrics. This monitoring database will also serve to track encounter data submissions and report valuable data quality information to Medi-Cal MCPs and DHCS data users. EDQU also worked with Medi-Cal MCPs as they engaged in system testing with DHCS' new Encounter Data Capture and Transmission (EDCT) system. The transition to EDCT will be ongoing throughout 2014 and will enhance DHCS' ability to implement the EDQMRP. Although many of these efforts did not specifically target SPDs, improving the quality of DHCS's encounter data will enable DHCS to better monitor the services and care provided to this population.

Outcome Measures and All Cause Readmissions (July 2014 – September 2014)

DHCS employs the following strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures

HEDIS measurement year 2012 was the first year in which DHCS reported a subset of HEDIS measures for SPDs compared to non-SPDs. DHCS considers these results preliminary because not all SPDs had transitioned into MCPs by January 1, 2013. In the measurement year 2013, the SPD rates for the selected HEDIS measures are higher than that of non-SPD.

Consumer Assessment of Healthcare Providers and Systems
During calendar year 2013, DHCS, through its external quality review organization (EQRO), administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. The survey closed in May 2013 with a response rate of 36% for adults and 40% for children. DHCS anticipates publishing the final report in November 2014.

Statewide Collaborative All Cause Readmissions
The Statewide Collaborative Quality Improvement Project (QIP) began in July 2011 and focused on reducing readmissions due to all causes within 30 days of an inpatient discharge among MCP members. DHCS worked with MCPs and DHCS's EQRO, Health Services Advisory Group, Inc. (HSAG), to develop guiding principles, a HEDIS-like measure specific to the Medi-Cal population, and a collaborative evaluation plan.

The Baseline Report includes All Cause Readmission rates for SPD versus non-SPD for measurement years 2011 2012, before the interventions began in 2013. As the SPDs joined managed care, the number of SPD hospitalizations increased from 24,750 in 2011 to 65,818 in 2012; the ACR rates for these years was 16 and 17% respectively. In the measurement year 2013, the number of SPD hospitalization increased to 73,326; the ACR rate for SPD was 16%. As expected for an older group of members with more health problems, the ACR was 1.8 times higher than for non-SPDs in the measurement year 2013.

Utilization Data (July 2013 – September 2013)
During the period July through September 2013, MCPs in Two-Plan and GMC counties enrolled 529,523 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 14.21% (75,221) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.76 times.
- Each SPD who visited an ER generated an average of 2.77 ER claims.

Pharmacy Services:

- 67.91% (359,581) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 13.97 claims.

Outpatient Services:

- 47.61% (252,088) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.4 visits.
- Each SPD who accessed outpatient services generated an average of 10.41 claims.

Inpatient Services:

- 4.92% (26,048) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 2.85 visits.
- Each SPD who accessed inpatient services generated an average of 3.48 claims.

Hospital Admissions:

- 5.68% (30,087) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 2.08 visits.

Top Ten Services Accessed by SPDs

12,041,409 total claims

	Jul 2013 – Sep 2013
1	Prescribed Drugs
2	Physicians
3	Lab and X-Ray
4	Other Clinics
5	Outpatient Hospital
6	Other Services
7	Personal Care Services
8	Targeted Case Management
9	Hospital: Inpatient Other
10	Rural Health Clinics

For the top ten diagnosis categories, MCPs submitted data for a total of 2,930,049 encounters. Mental Illness was in the top rank with 38.57% of the encounters. “Symptoms; signs; and ill-defined conditions and factors influencing health status” accounted for 13.28%. In the third position, “Diseases of the circulatory system” was 8.37%. The remaining seven categories ranged from 8.36% to 3.33% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment “DY10 Q1 Utilization Data.”

Enclosures/Attachments:

- “DY10 Q1 Defaults Transfers 2Plan GMC”
- “DY10 Q1 Ombudsman Report”
- “DY10 Q1 State Hearing Report.
- “Q1 2014 Risk Data”
- “Q2 2014 Continuity of Care”
- “Q2 2014 SPD Grievance”
- " Q2 2014 MERs Data”
- “Q2 2014 Network Adequacy”
- “DY10 Q1 Utilization Data”
- “MMCD Advisory Call Minutes July 24, 2014”

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 Department of Health Care Services (DHCS). Approximately 75 percent of CCS-eligible children are also Medi-Cal eligible.

The pilot projects under the Bridge to Reform Demonstration Waiver are focusing 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. Existing state and federal funding will be used for the pilot projects, which are expected to serve 15,000 to 20,000 CCS eligible children. The positive results of these projects could lead to improved care for all 185,000 children enrolled in CCS.

The projects are a major 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 outcomes for children served. DHCS will use the results of the evaluation to recommend next steps, including possible expansion.

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 from the entities listed below.

1. Health Plan of San Mateo: Existing Medi-Cal Managed Care Organization
2. Los Angeles Health Care Plan: Specialty Health Care Plan
3. Alameda County Health Care Services Agency: Enhanced Primary Care Case Management Program
4. Rady Children's Hospital: Accountable Care Organization
5. Children's Hospital of Orange County: Accountable Care Organization

There have been significant challenges with implementation in three of the five pilot projects, which did not have a start date as of the end of Quarter 4. These challenges are discussed in detail later in this report.

