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

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March 27, 2015

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REQUEST FOR RENEWAL OF CALIFORNIA'S SECTION 1115 WAIVER DEMONSTRATION: MEDI-CAL 2020

Dear Ms. Vikki Wachino:

The California Department of Health Care Services (DHCS) is pleased to submit an application to renew the state's Section 1115 Waiver Demonstration. This proposal is a result of over six months of DHCS outreach and engagement with stakeholders, Administration and Legislative partners, and the public to develop strategies for how the Medi-Cal program will continue to evolve and mature over the next five years.

As California continues to be a leader in implementing the Affordable Care Act (ACA), operating the nation's largest Medicaid program, our state seeks to partner with the Centers for Medicare & Medicaid Services (CMS) to ensure that strides made toward delivery of high quality, cost effective care are further expanded and sustained over time. A renewal of our Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

Because of the successes of the Bridge to Reform Waiver, California is in a position to focus its efforts on other critical components of health care reform such as expanding access, improving health quality, equity, and outcomes, and controlling the cost of care through a shift toward paying for value and outcomes instead of volume. The time is also right to partner with CMS in continuing to test innovative strategies that better coordinate care and align incentives around Medi-Cal members taking a whole-person approach to care.

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Thank you again for the opportunity to submit this waiver renewal request. We look forward to continuing to work with you and your staff on approval by November 1, 2015.

Sincerely,

[redacted]

Mari Cantwell
Chief Deputy Director
Health Care Programs

Enclosures:

- Medi-Cal 2020: Key Concepts for Renewal
- Appendix C: "Bridge to Reform" Evaluation Reports
  - Delivery System Reform Incentive Program (DSRIP)
  - Healthy Families Program (HFP)
  - Low Income Health Program (LIHP)
  - Indian Health Services (IHS) Uncompensated Care
  - DY 9 Annual Report
  - DY 10 Quarter 2 Report
- Appendix D: Proposed Budget Neutrality
- Appendix E: Existing Budget Neutrality

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Medi-Cal 2020: Key Concepts for Renewal

March 27, 2015

Medi-Cal 2020: Key Concepts for Renewal

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Section 2: Executive Summary

California's Medicaid Section 1115 Waiver embodies the shared commitment between the state and the Federal government to support the successful realization of some of the most critical objectives for improving our health care delivery system. As California continues to be a leader in implementing the Affordable Care Act, while at the same time operating the nation's largest Medicaid program, our state seeks to partner with the Centers for Medicare & Medicaid Services to ensure that strides made toward delivery of high quality, cost effective care can be further expanded and sustained over time. A renewal of our Medicaid Waiver is a fundamental component to California's ability to continue to successfully implement the Affordable Care Act beyond the primary step of coverage expansion.

Toward that end, California is seeking a Waiver Renewal that will build on the approaches, lessons learned and successes of the existing 2010 Bridge to Reform Waiver and move our Medi-Cal program forward through delivery system and payment transformation. Current Waiver initiatives such as the managed care delivery system for Seniors and Persons with Disabilities (SPDs) and the state's Coordinated Care Initiative (CCI) would continue through the waiver renewal, which will be known as Medi-Cal 2020.

Because of the successes of the Bridge to Reform Waiver, California is in a position to focus its efforts on other critical components of health care reform such as expanding access, improving quality and outcomes, and controlling the cost of care. An ongoing commitment to the partnership between the Federal government and the state and CMS' ongoing support of California's efforts to realize the full potential of the Affordable Care Act through a successor 1115 Waiver will allow the state to continue its pursuit of better care and improved health equity and outcomes for the 12 million individuals served by our state's Medicaid program.

The focus of the Waiver Renewal will be on continuing to drive the transformation of our Medi-Cal program, ensuring ongoing support for the safety net in California, and ensuring the long-term viability of the program and the Medicaid expansion. The Waiver Renewal will continue to facilitate financing innovation in developing sources of the non-federal share of Medicaid matching funds as California has done in prior years through partnerships with the federal government and with our other public entity partners throughout the state.

Concepts included in Medi-Cal 2020 will complement other delivery system and payment transformation efforts California is undertaking, such as initiatives and building blocks under the State Health Care Innovation Plan, including a planned implementation of ACA Section 2703 Health Home Option, leveraging frontline workers, and advancing Accountable Communities for Health.

Existing 1115 Waiver authorities and programs that would continue under the next Waiver include California's Coordinated Care Initiative, the Community Based Adult Services (CBAS) waiver, managed care program, Indian Health Services (IHS) uncompensated care, Designated State Health Programs (DSHPs), and the pending amendments to implement a county-based Drug Medi-Cal Organized Delivery System program and to provide full scope benefits for pregnant women with incomes between 109% to 138% of the federal poverty level.

2.1 Medi-Cal 2020

As a result of the "Bridge to Reform" Waiver's successful health coverage expansion and foundational managed care infrastructure development, California will transform and align the Medi-Cal delivery system around improving health outcomes for the member. In order to achieve a healthier California, Medi-Cal 2020 would invest $15 to $20 billion in Federal funds to facilitate the system transformation, including whole-person health care integration across the physical health, behavioral health, and long-term care spectrum in order to improve health outcomes and quality of life overall and support long-term sustainability of the program, and ensuring the ongoing viability of the safety net, particularly for the remaining uninsured. At the center of this effort is the Medi-Cal member, who will benefit from the creation of shared accountability among all providers to achieve high-value, high-quality, and whole-person care. By 2020, Medi-Cal will be a more accountable and sustainable program for Medi-Cal members and for California's safety net population which in turn strengthens California's health care system more broadly.

The rapid increase in Medi-Cal enrollment – nearly 50% (or about 3.8 million people) in the last 24 months – and the advancement of Medi-Cal managed care throughout the state and across populations are important achievements and also provide new opportunities for California. Enrollment in our managed care delivery system is now at 80%, up from 55% when the 2010 *Bridge to Reform* demonstration began. This growth has resulted in stronger partnerships between local and state entities in the delivery of health care services. In addition, the expansion of Medi-Cal benefits to augment the availability of mental health and substance use disorder services for members provides an important stepping stone for the next phase of the demonstration.

The lessons learned over the past five years highlight the need to continue to build Medi-Cal capacity in ways that better coordinate care and align incentives around Medi-Cal members to improve health outcomes while also containing health care costs. California also needs to ensure sufficient access and capacity in the broader delivery system, and maintain the health care safety net that is critical in serving all Californians, but particularly for in supporting those with unmet health care needs.

2.2 Key Strategies

Demonstrating California's commitment to improving quality and better integrating care, Medi-Cal 2020 will combine a set of strategies to collectively build a stronger and healthier system for all Medi-Cal members. Medi-Cal 2020 is built around specific, interconnected strategies that will improve health of members by strengthening the health care system as a whole, while also assisting in targeting populations in need of specific focus or services to improve coordination, utilization, equity, and at the same time control health care costs.

Within each of these strategies, specific population focus areas may be included, as appropriate, to ensure health equity and elevate support for the Californians with the most complex and acute needs.

- **Delivery System Transformation and Alignment Programs –** The Department of Health Care Services (DHCS) conceptualized and developed the nation's first Delivery System Reform Incentive Payments (DSRIP). California is ready to reinvent thinking on how to promote quality,

improve health outcomes, expand access and promote cost efficiency through a series of programs aimed at delivery system transformation and alignment. Under the renewed Waiver, we will pursue a set of six, cross-cutting approaches that together will advance delivery system transformation in California:

- Managed Care Systems Transformation & Improvement Program
- Fee-for-Service Transformation & Improvement Program
- Public Safety Net System Transformation & Improvement Program
- Workforce Development Program
- Increased Access to Housing and Supportive Services Program
- Whole Person Care Pilots

- **Public Safety Net System Global Payment for the Remaining Uninsured –**This Waiver renewal will transform California's public safety net for the remaining uninsured by unifying the disproportionate share hospital and safety net care pool funding streams into a global payment system. Medi-Cal 2020 will align incentives to deliver quality, coordinated care to California's remaining uninsured by moving away from a cost-based uncompensated care payment structure toward a value-based methodology.

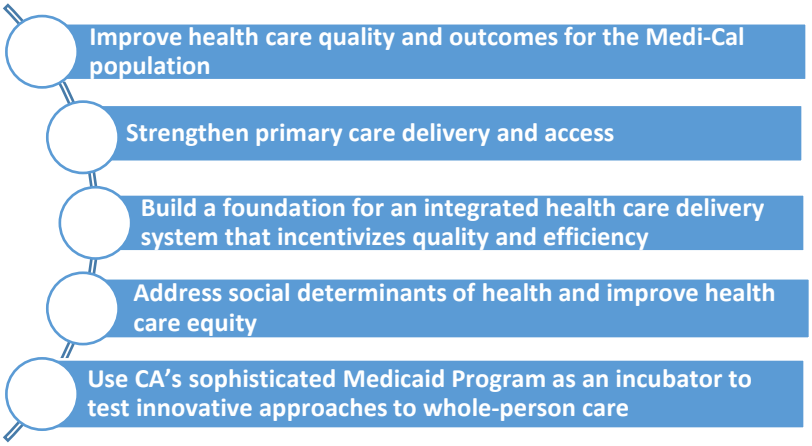
  The funding pool would support public safety net systems in their efforts to deliver comprehensive care for the remaining uninsured that includes primary care in lower cost outpatient and clinic settings. Under the proposed global payment structure, the public safety net systems would be paid a global budget amount for all services provided to the remaining uninsured, the systems would be required to meet service thresholds in order to receive their global budget amounts. The thresholds would be designed to incentivize high-value, low-cost care through recognizing the importance of primary care as well as alternative methods of providing care in ways that best meet the needs of the population. The range of services to be provided would span traditional inpatient facility stays, face-to-face and technology based outpatient encounters, as well as non-office based outpatient encounters and preventative, case management, and health education services.

- **Shared Savings –** In support of California's efforts to achieve the goals outlined above, the state seeks to test a new investment strategy in partnership with the Federal government by initiating a Federal-state shared savings model. California's shared savings initiative would involve a reinvestment of Federal funding in recognition of the savings that California's section 1115 demonstration initiatives generate to the benefit of both the state and the Federal government. This reinvestment would provide the state with a portion of the Federal savings that are generated through the demonstration to facilitate and augment continued Medi-Cal delivery system transformation. Under this initiative, California would be required to demonstrate that the Federal savings generated under the Waiver are substantial enough to permit California to retain a portion or percentage of that savings. The state would need to demonstrate that, even after reinvestment in the Waiver strategies, the Federal government will continue to realize savings. If the Waiver strategies implemented through Medi-Cal 2020 do not result in the level of Federal savings that is projected, California would be required to limit the spending on Waiver reinvestment initiatives to ensure overall savings and budget neutrality.

2.3 Goals and Metrics

Medi-Cal 2020 is designed to improve the quality of care and ultimately the health of Medi-Cal members by driving quality and health outcomes improvement across settings of care, promote system integration, and align incentives. This effort will bring together the Department of Health Care Services, CMS, other state and local agencies, plans, providers, and safety net programs to share accountability for Medi-Cal members' health outcomes, which will result in high-quality, integrated care and increase the value of California's health care dollar, promoting the long-term viability of the program.

The core goals of Medi-Cal 2020 are to:



The success of these interlocking strategies will be demonstrated by a clear set of performance metrics – including statewide measures as well as measures focused at the regional, plan, and provider system level. In particular, DHCS is committed to achieving measurable improvement through the initiatives pursued in this Waiver.

While the details of these measures are still under development, we are looking at the key arena of reducing preventable events (such as readmissions and inappropriate emergency room use) and improved access to timely care in alignment with the overarching goals described above.

Metrics will be selected based on their ability to reflect the underlying opportunities for an improved Medi-Cal health system. These demonstration goals seek to balance quality, efficiency, and patient experience, all key components of a high performing health system. Taken together, the result will be a health system where care shifts away from high cost settings that are most often the last resort for individuals whose care has not been sufficiently coordinated and managed, into settings where patients can easily access coordinated care, when they need it and from a care team that is attuned to the specific needs of the individual. Patient health and care outcomes will improve, fewer Medi-Cal patients will report having poor health, and overall costs will reduce. The goals established for this purpose will complement the broader evaluation of the Medi-Cal 2020 Waiver, as discussed in Section 11.

Section 3: Medi-Cal 2010 Success: Crossing the Bridge to Reform

In November 2010, the Federal government approved California's five-year Medicaid section 1115 *Bridge to Reform* waiver, through which the state received the necessary authority and corresponding Federal support to invest in its health care delivery system and prepare for the full implementation of the Affordable Care Act. The goals for the demonstration were centered on simultaneously implementing an historic coverage expansion, beginning the process of transforming the health care delivery system and reinforcing California's safety net to meet the needs of the uninsured.

The *Bridge to Reform* Waiver was initially designed to support the following primary initiatives:

- Phased-in coverage in individual counties for adults aged 19-64 with incomes up to 200% of the federal poverty level (FPL) through the **Low Income Health Program (LIHP)**

- Improved care coordination for vulnerable populations by mandatorily enrolling **Seniors and Persons with Disabilities (SPDs)** into Medi-Cal Managed Care

- Supported California's public hospitals in their effort to enhance quality of care by providing payment incentives through the **Delivery System Reform Incentive Pool (DSRIP**) Program for projects that support infrastructure development, innovation and redesign of the delivery system, population-focused improvements, and urgent improvements in care.

- Supported the ongoing provision of services to otherwise uninsured individuals through the **Safety Net Care Pool (SNCP) Uncompensated Care** Component and federal funding of **Designated State Health Programs (DSHP)**.