Enrollment information:

The current quarter monthly enrollment for HPSM is shown in the table that follows. Eligibility for CCS and health plan member is extracted from the Children's Medical Services Network (CMSNet) system, verified by Information Technology Services Division (ITSD) using Medi-Cal Eligibility Data System (MEDS) and forwarded to Office of HIPAA Compliance (OHC) where the file is then sent to HPSM and an invoice is generated from the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference
Prior Quarter June 2014	1,438	
July 2014	1,472	34
August 2014	1,457	-15
September 2014	1,435	-22

Outreach/Innovative Activities:

The Department of Health Care Services (DHCS) developed and implemented a "Family Satisfaction Phone Survey" (Family Survey) during the months July through September 2014 for the Health Plan San Mateo (HPSM) California Children's Services (CCS) Demonstration Pilot (DP). The Department conducted this survey to satisfy one of several components of the operational review for the CCS DP and DHCS is in the analysis stage of this process. The Department contacted 855 HPSM families and 379 HPSM families agreed to complete the survey (44%). The objective of the Family Survey 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.

Additionally, DHCS is developing a Provider Satisfaction email Survey (Provider Survey) for the HPSM DP, which also fulfills a component of the operational review for the CCS DP. The providers will be asked to provide feedback to help evaluate the current level of success of the HPSM DP and to identify those areas that need improvement. The Provider Survey will be administered through Monkey Survey and DHCS is anticipating emailing the survey in late November 2014 to providers. Both of these surveys will help the Department improve the services provided to CCS clients and to determine how the DP is working for CCS clients enrolled within the CCS Program.

Operational/Policy Issues:

DHCS continues to collaborate with Demonstration 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.

Health Plan San Mateo (HPSM) Demonstration Project

Department Communications with CMS

DHCS participated in pre-scheduled reoccurring meetings with Center for Medicare & Medicaid Services (CMS) which included CMS Region IX staff, CMS Central Office staff, and other DHCS organizations who are participating in other components of the 1115 Bridge to Reform Waiver. The Department also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Department Communications with HPSM

DHCS and HPSM conduct bi-weekly conference calls to discuss various issues, inclusive of those related to financials, information technology, report deliverables, and DHCS site visits with both HPSM and San Mateo County which is scheduled to occur on October 17, 2014.

Capitated Reimbursement Rates

The Department is working with ITSD to establish a 9D aid code which will allow CCS State-Only children to enroll in CCS Demonstration Pilots. The goal is to be able to automate enrolling the CCS State-Only children and for payment to occur through CAPMAN payment system.[1] It is anticipated that the 9D aid code for "CCS State-Only beneficiaries" will be active by December 2014.

Aid Codes

HPSM DP will begin to enroll children into the pilot with eligibility codes 7U, 7W and K1. The anticipated date these codes will be effective is October 25, 2014.

Rady Children's Hospital of San Diego Demonstration Project

DHCS has been working with Rady Children's Hospital of San Diego (RCHSD) toward commencing their CCS DP. Communications include contract documents (scope of work, reporting requirements etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, and other operational issues.

Capitated Rates

Continuing from mid-October 2011, DHCS has been working on development of rates. Development of rates had been delayed until conditions covered, population, and pharmaceuticals covered have been decided.

[1] February 10, 2014 SCD received the approved memorandum from MCED to ITSD and CA-MMIS to request the development and implementation of a new aid code "9D" for CCS State-Only beneficiaries. The aid code with be described as 9D, CCS State-Only, Child Enrolled in a Health Care Plan.

Department Communications with RCHSD
DHCS has been participating in weekly conference calls with RCHSD to discuss and resolve various issues such as:

- **PHARMACEUTICALS**
  RCHSD does not have a pharmaceutical administration structure in place. RCHSD is investigating partnerships with different Pharmaceutical Benefits Management (PBM) firms; however, this has been a challenge for RCHSD because PBM's are reluctant to provide services due to the small size of the initial population. This is an on-going challenge but resolution hoped to be achieved in the near future.

- **UTILIZATION DATA**
  On August 14, 2014, DHCS performed a utilization snapshot which included the conditions by identifying ICD-9 codes. On August 21, 2014, aggregate cost information was given to RCHSD per their request from the Department, 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 "Visit" types. This utilization data was sent to RCHSD on September 8, 2014.

- **MEMBER HANDBOOK / EVIDENCE OF COVERAGE (MH/EOC)**
  DHCS reviewed and provided comments to RCHSD's Member Handbook (MH) and Evidence of Coverage (EOC) on July 10, 2014.

- **PROVIDER MANUAL**
  RCHSD is developing their provider manual for DHCS's review to satisfy a CCS DP Readiness Review component.

- **ACCESS STANDARDS**
  On August 21, 2014, DHCS approved the GEO Access Report to satisfy a CCS DP Readiness Review component.

- **MEMBER ELIGIBILITY FILE**
  County, RCHSD Information Technology (RCHSD IT), and DHCS IT are in the process of discussing the "flow and process" of member eligibility files.

- **RCHSD READINESS REVIEW DELIVERABLES**
  On July 2, 2014, RCHSD began submitting, for DHCS's review and approval, their policies and procedures (P&Ps) as indicated in the Readiness Review document.[2] As of September 30, 2014, of the 67 required deliverables, 37 deliverables have been approved by DHCS, 20 deliverables were not approved, nine deliverables were in the Department's review, and one deliverable has yet to be submitted by RCHSD.

[2] DHCS gave RCHSD a Readiness Review document indicating required deliverables (P&Ps) in Summer/Fall 2013.

- **CONTRACT ITEMS**
  On July 2, 2014, RCHSD returned comments on Exhibit A: Scope of Work of the contract to DHCS. On August 21, 2014, the Department proposed revised language to RCHSD. Lastly, 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.

90-Day, 60-Day, and 30-Day Notices

DHCS is drafting 90, 60, and 30-Day notices to patients, providers, and the GMC plans. 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 will consist of the following:

- Announcement of a pilot to CCS Member enrolled in a GMC Plans;
- Pilot would coordinate health care services for 5 medical conditions [Hemophilia, Cystic Fibrosis, Sickle Cell, Diabetes Type I and II (age 1-10 years) and Acute Lymphoblastic Leukemia];
- No changes in member's health, dental, or vision coverage, in addition to retaining your current medical doctor;
- Enhanced benefits (coordination of health needs, community referrals, resources for parenting, education, and emotional support);
- Automatic enrollment;
- Receipt of an identification card for doctor visits, pharmacy, and hospital; and
- Phone number for questions.

Pilot Schedule

It is anticipated Rady Children's Hospital of San Diego County (RCHSD) demonstration pilot will be operational in early 2015. It should be noted that the projected implementation time table for RCHSD is contingent on a number of factors including acceptance of capitated rates by RCHSD, the ability of the contractor to demonstrate readiness to begin operations, and approvals by CMS.

There is no projected start date for the remaining three pilot models at this time.

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

Milestones

HPSM

During this quarter, SCD developed and implemented a Family Satisfaction Phone Survey (Family Survey) and a Provider Satisfaction email Survey to satisfy components of the operational review for the HPSM CCS DP. These surveys will help DHCS improve services provided to CCS clients and determine how the demonstration program pilot is working for CCS clients enrolled within the CCS Program.

Complaints, Grievances, and Appeals

On July 29, 2014, HPSM submitted a "Pending and Unresolved Grievances Quarterly Report" for the second quarter, January - March 2014. The Grievances Report shows during the quarter:

- 10 grievances were received; (Coverage/Benefit 1, Medical Necessity 7, Access 1, Customer Service 1)
- 5 grievances were resolved timely
- 5 grievances not resolved timely
- 4 grievances took over 30 days for resolution

The Grievances Report further disseminates the types of grievances that are tracked and follow: Coverage/Benefit, Medical Necessity, Quality of Care, Access, Customer Service, Privacy Issues, Quality of Care, Fraud/Waste/Abuse, and Other.

Consumer Issues:

On July 25, 2014, a Kick-Off Webinar took place discussing the Medi-Cal 1115 Waiver Renewal and DHCS presented an update on the CCS Program Improvements. DHCS is interested in potentially exploring improvements to the CCS Program aimed at improving care delivery, quality, and cost. Program improvements could be similar to other initiatives being considered including pay-for-performance programs or efforts to move toward a more coordinated and organized delivery system. Efforts in this area will be aimed at improving the program for beneficiaries while recognizing the important value of the specialized care they required and the certified providers who serve them.

On August 8, 2014, the Stakeholder Process for CCS was posted to the DHCS website. This document briefly discusses topics such as the overview, stakeholder process, goal, guiding principles, and the next steps; the documentation link follows:
http://www.dhcs.ca.gov/Documents/ADAComp_CCS_Stakeholder_Process_FINAL.pdf

On September 11, 2014, DHCS presented an update on the CCS pilots to members of the DHCS Waiver Stakeholder Advisory Committee, which was open to the public. Attached below is the presentation link:
http://www.dhcs.ca.gov/Documents/SAC1115Presentation9-11-14.pdf

Financial/Budget Neutrality:

HPSM

Financial Review
DHCS completed a second financial review on HPSM's DP quarterly reports; specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with

85%< being the target. Please refer to Attachment 1, Department of Health Care Services – Systems of Care Division, Health Plan of San Mateo: Plan Analysis.

Quality Assurance/Monitoring Activities:

On August 4, 2014, HPSM submitted contractual report, "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

HPSM deliverables submitted during this quarter are located in the table below, along with DHCS's internal review and approval for each deliverable.

Report Name	Date Due	Received	Pending Review	DHCS Approved
Provider Network Reports (Rpt #5)	7/30/2014	8/5/2014		YES
Grievance Log/Reports (Rpt #5)	7/30/2014	7/29/2014		YES
Provider Manual	8/1/2014			Due 4/30/2014. Approved an extension until August 2014
Quarterly Financial Statements (Rpt #5)	8/15/2014	8/5/2014	✓	
Report of All Denials of Services Requested by Providers (Rpt #4)	8/15/2014			

Enclosures/Attachments:

Attached enclosure "California Children 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*.

LOW INCOME HEALTH PROGRAM (LIHP)

The Low Income Health Program (LIHP) includes two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE enrollees have family incomes at or below 133 percent of the federal poverty level (FPL). HCCI enrollees have family incomes above 133 through 200 percent of the FPL. Local LIHPs may elect to operate only an MCE program, but must operate a MCE in order to implement a new HCCI. The local LIHP can set the income levels below the maximum allowable amount according to the Special Terms and Conditions (STCs) approved by the Center for Medicare and Medicaid Services (CMS).

In addition to being classified by family income, enrollees are designated as "Existing" or "New" based on guidelines set forth in the STCs. Existing MCE or HCCI enrollees are enrollees whose enrollment was effective on November 1, 2010. An existing enrollee continues to be considered existing even as the enrollee may move from one component of the program to the other based on changes in the enrollee's FPL. After an existing enrollee is disenrolled, he/she will be considered a new enrollee if he/she re-enrolls at a later date.

New MCE or HCCI enrollees are enrollees whose enrollment was effective after November 2010. This includes enrollees who were enrolled during the period legacy counties with prior HCCI programs transitioned from the HCCI to the LIHP. Legacy counties had the flexibility to continue enrollment during this transition period. Santa Clara County did not enroll new applicants until July 1, 2011.

Enrollment is effective on the first of the month in which the application was received except for a non-legacy LIHP that did not have a HCCI Program prior to November 1, 2010, and implemented the LIHP after the first of a month. During this first month of implementation, the enrollment effective date is the date the local LIHP was implemented. After this initial implementation month, enrollment follows the normal effective date of the first of the month.

Additionally, non-legacy LIHPs which offer retroactive enrollment from one to three months follow the same process. The enrollment cannot be retroactive beyond the implementation date until the one to three month timeframe has passed beyond the implementation date.