In addition, several amendments were made to augment the original framework of the demonstration over the years, including:

- **Effective April 1, 2012**: The Department of Health Care Services (DHCS) began operating an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Medi-Cal members enrolled in a managed care organization at Community-Based Adult Services Centers (CBAS).

- **Effective January 1, 2013**: Children enrolled in California's Healthy Families Program were transitioned into Medi-Cal's Optional Targeted Low-Income Children's (OTLIC) Program, where they will continue to receive comprehensive health, dental, and vision benefits. The OTLIC Program covers children with family incomes up to 250 percent of the FPL.

- **Effective April 2013:** The state received CMS approval for the DHCS to make uncompensated care payments to Indian Health Service (IHS) and tribal facilities to assist them with their uncompensated care costs. Qualifying uncompensated encounters include primary care encounters furnished to uninsured individuals with incomes up to 133 percent of the FPL who

are not enrolled in a California County LIHP. In December 2014, DHCS received approval to extend the Indian Health Services uncompensated care payments for tribal providers through October 31, 2015.

- **August 29, 2013:** DHCS received approval to expand Medi-Cal Managed Care into 28 additional counties, with phased-in enrollment beginning in September 2013, with additional approval in 2014 to enroll SPDs into managed care in all but one of California's counties.

- **Effective January 1, 2014**: Individuals newly eligible for Medi-Cal with incomes up to 133% of the FPL were added to the Medi-Cal managed care delivery system. The waiver amendment allowed for a seamless transition of the Medi-Cal Expansion Low-Income Health Program into Medi-Cal managed care. The state also received approval for an expansion of 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) on April 1, 2014. The CCI is providing integrated care across delivery systems and working to rebalance service delivery away from institutional care and into the home and community. The CCI was authorized in eight counties across California: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.[1] 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.

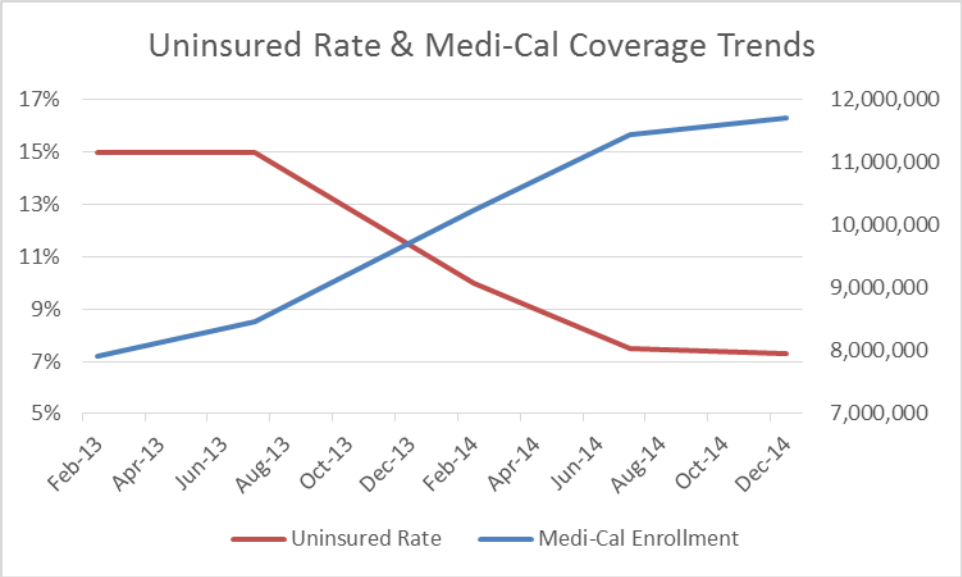
DHCS also has two amendments pending approval with CMS. The Drug Medi-Cal Organized Delivery System waiver seeks to provide better coordination of care and a full continuum of care for substance use disorder treatment services, including residential treatment services which would be unavailable for most beneficiaries absent a waiver. The second amendment seeks to expand full scope Medi-Cal eligibility to pregnant women with incomes between 109% and 138% of the FPL.

Results

California has successfully achieved all of the established goals in the Bridge to Reform demonstration and has used the resources available through the demonstration to begin the process of transforming the Medi-Cal delivery system and putting the program on a path to long-term viability. While there is more refinement to be done, this Waiver has successfully advanced access to comprehensive, affordable health coverage while also putting the tools in place for achieving long-term quality improvement and financial sustainability.

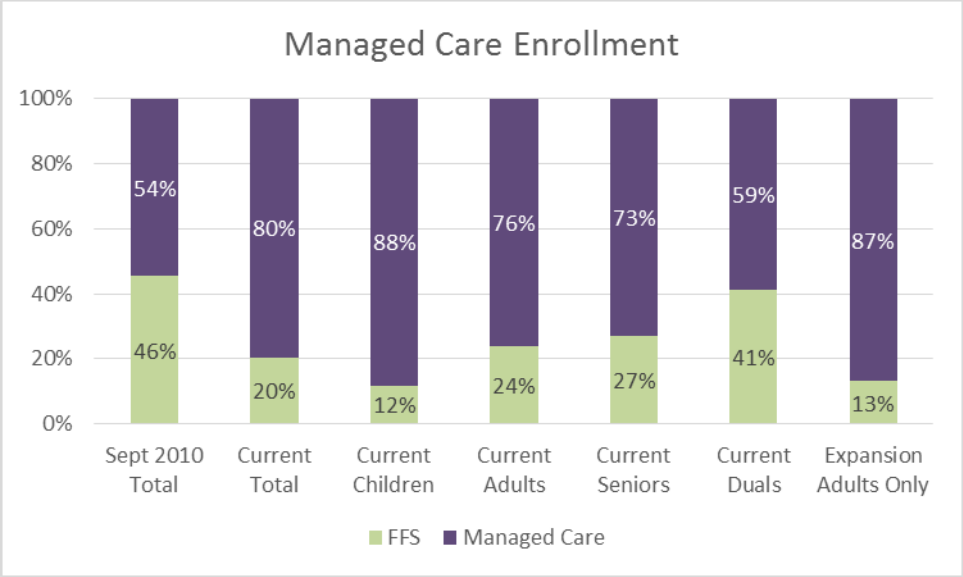
[1] Alameda is no longer implementing a CCI program. The state has implemented the CCI program in 6 of the 7 remaining counties to date.

Coverage Expansion. As a result of the state's commitment to fully expanding Medi-Cal coverage to its low-income residents and providing an affordable coverage option through the state's health insurance Marketplace -- Covered California – the uninsured rate in the state has declined from 15% in late 2013 to just over 7% today. Medi-Cal enrollment has increased by nearly 50% in 24 months, and Covered California is serving 1.12 million residents. (See Figure 1)



Transition to Managed Care. As one of the leading states in testing the value of managed care delivery systems in providing cost-effective coverage for its Medicaid population, California has proven that managed care can be an important option for people of all ages and health conditions. Under the *Bridge to Reform* demonstration, we expanded managed care to 28 new counties and to provide coordinated care for some of our most vulnerable populations such as Seniors and People with Disabilities (SPDs) and in certain counties, members who are dually eligible for Medicare and Medicaid. Presently, 80% of Medi-Cal members, or 9 million plus individuals, are enrolled into the managed care delivery system across all 58 California counties, up from around 54% at the start of the Waiver in 2010. This continuing effort to provide high quality care while containing costs has proven to be a critical element of the sustainability of the program.

Figure 2 -- Medi-Cal Managed Care Enrollment – By Population



Delivery System Reform. The *Bridge to Reform* demonstration was the first in the nation to include a Delivery System Reform Incentive Payment (DSRIP) program. One of 7 states with approved DSRIP programs in their demonstrations today, California has many lessons to share from its experience, including[2]:

- **Primary Care.** The public hospital systems in California used the DSRIP program to expand primary care medical homes. Eleven of the systems expanded primary care capacity and seven focused on primary care redesign. These activities included offering more weekend and evening appointments, increasing the number of patients assigned to primary care providers, improving panel management, and instituting navigation programs to connect patients from the emergency department to primary care providers.

DSRIP Success: Kern Medical Center

In 2011, Kern Medical Center launched its Emergency Department (ED) Navigator Program to help ED patients, particularly those seen for non-urgent conditions, better navigate the health care system. The ED Coordinator educates patients about the importance of primary care and coordinates with community and county-run clinics to schedule primary care appointments upon the patient's discharge from the ED. The program also connects patients to care management services, resulting in a 61% reduction in ED visits and 66% reduction in avoidable inpatient admissions in 2012.

[2] The following examples are an excerpt from an issue brief released by the California Association of Public Hospitals entitled "Leading the Way: The Delivery System Reform Incentive Payment Program (DSRIP)", September 2014. Available at http://caph.org/wp-content/uploads/2014/09/Leading-the-Way-CA-DSRIP-Brief-September-2014-FINAL.pdf

- **Improved Use of Data**. A number of the hospital systems used the DSRIP to develop disease registries, standardize quality data reports and capture race, ethnicity, and language data. Once data systems were accessible, care teams were able to utilize more sophisticated data for population health management, including personal health records for complex care management and self-management. Teams were also able to run reports that identified patients based on condition or assigned provider for panel management efforts.

DSRIP Success: San Joaquin General Hospital

San Joaquin General Hospital's (SJGH) primary care clinics implemented the i2i Tracks disease management registry. Between July 2012 and June 2013, more than 20,000 patients were assigned to medical homes using i2i Tracks, enabling medical home teams to more systematically monitor and manage the health of their patient population. For example, the registry helps providers identify diabetic patients with unsafe blood sugar levels for targeted outreach and support.

- **Care Coordination.** The public hospital systems have improved care coordination for patients by enhancing linkages between primary care, specialty care and inpatient settings. Efforts have included expanding chronic disease management programs, and piloting targeted care management approaches for patients who were frequent utilizers of the emergency department. These programs aim to ensure that patients receive the right care, at the right place, at the right time to produce better health outcomes and more efficient use of health care resources.

DSRIP Success: UC Irvine Medical Center

UC Irvine Medical Center's "Care Connect" patient navigation system assigns patients with complex treatment regimens to chronic disease coaches to ensure a high level of coordination between their providers and services across the care continuum. Coaches work closely with primary care doctors to improve outcomes for high-risk patients identified using risk-stratification algorithms. After just six months of enrollment, the system achieved a 52% reduction in inpatient visits and 60% reduction in emergency department visits.

- **Patient Safety.** Making hospital care safer has been a critical component of the DSRIP. All of the 21 participating hospitals are working on reducing sepsis and central line associated blood stream infections (CLABSI) and working to prevent hospital acquired conditions.

Collectively, these accomplishments have ensured that California is well on its way to achieving full delivery system transformation, but there is more work to be done. Medi-Cal 2020 is a critical component in enabling the state to continue on its path toward meeting the Triple Aim and ensuring long-term financial stability for the Medi-Cal program and the California health care system as a whole.

Section 4: Delivery System Transformation and Alignment Programs

The California Department of Health Care Services developed the first DSRIP program in the country. California is again ready to step up as a pioneering partner to reinvent thinking on how to promote quality, improve health outcomes, reduce disparities, expand access and promote cost efficiency through a series of programs aimed at transformation and alignment across the full spectrum of the delivery system. Additional descriptions of each Delivery System Transformation and Alignment Programs proposal are detailed in Sections 4.1 – 4.6.

Managed Care Systems Transformation & Improvement Programs: Regional Incentives among Managed Care Organizations, County Behavioral Health Systems, and Service Providers

The Waiver will transform Medi-Cal's historically disparate financial incentives through a culture of shared accountability across providers and plans. Historically, managed care plans have served as incubators for innovation; one of the goals of the waiver renewal will be to extend payment reforms across the entire managed care plan network, as well as bridging care across delivery systems to include behavioral health care, serving Medi-Cal members in ways that can flexibly meet the specific needs of each region.

Innovative value-based purchasing strategies, such as joint incentive pools with Medi-Cal's plans, behavioral health systems, and providers, will align incentives at each layer of the delivery system, ensuring that members receive the right care in the most appropriate setting, which will improve health outcomes while reducing the overall cost. Incentive arrangements would require Medi-Cal managed care plans, county behavioral health systems, and providers to work together to achieve specific metrics.

California would use Waiver authority and funding to test alternative flexibilities to traditional Medicaid services that address social determinants of health, enhance plan/provider capacity, and foster enhanced care coordination. As a long-term goal, these incentives would enable the delivery system to transition away from eligibility group-specific cost-based rate setting to blended value-based models.

A series of incentive programs are envisioned to strengthen partnerships and collaboration between Medi-Cal managed health care plans, county specialty mental health plans, substance use disorder treatment services, and contracted providers.

Fee-for-Service System Transformation & Improvement Program

Through the Waiver, DHCS would also target FFS incentives in two key areas where FFS continues to play a critical role in care delivery – dental and maternity care.

DHCS is looking to address local needs to expand access to dental services through Waiver incentives. Strategies include targeted incentives to increase provider participation, and incenting delivery of preventative services in lieu of more invasive and costly procedures.

Pregnant women are one of the largest remaining Medi-Cal populations in fee-for-service. Medi-Cal currently pays for nearly 60 percent of all deliveries in California, giving the program tremendous ability to promote value in maternal and child health. Under the Waiver, we will look at cost and quality drivers in prenatal, delivery, and postpartum care and help improve health outcomes and promote a standard for efficient care that will benefit all Californians.