As of January 1, 2014, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

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, "Total Funds Expenditures of other Governmental Entity", to add other entities that could provide CPEs for claiming purposes.

DHCS continued to provide to the counties technical expertise and recommendations for evaluation and monitoring of activities to optimize federal financial participation (FFP) and maximize financial resources.

DHCS submitted the revised Attachment G, Supplement 2, "Cost Claiming Protocol for Health Care Services Provided under the LIHP- Claims Based on Capitation" for CMS approval on July 1, 2014.

DHCS continued collaboration with the University of California Los Angeles Center for Health Policy Research (UCLA), the independent evaluator for the LIHP, to produce data reports that are used to monitor and measure the effectiveness of the local LIHPs and aid in the evaluation project. On August 11, 2014, DHCS received CMS approval of the LIHP evaluation design plan.

DHCS continued to work on implementation of the primary care provider (PCP) increased payment claiming process for specified evaluation and management and vaccine administration services for which enhanced payments are required per Title 42, Part 447 of the Code of Federal Regulations (CFR). This work effort included communication with local LIHPs and continued follow-up with CMS to obtain a decision on the request submitted December 27, 2013, regarding the exclusion of HCCI for the PCP bump increased payment per the CMS ruling 42 CFR Part 438, 441, and 447 which entitles the LIHPs to receive the difference of the increased amount for the calendar year (CY) 2013. Section 1902(a)(13)(C) of the Act requires the states pay a minimum payment amount for certain primary care services delivered by designated primary care physicians. Primary care services are defined in the section 1902 (jj) of the Act and include certain specified procedure codes for evaluation and management (E&M) services and certain vaccine administration codes. Under this provision, states must reimburse at least as much as the Medicare physician fee schedule rate in CYs 2013 and 2014.

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 communicated with the local LIHPs and county social services agencies to discuss issues and current status of the transition.
- DHCS provided guidance on the transition process and data to assist in the continued transition of LIHP enrollees.
- 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 provide data on cases that need investigation regarding eligibility status and transition issues.

DHCS continued to work with the California Department of Public Health, Office of AIDS (OA), to ensure the smooth transition of eligible former Ryan White clients (who transitioned to a local LIHP prior to January 1, 2014) to Medi-Cal or Covered California eligibility. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- Designated Public Hospitals (DPHs) submitted their semi-annual report for DY9.
- DHCS began reviewing the DPHs semi-annual reports.

DHCS was the liaison between UCLA and CMS regarding the UCLA DSRIP External Evaluation. DHCS reviewed California's DSRIP Interim Evaluation Report.

DHCS continued the contract compliance process with LIHPs. DHCS requested and reviewed submissions from the local LIHPs to ensure compliance with the LIHP contracts, including the annual maintenance of effort and quality improvement reporting. DHCS communicated with LIHPs to follow up and complete contract compliance reporting.

DHCS continued the process to initiate the receipt of funds, from all 19 LIHPs, for reimbursement of costs that DHCS has incurred related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems.

Consumer Issues:

DHCS continued to conduct and/or participate in the following stakeholder engagement processes during the quarter. These processes continued as needed after the LIHP transition on January 1, 2014, to ensure that LIHP enrollees successfully transitioned to Medi-Cal or Covered California eligibility:

- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition to health care coverage under Medi-Cal of individuals diagnosed with HIV, who had been receiving health care services through the Ryan White programs and had transitioned to a local LIHP prior to

January 1, 2014. In addition, the LIHP Division meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

- Weekly LIHP/Medi-Cal Eligibility Division/Safety Net Financing Division/California Department of Corrections and Rehabilitation for discussion on populations determined eligible for Medi-Cal and LIHP by DHCS.

DHCS continues to provide guidance to, and solicit feedback from, stakeholders and advocates on program policy concerns, and to respond to issues and questions from consumers, members of the press, other state agencies, and legislative staff through the LIHP e-mail inbox and telephone discussions. DHCS continues to maintain the LIHP website by updating program information for the use of stakeholders, consumers, and the general public.

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
Administrative Activities (Qtr. 1)	$501,798.97		$1,003,597.94	DY9	$501,798.97
CDCR (Qtr. 1)	$2,823,061.84		$5,646,123.68	DY8	$2,823,061.84
	$9,636,722.74		$19,273,445.48	DY9	$9,636,722.74
Health Care (Qtr. 1)	$18,054,343.57		$36,108,687.14	DY6	$18,054,343.57
	$13,785,313.01		$27,570,626.02	DY8	$13,785,313.01
	$21,134,728.64		$42,269,457.28	DY9	$21,134,728.64
	$11,645,864.74	$11,645,864.74	$0.00	DY7	$23,291,729.48
	$2,083,782.16	$2,083,782.16	$0.00	DY9	$4,167,564.32
Total	**$79,665,615.67**	**$13,729,646.90**	**$131,871,937.54**		**$93,395,262.57**

Quality Assurance/Monitoring Activities:

DHCS continues to monitor activities and analyze information submitted by local LIHPs to ensure final compliance with LIHP contracts.

Enclosures/Attachments:

Nothing to report.

COMMUNITY BASED ADULT SERVICES (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, sought to challenge the elimination of ADHC services. In settlement of this lawsuit, ADHC was eliminated as a payable benefit under the Medi-Cal program effective March 31, 2012, to be replaced with a new program called Community-Based Adult Services (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, which was approved by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2012. CBAS is operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

In anticipation of the end of the CBAS BTR Waiver period, DHCS and California Department of Aging (CDA) conducted extensive stakeholder input regarding the continuation of CBAS. CMS approved an amendment to the CBAS BTR waiver which extended CBAS for another five years, with an effective date of December 1, 2014.

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 State Plan beneficiaries that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing, Medicaid , and waiver program standards; 2) provide services in accordance with the participant's physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements identified in the CMS approved BTR waiver; and 4) demonstrate ongoing compliance with above requirements.

All initial assessments for the CBAS benefit must be performed through a face-to-face review by a registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. The assessment may be conducted by DHCS, or its contractor, including a CBAS beneficiary's managed care plan. A CBAS beneficiary's eligibility must be re-determined at least every six months or whenever a change in circumstance occurs that may require a change in the beneficiary's CBAS benefit.

The State must assure CBAS access/capacity in every county in which ADHC services had been provided on December 1, 2011.[3] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) (See Attachment 4) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans (available in two counties), along with the final COHS county (Ventura) also transitioning

[3] CBAS access/capacity must be provided in every county except those that did not previously have ADHC centers, as identified in STC 91.I.i: Del Norte, Siskiyou, Modoc, Trinity, Lassen, Mendocino, Tehama, Plumas, Glenn, Lake, Colusa, Sutter, Yuba, Nevada, Sierra, Placer, El Dorado, Amador, Alpine, San Joaquin, Calaveras, Tuolumne, Mariposa, Mono, Madera, Inyo, Tulare, Kings, San Benito, and San Luis Obispo.

at that time. As of October 1, 2012, Medi-Cal FFS only provides CBAS coverage for those CBAS eligible beneficiaries who: 1) do not qualify for managed care enrollment, 2) have an approved medical exemption, or 3) reside in CBAS geographic areas where managed care is not available (four counties: Shasta, Humboldt, Butte; Imperial).

If there is insufficient CBAS center capacity to satisfy the demand in counties with ADHC centers as of December 1, 2011 (as a base date), eligible beneficiaries receive unbundled CBAS (i.e., component parts of CBAS delivered outside of centers with a similar objective of supporting beneficiaries, allowing them to remain in the community. Unbundled services include senior centers to engage beneficiaries in social/recreational activities and group programs, home health nursing and therapy visits to monitor health status and provide skilled care, and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the beneficiary's Activities of Daily Living or Instrumental Activities of Daily Living) through Medi-Cal FFS or, if the beneficiary is enrolled in managed care, through the beneficiary's Medi-Cal managed care health plan.

Beneficiaries that received ADHC services between July 1, 2011 and February 29, 2012, and are determined to be ineligible for CBAS are eligible to receive Enhanced Care Management (ECM) services as defined in the BTR waiver. ECM will be provided through Medi-Cal FFS or, if the beneficiary is enrolled in Medi-Cal managed care, through the beneficiary's Medi-Cal managed care health plan.

Enrollment and Assessment Information:

Community Based Adult Services (CBAS) Enrollment:

The CBAS Enrollment data for both FFS and Managed Care Organizations (MCO) beneficiaries for DY10, Quarter 1 is shown in Table 2, *Preliminary CBAS Unduplicated Participant Data for FFS and MCO Enrollment,* at the end of this report section.

There was a change in payment and reporting mechanisms for CBAS through Managed Care Plans effective July 2013. The cost of CBAS is built into the capitation rate for all plans, instead of prior periods when plans received additional payments for each individual plan member receiving CBAS services. As such, CBAS Enrollment data is based on self-reporting by the Managed Care Plans (Table 2), which is reported quarterly. In addition, some Managed Care Plans report based on their covered geographical areas, which may include multiple counties. Table 2 reflects this quarterly reporting as well as grouping of specific counties.

Given this change in the reporting process and format, enrollment data reflects that the CBAS participation remains under 29,000 statewide. FFS Claims data, which has a lag factor, is used for the FFS enrollment data.

CBAS Assessments:
During DY10, Quarter 1 (July 2014 through September 2014), Managed Care Plans reported that they conducted 2299 new face-to-face CBAS assessments by registered nurses. Of these new assessments 98% were found eligible for CBAS; only 48 were found not-eligible or 2% of the assessments. Plans' median response time from receiving request for an assessment to making an eligibility determination was 8 days, a response time that is within the 30 days standard.

During the same Quarter, approximately 260 new CBAS eligibility assessments for FFS beneficiaries were requested and completed by DHCS' registered nurses. Of these new assessments 98.5% were found eligible for CBAS.

Enhanced Case Management (ECM) – ending August 31, 2014

The ECM Participant Average Quarterly Data (ECM Table below) shows the number of FFS ECM-eligible individuals. These individuals were served at a local ADHC Center from July 1, 2011 through March 31, 2012, prior to the CBAS start date. However, at the time of their re-evaluation they were found not-eligible for CBAS due to lack of meeting medical necessity. ECM-eligible class members that enroll in managed care health plans receive ECM through their plan's case management services. ECM-FFS members receive ECM with DHCS nurses contacting participants regarding their care needs, coordinating services and reaching out for community referrals.

ECM services were slated to sunset on August 31, 2014, as stated in the Waiver Amendment and in the Settlement Agreement. To notify all possible beneficiaries that ECM would no longer be available to assist with outreach to local services or care management, a notice was sent to all possible ECM beneficiaries on August 21, 2014.

Over 900 contact letters were mailed out, which included managed care and FFS beneficiaries, many of which chose not to participant in ECM. Their overall care coordination had been established and the need for further interaction diminished. This notice allowed beneficiaries to contact DHCS' ECM nursing staff through September 22, 2014, with any questions, concerns or additional outreach or care coordination needed, and to receive the same scope of care coordination services through their existing provider network.