Public Safety Net Transformation & Improvement Program

Building on lessons learned over the past five years and from the experiences in other states, California will continue its drive toward quality, improved outcomes and accountability in public safety net systems. In the Waiver renewal, California will continue to advance quality improvement through the 21 large public safety net systems (Designated Public Hospitals). In addition, California will provide an opportunity for the state's 42 safety net systems run by health care districts (Non-Designated Public Hospitals) to participate in this program, provided that the hospitals are able to meet specified criteria.

The District hospital systems are often located in more rural areas of the state and as such are frequently the only hospital system for the community. We anticipate that many of these health systems will both be interested and equipped to participate in this program. This Program will contain fairly standardized and rigorous evaluation metrics, new improvement categories, and an expanded focus on advancing the Department's three linked goals: Improve population health and overall health outcomes; Improve quality and access, and therefore the experience of care; and reduce the per capita cost of care.

The projects will be organized in five core domains that will each include required core components and standard quality and outcome metrics:

- *Systems Redesign* – focused on redesigning ambulatory care, improving care transitions, and the integration of behavioral health (both mental health and substance use disorders) and primary care services.
- *Care Coordination for High Risk/High Utilizing Populations* – focused on complex care management, health homes, and advanced illness planning and care.
- *Resource Utilization Efficiency* – focused on appropriate use of antibiotics, high cost imaging and pharmaceuticals.
- *Prevention* – focused on core areas such as cardiovascular health, obesity, cancer, perinatal care.
- *Patient Safety* – focused on improving safety in ambulatory care (e.g., medication reconciliation) and creating a culture of safety.

Workforce Development Program

California is facing several workforce challenges for Medi-Cal providers, such as enrollment growth and increased competition for providers under the ACA, an aging workforce and Medi-Cal population, geographic and cultural differences between provider and member distribution, and a long educational "pipeline" with limited capacity for some professions. To achieve better outcomes through whole-person care, the Medi-Cal provider workforce must become more integrated and coordinated across the full array of services: physical health, mental health, substance use disorder services, and long-term services and supports.

Medi-Cal 2020 will increase beneficiary access to the full spectrum of Medi-Cal providers and augment the Medi-Cal workforce by developing a system that rewards providers' commitment to serving the

Medi-Cal and safety net populations. The Waiver will invest in evidence-based opportunities and align financial incentives to enhance workforce capacity.

- The Waiver will provide financial incentives to health professionals who have not previously cared for Medi-Cal members, and to existing Medi-Cal providers who treat additional Medi-Cal beneficiaries. Financial incentives would be targeted to health professionals in geographic areas with the greatest need for Medi-Cal participating providers and to professions and specialties where recruiting is most challenging.

- Medi-Cal 2020 will develop a culturally-competent workforce that leverages non-physician and frontline workers to ensure that Medi-Cal members are receiving appropriate and timely care. Under the Waiver, the health system will utilize non-clinical members of the care team to help those new to coverage navigate the health system through health education and other outreach efforts. As needed to improve care quality, the Waiver would provide for voluntary training opportunities for these workers.

- The Workforce Development Program strategy ties into the overall focus of the Waiver on improving whole-person care through creating incentives and programs to expand cross-training of providers in primary care, mental health, substance use disorder services, and long-term services and supports, to support integration of multi-disciplinary teams across care settings.

Increased Access to Housing and Supportive Services Program

The Waiver will provide tools to better coordinate care for the most vulnerable Medi-Cal members through policies, data analysis and measurement that facilitate access to supportive services that are also proven to reduce costs, including improved access to affordable housing. Medi-Cal 2020 will elevate community resources and align incentives to provide the supportive services for Medi-Cal's most vulnerable population on the premise that the availability of stable housing arrangements ultimately serves the goal of improving health outcomes.

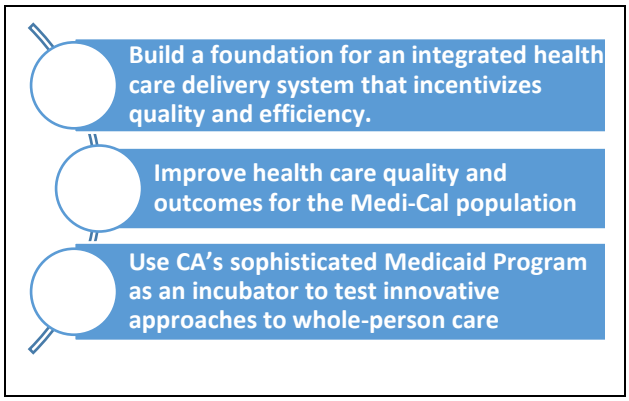
Research suggests that individuals experiencing homelessness, particularly those individuals with multiple chronic conditions, often struggle to receive appropriate health care services and are disproportionately likely to be high utilizers of the health care safety net. For this population, targeted case management services can play an instrumental role in obtaining and maintaining housing and reducing health care utilization while improving health outcomes.

Regional Integrated Whole-Person Care Pilots

Through this Waiver, DHCS seeks to offer an option for enhanced model of regional partnerships requiring proposals for a geographic region-- a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans-- for that region. Managed care plans, counties, and local partners would provide Whole-Person Care for target high need patients through collaborative leadership and systematic coordination with other public and private entities identified by the county. Pilots would be subject to state and federal approval. The pilot design would encourage innovation in delivery and financing strategies to improve health outcomes of target populations. The pilots would include approaches outlined in the delivery system transformation and alignment incentives section of this concept paper across the spectrum of whole-person care delivery (MCO/provider, MCO/county, and access to housing and supportive services, workforce development).

4.1 Managed Care Systems Transformation & Improvement Programs: Regional Change through Incentives among Managed Care Organizations, County Services, and Service Providers

Medi-Cal has been at the forefront of Medicaid payment reform, with widespread adoption of a delegated, sub-capitation model, wherein provider organizations receive a per-member-per-month capitated payment to provide both primary care and specialty services. In addition to this model, several Medi-Cal managed health care plans have implemented other innovative payment reforms to eliminate the perverse incentives for volume-based care that underlie fee-for-service systems, improve the quality of care, and make the delivery of health services more efficient. Under Medi-Cal 2020, reforms will include pay-for-performance based on quality and resource utilization as well as shared savings between providers, managed care plans, and the state that will lower the total cost of care, relative to expected trends.



The current managed care capitation rate setting process has limited long-term ability to incentivize widespread adoption of payment reforms that promote investments in strategies that incent efficiencies such as appropriate reduction in costs and utilization. . When capitation rates are set, actuaries consider the managed care plans' data as one factor in determining actuarially sound rates. For plans that achieve lower utilization through payment reforms, the current methodology allows those plans to benefit from those utilization gains until the rates are revised using data from this time period. This approach creates a negative tension between the state and the plan because the financial incentives are misaligned. New contracting and capitation models could be structured to recognize potential benefits to purchasers (state and federal government), plans, and providers thus creating rewards and incentives throughout the system that are sustainable over the long run.

During the course of the Waiver, the state would move toward restructuring the capitation rate setting methodology to enable shared savings between managed health care plans and providers, the state, and CMS. The goal of the Waiver programs outlined below is to demonstrate that this type of shift in managed care rate-setting will result in better outcomes and reduced total cost of care. A shift to this approach would better align incentives for pursuing payment reforms across the continuum of the state, the managed health care plans, and providers, including behavioral health providers.

As part of Medi-Cal 2020, DHCS would take lessons learned from California and other Medicaid programs and spread these and other payment reform models more widely across the Medi-Cal managed health care plan network.

Proposed Payment Reform Strategies:

- *Strategy 1: Shared Savings Incentives with MCOs*
  Under this strategy, the state would identify targeted populations and/or services for which we would like to see change in outcomes and cost, and increased shared accountability among plans, county services and providers.

  The core of the proposal is to provide a shared savings calculation between the state and the MCO, based on the projected total cost of care. If the plan, in partnership with the providers and behavioral health systems (joined in what would be similar to accountable care groups) is able to demonstrate costs below total cost of care and meet mutually determined outcome and quality targets, the plan would be eligible to receive shared savings incentive payments. Improvements in access to and provision of preventive dental care would also be an opportunity to drive down overall costs and improve health. The value of the shared savings incentive would be calculated as the difference between projected expected costs, determined prior to the measurement period, and actual costs. This approach requires development of total cost of care measurement for Medi-Cal managed health care, including adjustment for geography and risk which is currently performed today. Quality performance would be based on a combination of attainment and improvement; plans that did not pass the quality threshold would be ineligible to share in any savings. Formal agreements such as contracts, MOUs, or MOAs would be required as appropriate to codify arrangements between impacted entities.

  A second complementary component of this proposal would address some of the social determinants of health that drive poorer health outcomes and higher costs for Medi-Cal members. The state would identify non-traditional services (e.g., tenancy supports, as detailed under the Section 4.5, Increased Access to Housing and Supportive Services) that a plan could provide and, depending on a demonstration of the impact on improved outcomes, would permit a plan to receive an incentive payment.

- *Strategy 2: Pay-for-Performance Strategies for Managed Care Plans to Implement with their Providers*. The majority of managed care plans have a pay-for-performance (P4P) program in place; however, these programs often vary across plans. Providers may find these differences burdensome, thus, standardization of metrics, whenever possible, will decrease administrative burden while at the same time driving improvement in quality.

  Managed care plans would adopt a P4P program that meets certain core design elements, with flexibility for tailoring to local area and provider sophistication. The core design elements would include standard quality, patient satisfaction, data completeness, and resource-use measures that all plans should adopt, as well as an optional set of measures from which plans could chose that reflect their member population and provider readiness. The core set of metrics would align with the core waiver goals. The optional measures would align with one or more of the following: the DHCS Strategy for Quality Improvement in Health Care, Medi-Cal Managed Care Quality Strategy, Let's Get Healthy California, other areas of focus under the waiver (DSRIP, housing, workforce), health plan quality improvement projects and improvement plans, and the overall DHCS mission and vision. Coordination would occur with other focus areas of the waiver; however, no duplicate payments would be made. Areas for targeted P4P programs are outlined on the DHCS website:
  http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MCO3_DHCS2.pdf

Strategy 3: Integrate behavioral health and physical health at the plan/county and provider levels. Under California's current structure, managed health care plans are responsible for physical health care and mental health services for individuals with "mild to moderate" mental health impairments, while county behavioral health systems (county mental health plans and substance use disorder systems) are responsible for specialty mental health services and substance abuse services. The goal of the following two proposed reform strategies is to better coordinate and promote integration of behavioral and physical health for a more seamless care experience and reduce the total cost of care through aligned financial incentives and value-based payments. The proposals would address the opportunity for better coordination at both the plan/county and provider levels. While highly complementary, these two models need not be implemented simultaneously.

- Plan/County Coordination Model*:* Under the first component of this reform strategy, participating Medi-Cal managed care plans would be required to work with county mental health plans to support Medi-Cal members with identified mental health issues. This approach, as facilitated by the state, would build on the coordination and shared accountability approaches implemented in the Cal MediConnect program, and the current MOUs that Medi-Cal managed care plans (MCPs) are currently required to sign with county entities. MCPs and county specialty mental health plans (MHPs) would be jointly responsible for improving health outcomes and reducing avoidable emergency room visits and hospital stays by promoting care coordination and information sharing for members who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services. Progress would be measured using a set of metrics that MCPs and MHPs can jointly influence by improving care coordination and collaboration and demonstrate improved patient outcomes across both programs.

  An incentive pool would be allocated to MCPs and MHPs under two incentive payment streams. The first incentive payment would be allocated before performance measures or outcomes measures are met, when both plans commit to collaborate and sign an agreement that outlines specifics on health information exchange, data collection, shared accountability processes, and targeted improvement metrics and financial alignment incentives that are subject to DHCS review and approval. This first incentive payment would provide the MCPs and MHPs the necessary financial incentive to develop processes and procedures to truly affect change in the outcomes for these members. A second set of quality incentive payments would be available in subsequent periods of the demonstration for plans that meet joint performance goals for a set of quality and outcome measures. The state would define performance measures and methodology for distributing earned incentives. The quality incentive payments would be allocated after plans have met the measures, and would be the majority of the payments under this proposal. Over time, this incentive structure would ultimately evolve to a risk based shared savings model taking both quality and financial performance into account.

- Provider Integration Model: The state proposes a second reform strategy that would encourage physical health and mental health plans to implement an integrated care model for patients with serious mental health and other chronic health conditions at the provider level. Under this proposal, each MCP would offer incentives based on tiers of increasing physical health and behavioral health integration to ensure that team-based care is provided

to Medi-Cal members with mental health and physical health needs, using either a coordination or co-location approach. This could include incenting cross-training of providers, as well as the use of telehealth. Both primary care practices and mental health providers would be eligible to adopt this model, so there is "no wrong door" for a member who needs integrated care for both mental and physical health care who chooses to receive their care in each respective setting. This work would be integrated with the State's proposal under Workforce Development; no duplicate payments would be made.

4.2 Fee-for-Service System Transformation & Improvement Program

While the vast majority of services are provided through Medi-Cal managed care plans, there are still critical services provided through Medi-Cal's fee-for-service program, in particular dental services and deliveries. In order to improve care delivery and institute transformation in these areas, California proposes the following programs aimed at our FFS system.

Incentives in Medi-Cal Dental: Oral health is fundamental to improving overall health status and quality of life. California has actively participated in the CMS Oral Health Initiative for several years. In order to more rapidly meet these goals, California will implement statewide provider incentive payments for the provision of preventive services.

The provision of dental services in Medi-Cal is almost entirely done through our FFS system, although we do offer dental managed care in two counties, and with the recent restoration of adult dental service in California, the state proposes to test the efficacy of incentive payment strategies for dental providers to assess the impacts on access to care and utilization of services. California has two proposals for value based incentives in Medi-Cal dental services aimed at expanding access to oral health services and improving utilization of preventive services.