In the later part of 2012 and early 2013, many State Fair Hearing decisions overturned eligibility findings and ECM-FFS participation dropped as participants returned to CBAS. Additionally, many beneficiaries continue to move into managed care health plans, resulting in an ongoing decline in ECM-FFS eligible members. Many beneficiaries change between managed care plans, going back into FFS for brief intervals of time, and back to Managed Care. Given this frequent movement, incoming ECM participants continue to be slightly fluid month-to-month with eligibility changes. However, overall the ECM-FFS population has continued to drop as more beneficiaries move to Managed Care Plans.

The Table below tracks the ECM-FFS Participant Average Quarterly Data since ECM began in April 2012 (Original Count) to this current DY 10, Quarter 1 and ECM end date of August 31, 2014:

ECM Participant Average Quarterly Data			
Report Quarters	**Average Qrtly. Enrollment**	**Average Qrtly. Incoming Members***	**Average Qrtly. Outgoing Members****
Original Count	**1560**		
DY7 - Q 4			
April-June'12	1422	66	107
DY8 - Q1			
July-Sept'12	1546	79	45
DY8 - Q2			
Oct.-Dec.'12	1126	20	210
DY8 - Q3			
Jan.-Mar'13	918	23	48
DY8 - Q4			
April-June'13	708	17	33
DY9 - Q1			
July-Sept.'13	646	16	74
DY9 - Q2			
Oct.-Dec. '13	459	13	200
DY9 - Q3			
Jan.-Mar'14	453	19	25
DY9 - Q4			
April-June'14	414	11	50
DY10 - Q1			
July-Sept.'14	398	3	26

DHCS ECM Data 08/20/2014

Outreach/Innovative Activities:

During DY9 Q4, DHCS continued to work closely with CBAS Center providers and various Managed Care Plans regarding CBAS program benefits and eligibility of participants.

Operational/Policy Development/Issues:

CBAS Centers/Provider Issues:

As of September 30, 2014, CDA, the state Department that certifies and provides oversight of CBAS Centers, had 244 CBAS Center providers open and operating in California. There was one closure that occurred in the Los Angeles County area (A Day Away ADHC in La Mirada) on September 30, 2014, for the DY10, Q1 period. Participants were discharged from the closed center and were able to transition to other centers within the vicinity. However, since the closure occurred on the last day of the quarter most details of placements and any need for unbundled services has not been reported. Preliminary data is as follows for ongoing Center Capacity:

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
April 2012	260	1	0	-1	259
May 2012	259	0	1	+1	260
June 2012	260	1	0	-1	259
July 2102	259	0	0	0	259
August 2012	259	3	0	-3	256
September 2012	256	1	0	-1	255
October 2012	255	2	0	-2	253
November 2012	253	4	0	-4	249
December 2012	249	2	1	-1	248
January 2013	248	1	0	-1	247
February 2013	247	1	0	-1	246*
March 2013	247	0	0	0	246
April 2013	246	1	0	-1	245
May 2013	245	1	0	-1	244
June 2013	244	1	0	-1	243
July 2013	243	0	1	+1	244
August 2013	244	1	0	-1	243
September 2013	243	0	2	+2	245
October 2013	245	0	0	0	245
November 2013	245	1	0	-1	244
December 2013	244	0	0	0	244
January 2014	244	1	1	0	244
February 2014	244	0	1	+1	245
March 2014	245	0	0	0	245
April 2014	245	1	0	-1	244
May 2014	244	0	0	0	244
June 2014	244	0	0	+1	245
July 2014	245	0	0	0	245
August 2014	245	0	0	0	245
September 2014	245	1	0	-1	244
				CDA data as of 9/30/2014	

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 notify CDA and carefully link participants with other local CBAS Centers or community resources, not all CBAS Centers do so. Occasionally, Centers will close, shutting their doors without any notification to participants, vendors, or CDA. Unfortunately, CDA finds out about the sudden or unexpected Center closure from CBAS participants or other CBAS Centers in the community.

CBAS participants affected by a Center closure and that are unable to attend another local CBAS Center, can receive unbundled services. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within the participant's local area. The large, statewide volume of In-Home Supportive Service (IHSS)

providers is a key characteristic of California's home and community-based services that help substitute institutional care for seniors and persons with disabilities. Participants can engage/employ their IHSS providers of choice and can self-direct their own care in their home and community setting.

To assist in tracking utilization of unbundled services, CDA has collected data from CBAS participants, CBAS Centers and their discharge summaries. Additionally, DHCS is able to review claimed benefit data from participants that were enrolled at a Center that closed, if they were able to participate at another CBAS Center, or if they received an ongoing or new unbundled service within the HCBS community.

As noted above (see CBAS Licensed Capacity Table), during DY10, Q1 period, there was one center closure (Los Angeles County). Due to data lag time, revised participants' data has yet to be updated, and we are unable to include the Sept. 30th CBAS center closure at this time. Since there was only one closure, which occurred on the last day of the Quarter, the data has not yet reached our data warehouse and there is no update to unbundled services. As indicated with the last quarter's data, all participants affected were able to receive unbundled services (i.e., IHSS, physical therapy, occupational therapy, speech therapy, and/or other HCBS waiver services). The table below shows the amount of time for participants to connect with another available service.

	Within 1 Week	Within 2 Week	Within 3 Week	Within 1 Month	Within 2 Months	Within 3 Months	Within 5 Months	TOTAL
CBAS	5	3	2	0	2	2	1	15
Unbundled	19		2					21
No Services	5							5
DHCS / CDA Compiled Data 7/2014							Total	41

CBAS Transition to Managed Care:

All 58 counties in California are covered by Managed Care plans, with CBAS available in 26 of those counties. Fee-for-service benefits continue in only 4 of the 26 counties (Shasta, Humboldt, Butte, and Imperial). These 4 counties are the only rural counties that have CBAS Centers. CBAS is scheduled to move to a Managed Care benefit in the above 4 counties on December 1, 2014. Call with providers and managed care plans have taken place to assist in the final conversion of CBAS as a managed care benefit.