Under this proposal, dental providers would be eligible to receive incentive payments for providing increased access to dental services for Medi-Cal beneficiaries. Incentive payments would be available for dental providers who are new providers to the Medi-Cal system and provide specified levels of access to Medi-Cal beneficiaries (e.g. provide space for X percent of their practice for Medi-Cal members). In addition, for existing Medi-Cal dental providers, incentives would be available to them for increasing the number of Medi-Cal members they treat.

Incentives in Medi-Cal Maternity Care*:* Over 500,000 babies are born every year in California. We have not, however, achieved optimal benchmark target rates across the state for procedures such as first-born, low-risk C-sections; vaginal birth after C-section and early elective deliveries. Although elective deliveries and C-sections are declining in California, there is more to be done to reduce avoidable complications and lower attendant costs.

Currently Medi-Cal finances approximately 60% of California births, which presents a tremendous opportunity to promote value in maternity care. While the State has successfully expanded their

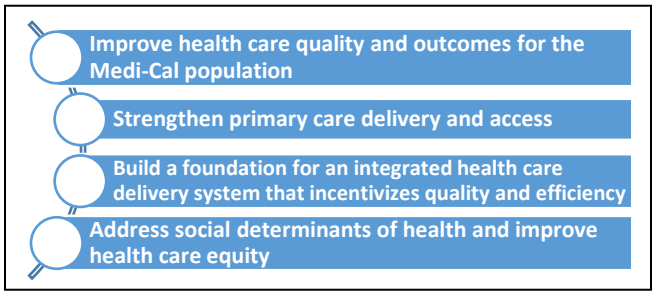
managed care infrastructure and now delegates the responsibility for most Medi-Cal members to managed care plans, pregnant women remain one of the largest Medi-Cal populations in fee-for-service. Over half of all hospital births financed by Medi-Cal are still paid on a fee-for-service basis.

To promote evidence-based obstetrical care and to reduce the quality shortfalls and high costs in Medi-Cal FFS, California proposes to pilot a hospital incentive program for hospitals. The Hospital Incentive Program will provide bonus payments to hospitals that meet quality thresholds. Hospitals will collect and report data on the four performance measures: (1) Early Elective Delivery, (2) Cesarean Section Rate for Low-Risk Births, (3) Vaginal Birth after Cesarean Delivery Rate[3], and (4) Unexpected Newborn Complications in Full-Term Babies. Hospitals will earn incentive payments if their performance meets or exceeds established benchmarks set for these four core measures.

This incentive program presents an opportunity to align with managed care plans' pay-for-performance and quality improvement initiatives to maximize the impact of delivery system transformation.

4.3 Public Safety Net System Transformation & Improvement Program

Over the past five years, the California Delivery System Reform Incentive Program (DSRIP) has supported the initial steps of transforming and stabilizing the public safety net health system, built important foundations for health care transformation (e.g., chronic disease registries, expansion of health homes, chronic care management programs), advanced patient safety and clinical quality, and developed data systems to support population health. While the DSRIP has helped public health care systems achieve impressive results, much work remains in order to fully transform these into high performing health systems that provide everyone with timely access to safe, high-quality, and effective care.



Under Medi-Cal 2020, California proposes to build upon DSRIP and the transformative changes started in the BTR Waiver, by creating a public safety net system transformation and improvement program. Concepts for this program are informed by several sources including: (1) CMS guidance; (2) experience with the current 1115 waiver; (3) health care recommendations in the report of the Governor's Let's Get Healthy California Task Force Report (4) consideration of the leading causes of preventable mortality and morbidity; and (5) alignment with state (e.g., DHCS Strategy for Quality Improvement in Health Care) and national health targets (e.g., as identified in the National Quality Strategy and the National Prevention Strategy). The goals of this program are to drive even further change in the public safety net systems, while also providing a more standardized approach and outcomes focused metrics to demonstrate statewide changes occurring in the public safety net systems.

[3] If applicable to a particular hospital

Domains
Under this program, California is proposing five core domains representing important themes that drive quality improvement and population health advancement. Within each domain, public safety net systems will embark on multiple projects, each with a required set of core components and standardized quality and outcomes metrics.

Domain 1 - System Redesign. Major health system transformation has been called for to make significant progress toward advancing the Triple Aim, in part through improved system integration including physical and behavioral health services.

Projects in the System Redesign domain seek to advance the transformation and integration of the delivery system by emphasizing high-quality and efficient primary care in coordination with specialty care services. All projects in this domain are required and their areas of focus include: (1) ambulatory care redesign for primary care, to improve the effectiveness of care delivery; (2) ambulatory care redesign for specialty care, to improve access to specialty expertise and the coordination and collaboration with primary care; (3) integration of post-acute care to prevent avoidable readmissions; and (4) integration of behavioral health and primary care services to ensure coordinated and comprehensive care for our members.

Domain 2 - Care Coordination for High Risk, High Utilizing Populations. Researchers, policymakers, and clinicians have all emphasized the need to better coordinate care within and across the sectors of physical health, behavioral health, and social aspects of health (e.g., access to food, housing, transportation, jobs, and education). This need for care coordination through more team-based approaches to care and better use of front-line workers in care navigation, and in offering culturally and linguistically competent care, is particularly critical for high-utilizers of health resources. The state's health care system has not generally addressed care across sectors. This coordination is a fundamental element of delivery system transformation.

Transformation and improvement in care coordination for high-risk, high-utilizing populations including foster children, individuals who have recently been incarcerated, and patients with advanced illness, will focus on identifying target populations, conducting qualitative assessments of high-risk, high-utilizing patients, developing evidenced-based complex care management programs, and implementing data driven systems for rapid cycle improvement and performance feedback to address quality and safety of patient care in order to achieve specific objectives and metrics. These objectives include: (1) increasing patients' capacity to self-manage their condition; (2) reducing avoidable acute care utilization; (3) improving health indicators for chronically ill patients including those with mental health and substance use disorders; and (4) improving the patient experience.

Domain 3 - Prevention. McGinnis and Foege and Mokdad and colleagues[4] have demonstrated the importance of prevention in reducing preventable morbidity and mortality. The leading underlying causes of death (smoking, poor nutrition, physical inactivity, alcohol abuse) account for 35-50% of preventable mortality depending on the specific population. The U.S. Preventive Services Task Force and other sources have specified the evidence-based preventive services that can reduce morbidity and mortality while also reducing the financial burden of care.

[4] McGinnis JM, Foege WH. *Actual causes of death in the United States*. JAMA. 1993; 270:2207-2212; AH Mokdad, JS Marks et al*. Actual causes of death in the United States*, 2000. JAMA. 2004; 291:1238-1245.

Delivery system improvements in prevention will focus on identifying and implementing standardized, evidence-based and population resource stewardship approaches that address, in large part, the leading causes of preventable morbidity and mortality, reduce disparities, and reduce variation and improve performance. Areas of emphasis in this domain include: (1) meeting the Million Hearts® initiative clinical targets, starting with tobacco cessation, hypertension control, and aspirin use for secondary prevention; (2) increasing rates of screening and completion of follow-up for breast, cervical, and colorectal cancer; (3) improving performance on obesity screening and referral to treatment for children, adolescents, and adults, as well as supporting the provision of healthful food in clinical facilities by implementing the Partnership for a Healthier America's Hospital Healthier Food Initiative; and (4) improving timely prenatal and postpartum care, decreasing cesarean section rates, and improving breastfeeding initiation, continuation, and baby-friendly practices.

Domain 4 - Resource Utilization Efficiency. Eliminating the use of ineffective or harmful clinical services and curbing the overuse and misuse of clinical services have been championed by the Choosing Wisely Campaign (CWC). CWC was launched by the American Board of Internal Medicine and supported by the Robert Wood Johnson Foundation and the Consumers Union. Thus, improved resource stewardship is an important goal for a transformed health care delivery system.

Projects in this domain will use evidence-based guidelines and comparative data and benchmarking to drive improvement in the following areas: (1) antibiotic stewardship to reduce overuse and misuse from a system perspective; (2) employing proven intervention methods to drive reduction in high cost imaging; (3) apply value-based principles and drive shared decision-making to move pharmaceutical use to higher levels of cost-effectiveness; and (4) implement evidence based approaches to the use of blood products to improve the safety and appropriateness of use.

Domain 5 - Patient Safety. Using updated methods, a recent patient safety paper projected that 200,000 to 400,000 preventable deaths occur each year in the U.S. due to medical error.[5] There is widespread agreement that more can be done systematically to improve patient safety. However, there is also broad acknowledgement in the research and practice community that the challenges to achieving such improvement are real. One of the most serious challenges is developing data systems that can efficiently identify patient safety issues and track progress tied to corrective policies and programs. Additionally, despite the fact that the vast majority of health care takes place in the ambulatory care setting, efforts to improve safety have mostly focused on the inpatient setting. The ambulatory environment is prone to problems and errors that include missed/delayed diagnoses, delay of proper treatment or preventive services, medication errors/adverse drug events, and ineffective communication and information flow. However, a body of research dedicated to patient safety in ambulatory care has emerged over the past few years. These efforts have identified and characterized distinct factors that influence safety in office practice, the types of errors commonly encountered in ambulatory care, and potential strategies for improving ambulatory safety.

Transformation and improvement in patient safety will focus on substantially reducing adverse events through safety protocols and medication reconciliation in the ambulatory setting. Areas of emphasis in this domain include: (1) medication reconciliation and proper documentation of current medications in

[5] JT James. *A New, evidence-based estimate of patient harms associated with hospital care*. J Patient Saf. 2013; 9:122-128.

the medical record; (2) increasing levels of patient activation; and (3) creating a culture of safety in the ambulatory setting.

Eligible Public Safety Net Systems
The hospitals eligible to participate in this program include the spectrum of public safety net systems (county systems, University of California systems, and systems operated by healthcare districts or municipalities)

The 21 county and UC systems, known as the designated public hospitals (DPHs), participated in the 2010 DSRIP and their participation in this program will continue to drive transformation in the public safety net resulting in improved care delivery and outcomes for the Medi-Cal and other populations served by these systems.

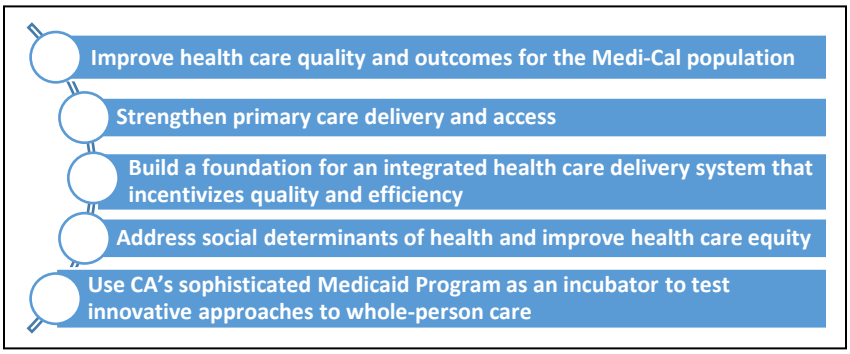
The 42 healthcare district/municipality systems, known as non-designated public hospitals (NDPHs), are also critical public safety net systems. Two-thirds of these systems are rural, and nearly half are designated as critical access hospitals. In addition, many of these facilities operate rural health clinics. These systems are located in 28 counties across the state. Due to the diversity among NDPHs, we propose to implement a "tiered" approach for these hospitals' participation in the DSRIP.
Large facilities would select/create multiple projects which would be scaled according to facility size and resources, while small facilities might only take on one project with a smaller scaled and may only focus on an area of improvement rather than multiple areas. Given that these 42 NDPH systems did not participate in the 2010 DSRIP effort, California is requesting a funded planning period of up to 12 months to give interested NDPHs time to get the tools and technical assistance in place to enable them to successfully operate these program, as has been done in New York and other states implementing DSRIPs.

This planning period will be critical to allow these facilities' limited time and resources to be focused on the extensive work required to finalize plans, milestones, metrics, etc. The NDPH systems likely will need to make investments beyond current staffing levels and a planning period would allow for both funding and time to ensure the appropriate innovative and non-traditional projects are thoughtfully considered before implementation has officially begun.

Evaluation and Accountability
Similar to all of the other Delivery System Transformation & Alignment Incentive Programs, the Public Safety Net Transformation and Improvement program will include a robust and rigorous evaluation to assess how these efforts contributed toward the state's 2020 goals, as well as how this work resulted in improvements in health for many of California's most vulnerable populations. These efforts, combined with the other elements of the California's proposal, will support our Medi-Cal 2020 vision to help our public safety net providers become models of integrated systems of care that are high value, high quality, patient-centered, efficient, equitable, with great patient experience and demonstrated ability to improve health care and health status of populations.

4.4 Workforce Development Program

California faces several workforce challenges for health care providers, including Medi-Cal, such as enrollment growth and increased competition for providers as a result of the Affordable Care Act, an aging workforce and Medi-Cal population, geographic and cultural differences between provider and member distribution, and a long educational "pipeline" for some professions. To achieve better outcomes through whole-person care, the Medi-Cal provider workforce must become more integrated and coordinated across the full spectrum of services: physical health, mental health, substance use disorder services, and long-term services and supports.



To address these challenges, California proposes to implement a combination of short- and long-term strategies under Medi-Cal 2020, targeted for the specific needs of Medi-Cal members and providers, and consistent with the overall goals of the Waiver. A particular focus will be paid to strategies that address the needs of members with mental health and substance use disorders. Other initiatives outlined in this application also incentivize the delivery system to focus on workforce strategies such as integration, team-based care, and enhanced provider participation. These strategies will also help managed care plans in their efforts to ensure network adequacy standards.