Consumer Issues:

DHCS continues to regularly respond to issues and questions, in writing or by telephone, from CBAS participants, CBAS providers, managed care plans, members of the Press, and members of the Legislature on various aspects of the CBAS program, as requested. DHCS also maintains the CBAS webpage for the use of all stakeholders. Emails are directed to CBAS@dhcs.ca.gov, from providers and beneficiaries for answering a variety of questions. Most issues are related to consumers changing managed care plans, changing between Medi-Cal FFS and

managed care plans, as well as changing of their Medi-Cal eligibility.

CBAS Fair Hearings:

CBAS Fair Hearings continue to be held through the normal State Hearing process, with the California Department of Social Services (CDSS) Administrative Law Judges' hearing all cases filed. As of DY 10, Quarter 1, there were 2 cases were filed/heard (from the approximate 29,000 participants), throughout the State. Hearings have typically been related to misunderstandings with Managed Care enrollment.

Complaints: [STC 91(l)(i)(d)]

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA. Summarized below, are the complaints that came in during this Quarter:

Demonstration Year 10 - Data on CBAS Complaints				
Demo Year 10 Quarters	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
DY10 - Qrt 1 (Jul 1 - Sep 30)	12	3	15	0.05%
			CDA data - Phone & Email Complaints	

Demonstration Year 10 - Data on CBAS Managed Care Plan Complaints				
Demo Year 10 Quarters	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
DY10 - Qrt 1 (Jul 1 - Sep 30)	13	3	16	0.06%
			Plan data - Phone Center Complaints	

Quality Assurance/Monitoring Activity:

DHCS continues to monitor CBAS Center locations and accessibility and considers provider requests as part of its ongoing monitoring of CBAS access as required under the BTR Waiver. AB 97 (Chapter 3, Statutes of 2011) imposed a 10% rate reduction on specified Medi-Cal providers including ADHCs. Based on DHCS' Medi-Cal Access Study of ADHCs, certain ADHCs were exempted from the 10% provider reduction. All rate reductions and exemptions applicable to ADHC were applicable to CBAS beginning on April 1, 2012. Centers may submit requests to DHCS for review of possible exemption to the 10% rate reduction, due to various hardships in their county area. DHCS and CDA review specifics to determine if exemptions need to be reviewed by the administration and approved for possible implementation. The table below indicates the consistency of each county's licensed capacity since the CBAS program became an approved Waiver benefit in April 2012. The licensed Capacity used below in Table 1, also shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 60% statewide. There is space available in almost all counties where CBAS is available to allow for access to CBAS by Medi-Cal beneficiaries.

Table 1:

County	CBAS Centers Licensed Capacity					
	DY7-Q4 Apr- Jun 2012	DY8-Q4 Apr-Jun 2013	DY9-Q4 Apr-Jun 2014	DY10-Q1 Jul-Sep 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	**355**	0%	73%
Butte	60	60	60	**60**	0%	31%
Contra Costa	190	190	190	**190**	0%	62%
Fresno	590	547	572	**572**	0%	69%
Humboldt	229	229	229	**229**	0%	29%
Imperial	250	315	330	**330**	0%	66%
Kern	200	200	200	**200**	0%	32%
Los Angeles *	17,735	17,506	18,184	**18,284**	1%	57%
Marin	75	75	75	**75**	0%	22%
Merced	109	109	109	**109**	0%	52%
Monterey	290	-	110	**110**	0%	40%
Napa	100	100	100	**100**	0%	53%
Orange*	1,897	1,747	1,910	**1,960**	3%	70%
Riverside	640	640	640	**640**	0%	37%
Sacramento	529	529	529	**529**	0%	63%
San Bernardino	320	320	320	**320**	0%	87%
San Diego	2,132	1,992	1,873	**1,873**	0%	60%
San Francisco	803	803	866	**866**	0%	49%
San Mateo	120	120	135	**135**	0%	66%
Santa Barbara	55	55	55	**55**	0%	4%
Santa Clara*	820	750	840	**830**	-1%	39%
Santa Cruz	90	90	90	**90**	0%	70%
Shasta	85	85	85	**85**	0%	31%
Solano	120	120	120	**120**	0%	26%
Ventura	806	806	806	**851**	6%	65%
Yolo	224	224	224	**224**	0%	74%
SUM =	29,009	27,967	29,007	**29,192**	1%	57%

CDDA Licenced Capacity as of 9/30/2014

Los Angeles - 2 centers closed, 2 centers increased licensee capacity; 2 centers opened and increased licensee capacity

Orange - 1 center increased license capacity

Santa Clara - 1 center decreased licensee capactity

Note: License capacities for centers that run a dual-shift program are now being counted twice, once for each shi

As the STCs require, if a county experiences a negative change of more than 5% in provider licensed capacity, a corrective action plan is to be in place. There is no drop of 5% or more during this Quarter. With current enrollment numbers for participants in counties with CBAS centers, there is ample licensed capacity for enrollment with the current capacity levels being utilized at 60%. The following Table 2 - *Preliminary CBAS Unduplicated Participant Data for FFS and MCO Enrollment* reflects a slightly lower count of participants than those actually serviced during this time period due to the lag in data.

DHCS continues to monitor access to CBAS Centers, average utilization rate, and available capacity. There is enough CBAS capacity (60% overall) to serve Medi-Cal beneficiaries in the counties with CBAS centers. With such excessive capacity in counties where there are multiple CBAS providers, closure of individual CBAS Centers (or consolidation of CBAS providers) continues to minimally impact the program or beneficiaries served.