The proposed strategies outlined below have been selected based on existing evidence of the effectiveness of each approach in California, and specifically for Medi-Cal:

Incentives to Increase Provider Participation*:* California would provide financial incentives to health professionals who are not currently serving Medi-Cal members, and to existing Medi-Cal providers to encourage them to accept additional Medi-Cal members into their patient panels. Financial incentives will be targeted to attracting health professionals in geographic areas with the greatest need for Medi-Cal providers and to professions and specialties in which it is most challenging to recruit providers. Emphasis would also be placed on recruiting racially/ethnically diverse health professionals to enhance Medi-Cal's ability to provide culturally competent care.

Financial Incentives for Non-Physician Community Providers: The state will provide incentives to managed care plans to support non-physician community providers including Community Health Workers and Peer Support Specialists. These providers would participate as part of the member's care coordinating team as appropriate.

- Front-line Workers/Community Health Workers***:*** Introduction of the Community Health Worker (CHW) as an addition to the current health care workforce will contribute to the goals of the Triple Aim. Numerous studies attest to the value of CHW's as liaisons to help navigate a member's medical needs through the challenges faced by communities of traditionally underserved populations. The use of CHWs as part of a primary care team has a positive impact on health care costs by way of reduced inpatient and emergency utilization as well as improved

health behavior and outcomes in health areas such as diabetes management, cancer screenings, and maternal/perinatal health. Serving in the capacity of a community extender as part of the traditional provision of health care, CHWs can help reduce barriers of access to health services and improve the quality and cultural competence of services delivered.

- Peer Support Specialists***:*** A substantial number of studies demonstrate that peer support specialists improve patient functioning, increase patient satisfaction, reduce family burden, alleviate depression and other symptoms, reduce hospitalizations and hospital days, increase patient activation, and enhance patient self-advocacy. Peer support specialists are used in at least 36 states and throughout the Veterans Health Administration. Peer support specialists participating in substance abuse treatment activities are currently a recognized Medicaid service provider in California for SUD services; however these providers are often limited in the services they are able to provide in traditional health care settings. The Waiver presents an opportunity to build upon existing infrastructure and statewide efforts. Expanded use of peer providers in MH and SUD as part of a care-team can further improve care coordination between behavioral health needs and physical health care needs of patients. Improved patient care management will lead to a reduction of high-cost care such as poor management of chronic conditions, hospitalizations, and emergency department visits

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training and Certification:
California would expand SBIRT services to be available in additional settings and make training and certification available to a broader spectrum of providers. SBIRT is an evidence-based practice used to identify, reduce, and prevent substance use and abuse problems. SBIRT training is used as a tool to promote better health outcomes and reduces overall health care spending. SBIRT is currently required for Medi-Cal enrollees in primary care settings.

Training:

- Targeted Training for Non-Physician Health Care Providers***:*** Non-physician workers who provide care and supportive services in the home and community are an important component of whole person care, and ensure Medi-Cal members are able to live healthy and independent lives. Under this strategy, the state will provide additional voluntary training, and in some cases certification, for non-physician health care providers such as IHSS workers, Community Health Workers, Patient navigators, Peer Support Specialists, and others to obtain training in mental health, substance use, and LTSS, to help improve their skills or gain new skills as appropriate. The state would work with stakeholders, including consumers, workers, managed care plans, local government and community partners and other key stakeholders to develop models based on lessons learned of existing programs and determine the options that would work best for targeted segments of the Medi-Cal population and delivery system.

  Palliative Care Training***:*** The state will work to increase participation in voluntary training programs on palliative care, for physicians, nurses and other appropriate licensed providers, and will emphasize cultural competency in training programs. Palliative care has an extensive evidence base for improved quality of life for patients, increased patient satisfaction, reduced hospital stays and lower overall health care costs. However California has insufficient numbers of physicians and nurse practitioners with adequate training in palliative care to meet the needs of

consumers with complex conditions who could potentially benefit from palliative care. As of 2012, it is estimated that less than 1% of physicians and nurses, 1% of certified nursing assistants, and 2% of social workers in California are trained in palliative care. Training would address the shortage of health professionals trained in administering palliative care. Additionally, DHCS is interested in palliative care education for families and consumers, consistent with the patient-centered approaches that are described throughout this document.

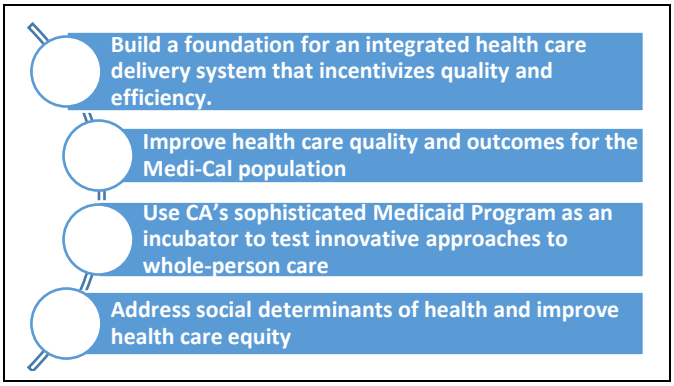
- Expand Physician Residency Training Slots***:*** The state would provide targeted funding for existing and new residency programs at teaching health centers or primary care sites, particularly those for which HRSA grant funding ends in 2015. This effort would help address the important need to maintain and expand health care access for Medi-Cal beneficiaries and to build program sustainability by investing in residency programs. Residents provide care to Medi-Cal members by serving in facilities that see high volume of Medi-Cal patients. Support for expansion of residency programs can improve recruitment and retention of physicians in the facilities that sponsor them. It is has been well documented that physicians tend to remain in the same geographic area as their training, therefore expanding residency programs will help build future capacity.

  In addition, under the waiver renewal, the state would provide incentives for additional training slots in geographic areas of the state where there are shortages in the number of physicians that participate in Medi-Cal, and for the specialties that are in the greatest need. The state would further target residency programs with incentives for medical school graduates to take positions in racially and economically diverse areas in order to improve access to culturally appropriate care for Medi-Cal members. We note that the Medicare Graduate Medical Education program (GME) does not precludes a state from contributing funds from Medicaid for new resident positions at hospitals, FQHCs, and RHCs who are sponsoring Residency Training institutions.

Incentives to Expand the Use of Telehealth*:* Under the Waiver, the state will expand access to specialty services by providing incentives for telehealth. Priority would first be given to geographic areas or certain specialists where access is more limited. Under the Waiver, the state will pilot-test incentive payments to encourage use of telehealth and require corresponding reporting of outcome data.

4.5 Increased Access to Housing and Supportive Services Program

As part of the overall vision for Medi-Cal 2020 and specifically in an attempt to improve care coordination for the state's most vulnerable populations, we propose a new approach to providing care to individuals experiencing homelessness, including enhanced tenancy support and intensive medical case management. Research suggests that individuals experiencing homelessness, particularly those with multiple chronic conditions, often struggle to receive appropriate health care services and are disproportionately likely to be high utilizers of the health care safety net who experience poor health outcomes.



Under this approach, the state will reimburse for a new set of tenancy-based care management services for plans statewide. These evidence-based services will support at-risk beneficiaries to allow them to stay in their homes, and will assist Medi-Cal

beneficiaries who are experiencing homelessness in securing stable housing. The state will also partner with Medi-Cal managed care plans, counties, community organizations, and Federal partners to develop county-specific pilot programs in counties where there is a commitment from the full spectrum of stakeholders that will provide the population with the support they need to find and maintain housing and gain consistent access to needed community supports. As a result, these individuals will be better equipped to effectively manage their health care utilization, seek appropriate medical services in appropriate settings, and ultimately improve their overall health outcomes.

It is our expectation that Medi-Cal managed care plans will see cost savings in this population and as part of their participation in the pilot program, the plans will designate a portion of those savings to be reinvested in the supportive services that will assist this population in maintaining their health, including housing supports. The reduced costs that will result from these efforts will, in turn, reduce costs for Medi-Cal overall and improve the sustainability of the program.

Target population. This program would target a portion of the estimated 60,000 at risk Medi-Cal members. Specifically, the target population includes:

- Individuals who are currently homeless, such as veterans, or will be homeless upon discharge from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, or state prisons); and
- Have repeated incidents of ED use, hospital admissions, or nursing facility placement; or
- Have two or more chronic conditions; or
- Mental health or substance use disorders.

Intervention Strategies.

- Managed Care Plans: Under the waiver, DHCS would provide access to intensive housing-based care management services and intensive care management to tenants who meet target population criteria. The level of care provided would be tiered based on the level of acuity and need of the individuals. Managed care plans will have the option of paying for non-traditional services (e.g. Nutritional services, continuous nursing, personal care, habilitation services) to the extent that such services improve health outcomes and reduce reliance on institutional-based care.

  Non-traditional Medi-Cal services would include tenancy supports like outreach and engagement, housing search assistance, stabilization, paying rent and bills on time, not disruptive to other tenants, maintaining SSI and other benefits. The managed care plan would also provide intensive medical case management and care coordination, discharge planning, creating a care plan, and coordination with primary, behavioral health and social services to improve health outcomes and reduce inpatient services among this high-utilizer, complex population.

- Regional housing partnerships: In counties that have strong partnerships or have a demonstrated interest in developing strong partnerships between the county, the managed care plans, and the housing authority, these partnerships may be eligible for incentive funding to establish and support regional integrated care partnerships specifically focused on housing. These partnerships would be required to include managed care plans, county health agencies (including county behavioral health plans), cities, hospitals, and housing and social service providers. A region could incorporate a single county, a portion of a large county, or counties

working collectively together to form a partnership. Counties, managed care plans, local non-profit coordinating organizations, or foundations could act as a lead in creating a partnership,

Managed care plans, counties, and other partners could be eligible to receive incentive or shared savings payments for their participation in these strategies. Incentive or shared savings payments could be available for entities that demonstrated the use of housing-based care management and/or partnership activities to improve access to subsidized housing units.

For managed care plans and counties to form regional housing partnerships:

- DHCS would request proposals from counties and plans that partner with providers and community-based organizations to pilot test approaches to house and coordinate care for the targeted populations. These pilots would intersect with and build on the section 2703 health homes program, where appropriate.

- The programs would support housing as a health care intervention approach, which would address the need for housing and supportive services, and could include various health care providers, payers, or other partners attempting to move eligible Medi-Cal members out of homelessness, hospitals, and nursing facilities into independent, and permanent supportive housing.

- Counties/plans would receive incentive payments under the pilot to create and maintain these partnerships, including support to develop MOUs/MOAs/contracts, create shared data systems, and develop processes for assisting eligible Medi-Cal members in moving into permanent housing.

- Counties and plans could also receive performance payments to the extent that such a pilot could achieve specific performance metrics which may include the number or percentage of plan members of the target population accessing subsidized housing units, certain HEDIS or other quality measures relevant to the characteristics of the population, and reductions in the use of ED and other institutional services.

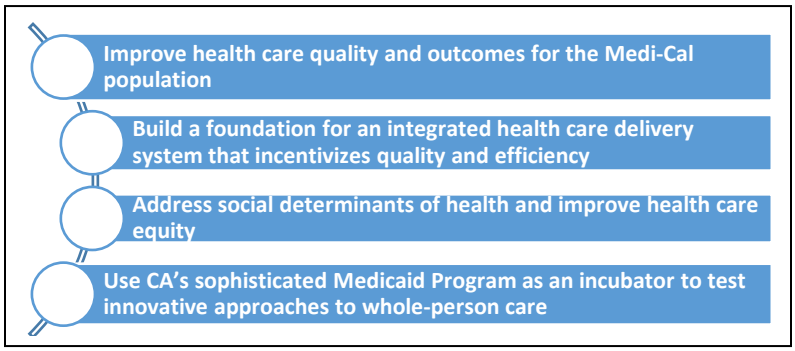
- Each Pilot must include a shared savings funding pool made up of contributions from plans and counties and based on savings generated from the reduction of institutional utilization that are expected to result from the introduction of housing-based case management for Medi-Cal members and spending flexibility for the plans.

The savings pool will provide needed support for services like respite care (or interim housing with services) to enable timely discharge from inpatient stays or nursing facilities while permanent housing is being arranged; fund support for long-term housing, including housing subsidies; finance further expansion of housing-based case management in addition to existing Medi-Cal medical, LTSS, county mental health, substance abuse services; and leverage local resources to increase access to subsidized housing units. The savings pool can also provide long-term rental subsidies and assistance.[6]

[6] It is important to note that although this strategy is focused on a particular high-need population, the approach is aligned with the Accountable Communities for Health Model proposed in the State HealthCare Innovation Plan.

4.6 Regional Integrated Whole-Person Care Pilots

Through this Waiver, DHCS seeks to offer an option for enhanced model of regional partnerships requiring proposals for a geographic region — a county or group of counties, jointly pursued by the county and applicable Medi-Cal plans — for that region. Managed care plans, counties, and local partners would provide Whole-Person Care for target high-need patients through collaborative leadership and systematic coordination with other public and private entities identified by the county. Pilots would be subject to state and federal approval. The pilot design would encourage innovation in delivery and financing strategies to improve health outcomes of target populations. The pilots would include approaches outlined in the delivery system transformation and alignment incentives section of this concept paper across the spectrum of whole-person care delivery (MCO/provider, MCO/county, access to housing and supportive services, and workforce development).



Pilot partnerships would be required to include all of the following, as appropriate to the targeted population:

1. Medi-Cal managed care plans (in counties with more than one plan, the pilot must include at least two plans participating)
2. County behavioral health systems
3. Hospitals
4. Clinics and doctors
5. Other medical providers, including dental providers
6. Social services agencies and providers
7. Public health agencies and providers
8. Non-medical workforce
9. Housing providers/Local housing authorities
10. Criminal justice/probation
11. Other community-based organizations with experience serving high need populations

DHCS would request proposals from counties and plans that partner with providers and community-based organizations to pilot approaches to fully coordinate care for the targeted populations. These pilots would intersect with and build on the section 2703 health homes program, where appropriate.

Participating entities in the pilots would receive incentive payments under the pilot to create and maintain these partnerships, including support to develop necessary MOU/MOAs and contracts, create shared data systems, and develop processes for care coordination across the spectrum of physical health, behavioral health, long-term care and other social service supports, including housing supports,

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The infrastructure, including community partnerships and the development of a shared saving financing strategy, could provide a foundation upon which an ACH could be built that would serve an entire community.

nutrition assistance and post-incarceration supports designed to improve the overall health of their members.

Participating entities could also receive performance payments, to the extent that such a pilot could achieve specific performance metrics, which may include the number or percentage of plan members from the target population that meet the specified outcomes metrics, certain HEDIS or other relevant quality metrics tied to the characteristics of the population and reductions in ED utilization and institutional services.

Participating entities will be responsible for identifying the cross cutting needs of the Medi-Cal members, provide coordination services and share data across all of the involved entities in order to achieve the whole-person care model. Members will have an individualized care plan and a single accountable, trusted care manager that ensures access to all needed services across the spectrum of care and support. Financial flexibility will permit providers across partnering sectors to do what is right for the client and will align incentives for providers to collaborate.

Critical Elements
In order to receive approval for a pilot program under Medi-Cal 2020, proposals must feature a clear governance structure that describes the role of the various partner entities and the proposed financing arrangements. Proposals must include a detailed plan for achieving care coordination and integration across all of the participating entities and must include behavioral health integration as a component.

- Target Population: Pilot partnerships must describe how they will identify a target Medi-Cal population who frequently use multiple systems, what data will be used, local partners they will work with, and the minimum enrollment target. At a minimum, the target population must be at least 50 Medi-Cal patients or the top 1% of emergency/inpatient users. Once a target population is identified, pilot partnerships must make a concerted effort to outreach to all eligible individuals to participate in the pilot.

- Patient Centered Care: The partnership must specify how they plan to structure care teams, how they will create individualized care plans for each patient that addresses the medical, behavioral, and social needs of the patient, and how they will select a single accountable individual on the care team that will be the patient's main contact and be accountable for ensuring the patient's care plan is carried out, in a culturally and linguistically competent manner. Pilots located in counties that are also expanding use of Medical Homes for Complex Patients (the 90/10 Health Home) will integrate their work with Health Homes and use those care coordination funds to advance patient support in the pilot.

- Social Supports: To identify the needed social supports, pilots must assess the needs of the target population. The additional social supports could include: Social services- i.e. CalFresh, child care, homeless services, foster care supports, job training, etc.; Benefit advocacy; Outreach and engagement strategies; Housing and enhanced care coordination and tenancy supports; Criminal justice/probation; Public health.

- Shared data and Evaluation: As part of pilot design, partner entities must describe how data will be shared across agencies, incompliance with all privacy laws, for identifying the target population; describe how shared data will be used for care coordination and patient-centered care. (If data restrictions prohibit certain agencies (e.g. substance use) from sharing data,

counties must describe how they will address these barriers when the pilot is implemented.); describe how they will use electronic medical records to support care coordination.

Specific evaluation criteria will include:

1. Improvements in health outcomes, health status, and disparities
2. Success at enrolling individuals for eligible social supports (i.e. enrollment in CalFresh, child care subsides, job training programs, etc.)
3. Housing- TBD
4. Evaluation component will also measure impact on total cost of care, scalability, and sustainability of pilot beyond Waiver term

- Financial Flexibility: Pilots must identify additional services and supports they expect to offer in addition to non-traditional Medicaid services and work with DHCS to establish appropriate reimbursement mechanisms. Partner entitles must agree to reinvest any savings from the pilot into areas that further support whole-person care. Partner entities must agree to report on an annual basis encounter and cost data on all non-medical services provided for which Medicaid financing is made available. The pilot application must describe how the partner entities plan to collect and report data on non-traditional services. In addition, the pilot application would need to identify the how the shared savings incentives and other incentive payments would be allocated and paid to all participating entities.

Section 5: Public Safety Net System Global Payment for the Remaining Uninsured

California's 21 public hospital and clinic systems are a critical element of the state's safety net for all Californians, and particularly for those who remain uninsured even after implementation of the Affordable Care Act. The public hospital systems serve more than 2.85 million patients annually with preventive, primary, and specialty, pharmacy, and emergency and inpatient services and provide 10 million outpatient visits per year.

Although the uninsured rate in California has declined remarkably from 15% at the end of 2013 to only 7.2% in November 2014, there will always be a significant population of residents who will remain uninsured indefinitely. Research shows that this group can be difficult to reach with limited ties to health insurance. According to a Kaiser Family Foundation survey, nearly 4 in 10 (37 percent) say they have never had health insurance (compared to 20 percent who became insured) and an additional 45 percent say they have been uninsured for two or more years. Overall, an estimated three million Californians will remain uninsured after full implementation of health reform.

In California, two important funding sources have historically helped core public safety net providers provide care to the uninsured – the Safety Net Care Pool Uncompensated Care Pool (SNCP), funded through the 1115 waiver, and the Medicaid Disproportionate Share Hospital Program (DSH) funded outside of the waiver. Since 2005, these funds have supported the 21 public hospital and clinic systems, which are a critical element of the state's safety net for all Californians, and particularly for those who remain uninsured even after implementation of the Affordable Care Act.[7] These systems are the primary source of care for the uninsured in the counties that are home to over 80% of the state's total population. While these funds have provided critical resources to support the safety net, they have also operated through a cost-based system that has not necessarily provided the best levers for coordinated or cost-effective care.

In an effort to transform funding from cost-based to value-based, and in light of the fact that there will be millions of remaining uninsured for which public hospital systems will continue to provide care, Medi-Cal 2020 proposes moving DSH and SNCP into a global budget structure where care for the remaining uninsured would be provided within a global budget for all uninsured services. By unifying DSH and SNCP funding streams into a county-specific global payment system, public hospital systems would have the incentive to provide more coordinated, upstream care for the uninsured and the opportunity to

[7] The levels of SNCP uncompensated care funding authorized under Bridge to Reform declined commensurate with the expansion of coverage through the LIHP and Medi-Cal, but recognizes that this level of reduced funding is still necessary to provide continued support post-2014 and beyond. DSH funds are also scheduled to decline to account for the impact of health reform, but about half will still remain, also acknowledging the continued need for support for uninsured services.

reduce inappropriate utilization. The new structure would recognize the higher value of primary care, ambulatory care, and other core components of care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stays. This proposal would encourage care delivery in more appropriate settings, including primary and preventive care as well as alternate modalities not currently explicitly recognized, such as phone and e-mail consults.

Methodology Overview. The proposed approach under the renewed demonstration would provide public hospital systems the opportunity to receive quarterly payments to provide services to the uninsured. The service value would reflect value for the patient, not simply cost to the health care system. Services like primary care visits or phone call consults would be recognized as high-value services, and their ability to draw payment would be weighted in a way that incentivizes their use and encourages more appropriate utilization of traditionally costly services such as emergency room visits. To operationalize such a system, the value of each service would be identified with commensurate points assigned. Health care systems would be required to reach a threshold amount of uninsured services (measured in points) provided in order to earn their entire global payment. The methodology would allow for the continuation of traditional services as they exist today, but encourage more appropriate and innovative care to ensure that patients are seen in the right place, given the right care, at the right time by assigning point values to those types of appropriate services where there is currently little to no reimbursement.

Specifically, points for services would be assigned in a manner that recognizes value, where higher values would be assigned to services that meet criteria such as:

- Timeliness and convenience of service to the patient
- Increased access to care
- Earlier intervention
- Appropriate resource use for a given outcome
- Health and wellness services that result in improved patient decisions and overall health status
- Potential to avoid future costs

Partial funding would be available based on partial achievement of the "points" target.

Services. A comprehensive, but not exhaustive, list of the services that would qualify for the global payment is shown below. Acknowledging that health care is delivered differently in different geographies, the public health care systems would not be required to provide every service on this list, but through the point system, would be required to provide a base level of services that address local needs. This flexibility in provision of services allows systems to tailor to their own needs while also encouraging a broad shift to more cost effective, person-centered care. The categories below represent groupings based on activities and settings, but credit for these services in the demonstration would be assigned based on the value of a given service, which may vary within any given category.

Items within each of the four categories would be grouped into tiers of similar service intensity for purposes of reporting and for developing tiers of point values. The development of point values will recognize the high-value of services designed to improve health, prevent unnecessary emergency room/inpatient stays, and prevent longer term health complications. Services that are currently afforded minimal to no reimbursement will be valued at levels recognizing the downstream impact they can have in generating positive health outcomes. Service groups that have the similar ability to impact

overall care delivery and quality will have relatively equal values. Service groups that may today have over-utilization and are not the most cost-effective or ideal delivery sites will have lower relative value than current reimbursement structures. Certain traditional services such as emergency room visits and inpatient stays will continue to be recognized for their value and importance, although at a slightly diminished valuation to incentivize increased use of outpatient and primary care services. The state will establish baseline threshold point targets for services currently provided today.

Category 1: Traditional Outpatient: Face-to-face outpatient visits an individual could have at a public hospital system facility

- Non-physician practitioner (RN, PharmD, Complex Care Management)
- Traditional, provider-based primary care or specialty care visit
- Mental health visit
- Dental
- Public health visit (TB Clinic, STC screening)
- Post-hospital discharge/post-ED primary care
- Emergency room/Urgent Care
- Outpatient procedures/surgery (wound check), provider performed diagnostic procedures, other high-end ancillary services (e.g.: chemo, dialysis)

Category 2: Non-Traditional Outpatient: Outpatient encounters where care is provided by nontraditional providers or in nontraditional or virtual settings

- Community health worker encounters
- Health coach encounters
- Care navigation
- Health education & community wellness encounters
- Patient support & disease management groups
- Immunization outreach
- Substance use disorder counseling groups
- Group medical visits
- Wound check
- Pain management
- Case management
- Mobile clinic visits
- Palliative care
- Home nursing visits post-discharge
- Paramedic treat & release encounters

Category 3: Technology-Based Outpatient: Technology-based outpatient encounters that rely mainly on technology to provide care

- Call line encounters (nurse advice line)
- Texting
- Telephone and email consultations between provider and patient
- Provider-to-Provider eConsults for specialty care
- Telemedicine
- Video-observed therapy

Category 4: Inpatient and Facility Stays

- Recuperative/respite care days
- Sober center days
- Subacute care days
- Skilled nursing facility days
- General acute care & acute psychiatric days
- Higher acuity inpatient days in ICU & CCU
- Highest acuity days & services such as trauma, transplant, and burn

Threshold. To determine an appropriate threshold amount, each system would estimate the volume and mix of uninsured services likely to occur based on historical data and projected estimates of uninsured care needed. These estimates would use the most recent complete data available trended, taking into account changes in utilization of uninsured services due to the implementation of the Affordable Care Act. Although thresholds would vary for each respective public health system, point values would be consistent across all systems. Threshold point values per unit of service would be established based on current, cost based reimbursement structures for DSH and SNCP. The intent of the threshold is to determine the level of services that would have been provided absent this proposal. The thresholds would need to be adjusted overtime to account for the federal DSH reductions.

Payment and Allocation. Under this new approach, the public hospital systems, in order to earn a global payment, would be required to reach a threshold amount of uninsured services provided, measured in points. The threshold amount would decline over time, tracking with the cuts to the DSH program in recognition of the likely decline in uninsured services that will be provided as health insurance coverage continues to increase. A public hospital system could achieve partial payment if it does not meet its threshold, with excess funds made available to other systems that exceed their threshold.

Evaluation and Accountability. The waiver renewal would seek to demonstrate that, while the need for sustained funding to support California's safety net continues, shifting payment away from cost and toward value can help ensure that patients are seen in the right place, and given the right care at the right time. The evaluation for this component of the demonstration would focus on relative resource allocation and the extent to which services and workforce investments shift the balance of primary and specialty care toward longitudinal care in primary care settings. Clear, concise metrics would be established to ensure accurate gauging of success. Public hospital systems participating in the demonstration would report data on the following:

Resource allocation**:** Measure the shift in balance of primary and specialty care toward longitudinal care in a primary care setting

Potential Metrics:

- Ratio of new to follow-up appointments within specialty care
- Average time to discharge from specialty care
- Ratio of primary care to emergency room/urgent care visits
- Mental health/substance use disorder visits
- Inpatient stays related to ambulatory sensitive conditions
- Non-emergency use of the emergency room

***Workforce involvement*:** Invest in alternative uses of workforce able to provide higher quality care and service for lower long-term costs on a per-patient basis

Potential Metrics:

- Use of non-traditional workforce classifications (e.g. CHWs)
- Expansion of roles/responsibilities (within scope of practice) for traditional workforce classifications

Section 6: State-Federal Shared Savings & Reinvestment

California's Federal-State Shared Savings initiative seeks recognition of the Federal savings that California's section 1115 demonstration generates and would provide the state with a portion of those Federal savings to be reinvested in the Medi-Cal program and facilitate continued delivery system transformation. This strategy is in alignment with the Waiver goals and initiatives to foster shared accountability and fiscal stewardship across providers, managed care plans, and payers to achieve high-value, high-quality and whole-person care. This concept has been incorporated into payment models in both commercial and public insurance markets (Medicare, Duals) over the last several years and should be explored in Medicaid as the Federal government becomes more vested in effective and efficient state delivery systems driving expenditures that are nearly fully funded by the Federal government.