TABLE 2:

Preliminary CBAS Unduplicated Participant - FFS and MCO Enrollment Data with County Capacity of CBAS															
	DY9 Q1 July - Sept 2013			DY9 Q2 Oct - Dec 2013			DY9 Q3 Jan - Mar 2014			**DY9 Q4 Apr - June 2014**			**DY10 Q1 Jul - Sept 2014**		
County	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used
Alameda	10	490	83%	9	535	90%	8	465	79%	8	464	79%	8	431	73%
Butte	46		45%	42		41%	39		38%	35	0	34%	32		31%
Contra Costa	12	193	64%	14	185	62%	10	119	40%	9	194	63%	6	194	62%
Fresno	10	615	68%	9	604	67%	7	659	69%	9	590	62%	5	661	69%
Humbolt	234		60%	116		30%	110		28%	109	0	28%	113		29%
Imperial	394		70%	389		70%	380		68%	369	0	66%	367		66%
Kern		113	34%		85	26%		89	26%	0	119	35%	0	110	32%
Los Angeles*	1,193	15,255	55%	1,039	15461	55%	1,020	15177	54%	1000	14898	52%	941	16707	57%
Merced		99	54%		110	60%		101	55%	0	105	57%	0	96	52%
Monterey			0%		66	35%		66	35%	0	77	41%	0	75	40%
Orange	12	1,870	60%	9	1899	61%	5	2515	81%	8	2217	69%	6	2313	70%
Riverside	22	386	38%	21	425	41%	18	389	38%	14	388	37%	13	383	37%
Sacramento	28	578	68%	25	398	47%	30	549	65%	20	532	62%	20	544	63%
San Bernardino	20	412	80%	19	477	92%	14	411	78%	14	418	80%	16	456	87%
San Diego*	41	1,549	47%	33	1418	43%	36	1403	42%	33	1448	47%	29	1873	60%
San Francisco	68	666	50%	58	746	55%	53	659	49%	55	688	51%	61	664	49%
San Mateo		142	70%		146	72%		136	67%	0	147	64%	0	151	66%
Santa Barbara		4	4%		4	5%		3	3%	0	9	10%	0	4	4%
Santa Clara	2	728	56%	4	592	46%		559	43%	0	588	41%	1	544	39%
Santa Cruz		104	72%		105	73%		100	66%	0	101	66%	0	107	70%
Shasta	82		57%	40		28%	40		28%	40	0	28%	44		31%
Ventura	8	486	36%	7	959	71%	10	911	67%	7	893	66%	1	940	65%
Yolo	3	227	61%	3	225	60%	2	220	59%	1	215	57%	1	280	74%
Marin, Napa, Solano**		271	54%		220	44%		224	45%	0	235	47%	0	177	35%
Total	**2,185**	**24,227**	**54%**	**1,837**	**24,660**	**54%**	**1,782**	**24,791**	**54%**	**1,731**	**24,326**	**53%**	**1,664**	**26,727**	**57%**
Combined Totals	**26,412**			**26,497**			**26,573**			**26,057**			**28,391**		
*Care1st has revised their methodology resulting in higher, more accurate particiant counts													DHCS / CDA Enrollment Data 9/2014		
** 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															

Financial/Budget Neutrality Development/Issues:

Nothing to report.

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$ 0		$ 0		$ 0
Total:	**$ 0**		**$ 0**		**$ 0**
DSRIP					
(Qtr 1)	$ 0	$ 0			$ 0
Total:	**$ 0**	**$ 0**			**$ 0**
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr1)	$ 381,935		$ (477,266)	DY 6 (Oct-Jun)	$ (95,331)
(Qtr1)	$ 15,520,725		$ 15,440,725	DY 9 (Jul-Jun)	$ 30,961,450
(Qtr1)	$ 48,721,450		$ 48,775,451	DY 10 (Jul-Sept)	$ 97,496,901
Total:	**$ 64,624,110**		**$ 63,738,910**		**$ 128,363,020**

I. DESIGNATED STATE HEALTH PROGRAM (DSHP) UPDATE

Program costs for each of the Designated State Health Programs (DSHP) are expenditures made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols.
This quarter, Designated State Health Programs claimed **$ 64,624,110** in federal fund payments for SNCP eligible services.

II. SAFETY NET CARE POOL UNCOMPENSATED CARE UPDATE

Expenditures may be made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received, furnished by the hospitals or other providers identified by the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, designated public hospitals received $ 0 in federal fund payments for SNCP eligible services.

California Children Services (CCS) Member Months and Expenditures

- California Children Services – Excludes CCS State-Only and CCS Healthy Families Only Eligibles
- Expenditures and Eligibles by Specific Time Periods
- Eligibility Sources: CCS/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)

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

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 Month of Payment
DY6, Q1	September – December 2010	551,505	138,443	$829,406,465
DY6, Q2	January – March 2011	406,113	135,693	$676,468,735
DY6, Q3	April – June 2011	404,674	134,774	$649,757,648
DY7, Q1	July – September 2011	408,149	135,612	$570,379,382
DY7, Q2	October – December 2011	403,452	135,812	$592,896,974
DY7, Q3	January – March 2012	405,879	136,489	$639,248,570
DY7, Q4	April – June 2012	409,451	137,496	$574,933,670
DY8, Q1	July – September 2012	404,973	135,775	$565,527,403
DY8, Q2	October – December 2012	409,169	137,698	$442,066,945
DY8, Q3	January – March 2013	426,875	142,507	$382,433,183
DY8, Q4	April - June 2013	457,711	152,598	$349,532,016
DY9, Q1	July – September 2013	449,582	149,612	$433,168,578
DY9, Q2	October – December 2013	457,645	153,488	$296,658,524
DY9, Q3	January – March 2014	463,509	154,851	$300,036,064
DY9, Q4	April – June 2014	471,221	157,788	$281,705,513
DY10, Q1	July – September 2014	478,266	160,331	$309,373,961