The Shared Savings initiative will test the impact of establishing a prospective state performance payment based on Federal Medicaid savings achieved for Medi-Cal 2020 enrollees over the life of the waiver. California would receive a portion of Federal savings in the form of ongoing performance payments as long net savings to the Federal government are demonstrated as calculated under the Waiver Budget Neutrality agreement. Absent this shared savings approach, California would be extremely limited in the ability to enact the proposed delivery system transformation and alignment programs that are so necessary to ensure the ongoing successful implementation of the ACA and the long-term sustainability of the Medi-Cal program.

Budget Neutrality and Shared Savings

In order to share in Federal savings, California would need to demonstrate that Federal savings generated under the Waiver are sufficient to permit California to retain a share of the Federal funding saved in the form of a performance payment. ***Even after the reinvestment of funding to support the Waiver strategies, there must still be overall savings to the Federal government, thereby ensuring that the Waiver is budget neutral.*** The methodology for calculating the shared savings payments would leverage the budget neutrality agreement for the Waiver but would include additional cost trend factors intended to further incentivize the state to slow the cost trend in California's Medicaid program relative to the cost trend the state would face absent the Waiver initiatives. All shared savings payments would be retrospectively reconciled as part of the ongoing reconciliation of actual expenditures to projected expenditures that occur under the budget neutrality agreement. California would be limited to utilizing the funds to support approved reinvestment strategies that are considered integral to meeting cost and program metrics. The concept does not cap Medicaid spending; rather, should California not attain the agreed-upon level of savings to be shared, expenditures on the reinvestment Waiver strategies would need to be reduced in order to maintain budget neutrality.

Section 7: Demonstration Financing & Budget Neutrality

The limit on expenditures in the current *Bridge to Reform* Waiver is based on a combination of per-capita and aggregate spending amounts and California will propose to continue this model for the Waiver renewal. For Medi-Cal State Plan populations, California proposes to continue to utilize historical fee-for-service expenditure information to develop annual, per capita cost projections for each demonstration year.

The Medi-Cal 2020 budget neutrality model will also propose to retain the existing "Bridge to Reform" (BTR) Waiver diversion of hospital Upper Payment Limit (UPL), "Limit B" that currently funds a portion of the Safety Net Care Pool.

New for Medi-Cal 2020

Budget Neutrality for the Waiver Renewal will include a new proposal to support California's key strategy for Alignment for Public Safety Net Systems. California will propose to include expenditures currently authorized as DSH expenditures in the Medi-Cal 2020 waiver spending limit. As described in Section 7, these DSH expenditures would be a component of the funding for the new county-specific global payment system.

Budget Neutrality for the Medi-Cal 2020 Waiver will also reflect California's Federal-State Shared Savings Initiative as described in Section 7. The Federal/State shared savings concept does not cap Medicaid spending in the methodology; rather, any excess spending on the reinvestment Waiver strategies over the anticipated amounts will be required to be counted against the Waiver Budget Neutrality margin.

Cost projections for the per-capita expenditures, historical hospital UPL funding and DSH expenditures will establish the "without waiver" budget ceiling. Actual waiver expenditures for covered populations and Medi-Cal 2020 initiatives will be applied against the without waiver budget limit. California has included the full budget neutrality calculations as an attachment to this document as well as the most current version of the BTR budget neutrality file. Table 1 below provides the proposed "without waiver" (WOW) per-member-per-month by the Waiver Medi-Cal eligibility groups (MEGs). Table 2 provides estimated WOW expenditures for the MEGs and the UPL limit. Table 3 provides projected "with waiver" (WW) expenditures and member months. Table 4 provides current estimates of BTR WW expenditures and member months.

Table 1: Proposed MEGs, PMPMs and Trend Factors (based on existing BTR)

			FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
WOW PMPM	**MEGS**	**Trend Rate**	**DY11**	**DY12**	**DY13**	**DY14**	**DY15**
TPM/GMC							
	Family	5.30%	$195.78	$206.15	$217.08	$228.59	$240.70
	SPDs	7.40%	$928.95	$997.69	$1,071.52	$1,150.81	$1,235.97
	Duals	3.28%	$121.84	$125.84	$129.97	$134.23	$138.63
	New Adult	4.10%	$527.95	$549.60	$572.13	$595.59	$620.01
COHS							
	Family	5.30%	$221.57	$233.32	$245.68	$258.70	$272.42
	SPDs	7.40%	$1,737.97	$1,866.58	$2,004.71	$2,153.05	$2,312.38
	Duals	2.47%	$450.10	$461.22	$472.61	$484.29	$496.25
	New Adult	4.10%	$715.68	$745.02	$775.57	$807.37	$840.47
CCI TPM/GMC							
	Family	5.30%	$197.76	$208.24	$219.28	$230.90	$243.14
	SPDs	7.40%	$1,128.79	$1,212.32	$1,302.03	$1,398.38	$1,501.87
	Duals	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70
	Cal MediConnect	3.40%	$774.83	$801.17	$828.41	$856.58	$885.70
CCI COHS							
	Family	5.30%	$225.08	$237.01	$249.57	$262.80	$276.72
	SPDs	7.40%	$2,183.24	$2,344.80	$2,518.32	$2,704.67	$2,904.82
	Duals	1.61%	$663.28	$673.95	$684.80	$695.83	$707.03
	Cal MediConnect	1.61%	$663.28	$673.95	$684.80	$695.83	$707.03
CBAS		3.16%	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30

Table 2: Estimated WOW Expenditures

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	**DY12**	**DY13**	**DY14**	**DY15**	**5 Year Total**
Total Population Expenditures	**$ 41,991,973,636**	**$ 44,627,527,507**	**$ 47,439,270,963**	**$ 50,439,658,680**	**$ 53,642,068,892**	**$238,140,499,678**
DSH	$ 2,352,648,102	$ 2,002,648,102	$ 1,852,648,102	$ 1,792,648,102	$ 2,052,648,102	**$10,053,240,510**
IP UPL PH	$ 3,730,300,150	$ 3,970,158,450	$ 4,225,439,638	$ 4,497,135,407	$ 4,786,301,214	**$21,209,334,860**
Total Without Waiver Ceiling (Tot	***$ 48,074,921,888***	***$ 50,600,334,059***	***$ 53,517,358,703***	***$ 56,729,442,190***	***$ 60,481,018,208***	***$269,403,075,049***

Table 3: Projected Member Months and WW Expenditures

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
	DY11	**DY12**	**DY13**	**DY14**	**DY15**	**5 Year Total**
Total Member Months	*102,305,153*	*103,328,205*	*104,361,487*	*105,405,102*	*106,459,153*	
Total Population Expenditures	$36,032,479,886	$38,133,908,104	$40,352,295,847	$42,694,203,383	$45,166,569,554	$202,379,456,774
Total Hospital Expenditures	$2,811,751,705	$2,992,547,340	$3,184,968,134	$3,389,761,585	$3,607,723,255	$15,986,752,019
Total Waiver Expenditures	$7,226,198,102	$6,876,198,102	$6,726,198,102	$6,666,198,102	$6,926,198,102	$34,420,990,510
Total With Waiver Expenditures	**46,070,429,693**	**48,002,653,546**	**50,263,462,083**	**52,750,163,070**	**55,700,490,910**	**252,787,199,303**

Table 4: Historical BTR Enrollment and Expenditures

	FY 10-11	FY 11-12	FY 12-13	FY 13-14	FY 14-15
	DY6	**DY7**	**DY8**	**DY9**	**DY10**
Historical Enrollment	51,576,881	58,420,445	63,769,315	66,558,574	83,233,890
Historical Expenditures	$15,397,202,160	$19,471,360,377	$21,129,317,683	$23,494,057,783	$30,867,521,032

Section 8: Waiver Authorities and Changes to the Demonstration

NOTE: The below is subject to change as substantive details for the eventual waiver components are refined in the application and approval processes.

BRIDGE TO REFORM AUTHORTIES EXPECTED TO CONTINUE

Managed Care Waiver Authorities:

1. **Freedom of Choice Section 1902(a)(23)(A)** (authorizing Medi-Cal managed care delivery models)

2. Statewideness Section 1902(a)(1) (authorizing county-by-county variance.)

3. Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) (specific to SPDs in the current waiver authority)

Safety Net Care Pool (SNCP) Expenditure Authorities:

The following expenditures are authorized under the existing Bridge to Reform Demonstration, subject to an overall cap.

1. **Uncompensated Care** (*only to the extent necessary to carry out SNCP uncompensated care activities authorized under the Bridge to Reform Demonstration*)

(Expenditures for uncompensated care meeting the section 1905(a) medical assistance definition incurred by hospitals, providers and clinics for Medicaid eligible or uninsured individuals, and to the extent that those costs exceed the amounts paid to the hospital pursuant to Section 1923)

2. **Designated State Health Care Programs (DSHP)**

(authorizing reimbursement of expenditures for certain state-funded programs: (1) Breast and Cervical Cancer Treatment Program (BCCTP); (2) Medically Indigent Adults/Long Term Care Program; (3) California Children's Services Program; (4) Genetically Handicapped Persons Program; (5) Expanded Access to Primary Care Program; (6) AIDS Drug Assistance Program; (7) Department of Developmental Services; (8) County Mental Health Services.)

3. **Workforce Development**

(Expenditures for workforce development programs in medically disadvantaged service areas: (1) Song Brown HealthCare Workforce Training; (2) Health Professionals Education Foundation Loan Repayment; (3) Mental Health Loan Assumption; (4) Training program for medical professionals at CA Community Colleges, CA State Universities, and the University of CA)

4. **Delivery System Reform Incentive Pool** (*only to the extent necessary to carry out DSRIP activities authorized under the Bridge to Reform Demonstration*)

(Expenditures for incentive payments from a Delivery System Reform Incentive Pool)

5. Uncompensated care for Indian Health Service (IHS) and tribal facilities
(Authorizing payments for certain uncompensated care expenditures)

Community Based Adult Services (CBAS) Expenditure Authority:

1. Authorizing expenditures for CBAS services to qualifying individuals

Drug Medi-Cal Organized Delivery System Proposed Authorities:
(The following expenditure authority has been requested in the DMC-ODS waiver amendment, and if approved for the current demonstration, would be expected to continue)

1. DMC-ODS residential-based services
(Expenditures not otherwise eligible for FFP for covered services furnished to Medi-Cal members who are residents in facilities that meet the definition of an Institution for Mental Disease under Section 1905(a))

AUTHORITIES EXPECTED TO CHANGE OR NEW AUTHORITIES REQUESTED

1. Federal-State Shared Savings and Reinvestment

To authorize the reinvestment of state-designated shared savings towards applicable demonstration expenditures. The amount of state-designated shared savings available for use under this authority will be based on the difference between the State's actual expenditures under the demonstration and pre-established per beneficiary per month amounts.

2. Public Safety Net Systems Global Payment for Remaining Uninsured
To authorize disproportionate share hospital (DSH) and uncompensated care payments under a global payment budget structure to public hospital systems (including affiliated hospitals, providers, and clinics) for services provided to the uninsured. This may include payment for services not recognized as medical assistance under Section 1905(a), and may extend to a broader set of modalities, provider types, and provider settings. Global payment expenditures under this authority would not be subject to title XIX requirements.

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to limit this demonstration component to certain counties or geographic areas that include designated public hospitals);

e(2) **Disproportionate Share Hospital payments, Section 1902(a)(13)(A)** (insofar as it incorporates Section 1923) (to exempt the State from making DSH payments to hospitals which qualify as a disproportionate share hospital in any year for which the public hospital system with which it is affiliated is receiving payments under the global payment budget structure).

3. Public Safety Net System Transformation & Improvement Program

To authorize expenditures for incentive payments pursuant to the Public Safety Net System Transformation & Improvement Program.

4. Increased Access to Housing and Supportive Services Program

To authorize reimbursement for housing-based case management and supportive services, to the extent not encompassed under the Section 1905(a) definition of medical assistance, for qualifying beneficiaries accessing Medi-Cal benefits. This includes, but is not limited to, housing-based expenditures made with respect to Medi-Cal beneficiaries in facilities that meet the definition of an Institution for Mental Disease under Section 1905(a).

Depending on the details of the proposal and the proposed mechanism(s) for payment, expenditure authority relating to the following provisions may be requested: (1) Section 1903(m) and 42 CFR §438.60 (to allow for direct payments to managed care providers).

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent housing-based case management is limited to only certain counties or geographic areas);

(2) **Amount, duration and scope of services and comparability, Section 1902(a)(10)(B)** (to limit housing-based case management to certain targeted groups of Medi-Cal beneficiaries);

5. Workforce Development Program

To allow for reimbursement for select workforce development subsidies, incentive payments, and related expenditures to or on behalf of targeted health care providers, including providers who have not previously participated in the Medi-Cal program, existing Medi-Cal providers who commit to treat additional Medi-Cal beneficiaries, or nontraditional provider types, to the extent not otherwise allowable as medical assistance or administrative costs under Section 1903.

Expenditure authority relating to the following provisions may also be requested, depending on the applicable payment mechanism envisioned: (1) Section 1903(m) and 42 CFR §438.60 (to allow for direct payments to managed care providers); (2) Section 1903(m) and 42 CFR §438.6(c)(5)(iii) and (iv) (to the extent subsidies and incentives included in capitation rate and as necessary to exceed the 105% limit for approved capitation payments)

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent workforce development programs are limited to only certain counties or geographic areas).

6. Plan/Provider/System Incentives and Whole Person Care Pilots

To allow for reimbursement for select provider, managed care plan, and/or system payments, geared toward performance, quality, system alignment and whole person care coordination principles, to the extent not otherwise considered allowable medical assistance or administrative costs under Section 1903. This may include both fee-for-service and managed care based incentive payments, reimbursement for services not recognized as medical assistance under Section 1905(a), and expenditures in support of value-based transformation strategies under contracts with managed care plans and providers that may not meet the requirements in section 1903(m)(2)(A).

This may also include specific waiver authority for the following provisions:
(1) **Statewideness, Section 1902(a)(1)** (to the extent plan or provider incentives, or regional whole person care pilots, are limited to only certain counties or geographic areas).

(2) **Freedom of choice, Section 1902(a)(23)(A)** (to allow the state to require certain beneficiaries to receive services from specified providers);

(3) **Amount, duration and scope of services and comparability, Section 1902(a)(10)(B)** (to allow the state to provide a different benefit package to those eligible to participate in regional whole person care pilots);

Section 9: Public Notice and Comment Process

Over the past several months, DHCS has engaged the stakeholder and provider communities and solicited public comment to gain input and insight into how the Medi-Cal program can continue to evolve and mature over the next five years.

DHCS began public input and stakeholder engagement on Waiver Renewal with the release of the initial concept paper in July 2014 which identified the central proposals for the renewal of the state's section 1115 Medicaid Waiver. The key proposals included: 1) Housing and Supportive services for vulnerable populations; 2) Managed Care Plan/Provider Incentives; 3) Delivery System Reform Incentive Payments (DSRIP) 2.0; 4) Workforce Development strategies; and 5) Safety Net Payment and Delivery System Transformation.

To facilitate public involvement and to solicit meaningful input with regard to the proposals, DHCS convened five distinct expert stakeholder workgroups composed of subject matter experts in Medicaid delivery system and payment reform, social determinants of health, care coordination and integration, and clinical practice improvement. The experts who participated represent a broad sample of stakeholders, including representatives from managed health care plans, hospitals, advocacy/special interest groups, counties and other members of the interested public. Between November 2014 and March 2015, DHCS convened approximately twenty stakeholder meetings on Waiver Renewal (date, times, materials detailed on DHCS website). Comprehensive descriptions of concepts considered for inclusion in the Waiver Renewal, including the goals and objectives and potential impact of the proposals are made available to the public on the DHCS Waiver Renewal website at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal.aspx.

Finally, DHCS hosted a broad stakeholder engagement session on January 30, 2015 to specifically solicit input and public comment on a financing strategy for achieving federal-state shared savings under Medi-Cal 2020.

Before each expert stakeholder workgroup meeting, the meeting agenda and meeting presentation materials have been posted on the DHCS Waiver Renewal website. The expert workgroup meetings have been open to the public with a conference call option for those who wish to participate, but cannot attend in person. Each meeting concludes with dedicated time for public comments and discussion.

The input provided by the stakeholder representatives has been documented in meeting summaries and made available on the DHCS website, along with the meeting presentation materials and in-depth background information on each topic.

Additionally, DHCS invites comment on the Waiver Renewal proposal from the public and interested stakeholders through a dedicated inbox: WaiverRenewal@dhcs.ca.gov as well as a physical address, made available on the website. All comments received via the inbox and by mail are made available to the public on the DHCS Waiver Renewal website.

DHCS published an abbreviated notice informing the public of Waiver Renewal efforts and concepts in the February 13, 2015 state register. The notice outlined upcoming opportunities for public engagement and input. DHCS also issued tribal notice on February 17, 2015 to provide opportunity for input from tribal entities and Indian Health Programs.

The Waiver stakeholder meetings have provided opportunity for stakeholders and other interested parties to provide feedback on the renewal proposal and to ask questions about the technical aspects of the State's plans for Medi-Cal 2020.

The stakeholder engagement process has been extremely robust and has substantially informed the content of the proposals included in this concept paper. We expect that the anticipatory approach that has been underway over the past several months has ensured that the stakeholder and provider communities are in full support of the Waiver Renewal.

Section 10: Medi-Cal 2020 Evaluation Design

As the Medi-Cal program evolves, evaluation of the Waiver gains more complexity as an analytic process and involves applying quantitative and qualitative research methods to test a set of questions or hypotheses that focus on the demonstration's goals and objectives. The intent of the Med-Cal evaluation is to produce valid and reliable information that fully and robustly assesses the impacts of the Waiver on the critical aspects of the program areas, and in the case of the DSRIP program, it also focuses on impacts relative to the three-part aim.

In the renewal, the state will work to develop an evaluation design for the Medi-Cal 2020 demonstration that builds upon and incorporates the lessons learned in the Bridge to Reform 2010. The demonstration design and evaluation plan will support generalized findings, and the evaluation reports should carefully explore and explain the limitations of the demonstration design, as well as the integrity and appropriateness of the data and the analytic methods used to support the study. In addition consideration will be given to the intervening and future expected effects of the Affordable Care Act in California. The evaluation plan will include use of comparison groups wherever possible, establish or identify baseline data, measure the programs and pilots, as well as the explore of the meaning of the findings in a lessons-learned format. The evaluation will aim to ensure sufficient causal factors and population effects.

Appendix A: "Bridge to Reform" Interim Evaluation

In accordance with the Special Term and Condition of the BTR Waiver paragraph 8(vi), the California Department of Human Services submits the following narrative summary of the evaluation designs, the status and findings to date.

Program and Design

The California Bridge to Reform Section 1115 Demonstration Program (Waiver) was approved on November 1, 2010. The renewed demonstration created multiple initiatives to ensure that adequate support was provided by the state in their efforts to prepare safety net providers for expansion to the new adult group in conjunction with the state based Exchange operations as provided for by the Affordable Care Act. The majority of existing Medi-Cal managed care programs participate through the Waiver including multiple California specific seniors initiatives such as the program dual Medicare and Medicaid beneficiaries known as the Coordinated Care Initiative (CCI). The demonstration also expanded the state's Safety Net Care Pool (SNCP) to continue support for uncompensated care payments to safety net providers and to incentivize safety net hospitals via the Delivery System Reform Incentive Programs (DSRIP).

Due to the diversity of the Bridge to Reform (BTR) programs and the varied timing of the roll out of each of the unique programs, it was determined that it was most effective and appropriate to focus specific demonstration evaluations on specific initiatives and their impact on target populations and DSRIP initiatives.

Given the nature of the BTR evaluation design, this interim evaluation report provides for an individual evaluation and program specific hypotheses and measures as appropriate for each of the targeted programs:

- Delivery System Reform Incentive Program (DSRIP)
- Low Income Health Program (LIHP)
- Indian Health Services (IHS) Uncompensated Care Pool
- Healthy Families Program Transition to Medi-Cal

Evaluations on some of the more recent Waiver initiatives which became active in during or after 2013 and for the implementation of health care reform were not included in this interim report. Because evaluation for the following programs are still under development or are in process, for the interim period we have included operational reports for each of the following:

- Seniors and Persons with Disabilities (SPD)
- California Children's Services (CCS) pilots
- Coordinated Care Initiative (CCI) initiative

Transition of SPDs into Managed Care

In compliance with State Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010), DHCS took its first steps toward implementing the Waiver by transitioning Medi Cal-only SPDs from FFS Medi-Cal into Managed Care Plans (MCPs) in 16 of the 30 counties that participated in Medi-Cal Managed Care at that time. (The other 14 counties operated under the County-Organized Health System model, which already enrolled all SPDs into their MCPs.) During 2013 and 2014 DHCS expanded managed care into an additional 27 counties in California and as part of the expansion, also transitioned the SPD population into MCPs in these counties.

DHCS will work with CMS towards an approval of an evaluation design to that addresses policy questions in five areas of the transition of SPD beneficiaries into MCPs: eligibility and enrollment processes, network adequacy and coverage, access to care and continuity of care, quality of care, and value-based care (costs associated with the transition).

CCS Pilots

Health Plan of San Mateo pilot:

The Health Plan of San Mateo (HPSM) California Children Services Demonstration Project (CCS DP) pilot was implemented on April 1, 2013. HSPM's pilot includes ~1,500 Medi-Cal CCS members in San Mateo County and covers most healthcare conditions with a few exclusions.

As part of the CCS DP operational review, DHCS developed and administered a "Family Satisfaction Phone Survey" (Phone Survey) to HPSM CCS DP families between the months of July through September 2014. 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.

DHCS also developed a Provider Satisfaction e-Mail Survey (Provider Survey) for the HPSM CCS DP. It is anticipated the Provider Survey will be e-Mailed spring 2015. The survey objective is to assess the providers' CCS DP knowledge and satisfaction.

On October 17, 2014, DHCS conducted site visits with both HPSM and San Mateo County CCS office. These first annual site reviews discussed the main goals of the CCS DP (focused on care coordination, medical home, and family centered-care), successful components of the CCS DP, and unexpected challenges of the CCS DP.

Rady Children's Hospital San Diego Pilot

Rady Children's Hospital San Diego (RCHSD) CCS DP pilot is anticipated to be operational by summer 2015. RCHSD's pilot will include ~450 Medi-Cal CCS members with Sickle Cell, Cystic Fibrosis, Hemophilia, Acute Lymphoblastic Leukemia or Diabetes Type I and II (for ages 1-10 yrs.)

As part of the CCS DP operational review, SCD intends to conduct Phone Surveys, Provider Surveys and annual site reviews. In addition, SCD and RCHSD are working on an evaluation metric, consisting of two clinical measures per health condition covered in the CCS DP that RCHSD will report to SCD. The first year's clinical data will be utilized as a baseline to measure future outcomes.

CCI

Several CCI evaluation efforts are currently in various stages of the implementation. The SCAN Foundation has funded two evaluation projects that will be conducted by third party organizations that are working collaboratively with The SCAN Foundation and DHCS in the evaluation design. The more near term evaluation is the Rapid-Cycle Polling Project that will be conducted by Field Research Corporation to evaluate the Cal MediConnect enrollment process and beneficiary satisfaction. Field Research Corporation will be selecting a random sample of beneficiaries that have enrolled in and/or opted out of Cal MediConnect to conduct two telephone surveys, one in the spring of 2015 and another in the fall of 2015.

The second evaluation is a three year longitudinal evaluation that will be conducted by UC Berkeley. The results of the Rapid-Cycle Polling Project will be used to help design the more detailed evaluation that will be comprised of telephone surveys as well as advisory and focus groups. This evaluation is in the beginning phase, with the survey design currently in the development process.
All plans participating in Cal MediConnect are required to routinely submit quality reporting data to CMS which includes quality measures for Medicare and Medi-Cal benefits and services. CMS and DHCS currently review these reports and are working with the plans to ensure data is reported consistently for evaluation purposes. DHCS recently published the first quarterly Health Risk Assessment Dashboard (http://www.calduals.org/enrollment-information/hra-data). The report compares how each participating plan is complying with the completion of Health Risk Assessments for participating members.

CMS' evaluation vendor, Research Triangle Institute, has been contracted to conduct a national and state-wide evaluation of the Demonstration. RTI is currently collecting data from California and will be submitting evaluation reports to CMS at various points throughout the three year demonstration.

DSRIP – The First in the Nation

Many lessons were learned during this partnership and pioneering project period.
Designated Public Hospitals (DPH) varied in characteristics and choice of Categories 1 and 2projects, the challenges they faced in implementing their projects and the solutions they devised to address such challenges. Despite their unique situations, the great majority of the project milestones were achieved. Specifically:

- Participating DPHs include five University of California and 12 County-owned and operated systems and include six multihospital systems. DPHs varied in size from 76,000 to 4,128 discharges and from 1.2 million to 130,000 outpatient visits in 2010.
- Many DPHs selected specific and related projects in Categories 1 and 2, including expanding primary care capacity and implementing and utilizing disease management registries for their Category 1 infrastructure development, and expanding medical homes for their Category 2 innovation and redesign initiatives.
- Nearly 50% of the implemented projects were envisioned prior to DPHs participation in DSRIP, though most were not implemented extensively or system-wide.
- DPHs cited consistency with organizational goals, availability of project champions among existing staff, and synergy with existing projects as principal reasons for selecting DSRIP projects.
- DPHs achieved nearly all (99%) of their proposed milestones in DY 7-8, covered in this interim report. This success was achieved with high levels of planning, resource investments, and many DPHs reported high level of overall difficulty in implementing projects.
- DPHs perceived a high level of impact on improving quality of care and health outcomes, two of the three components of the Triple Aim. The third component, cost containment/efficiency, had a lower perceived impact in part because not enough time had elapsed to assess the full effect of implemented projects.
- Category 1 infrastructure development and Category 2 innovation and redesign were perceived as having the greatest impact on the Categories 3, 4, and 5.

For this evaluation, the DHPs were asked to provide summary level information of this DSRIP impact to their organization, the feedback included:

- DSRIP led to systematic and major change and was considered as an investment in the future of DPHs. The focus of DSRIP on population-based measures and outpatient care was particularly valuable.
- DSRIP significantly transformed the operations and information technology in DPHs.
- DSRIP provided the resources and financial incentives to effectively implement the selected projects and obtain buy-in from executives and staff.
  DSRIP led to new collaborations between DPHs and sharing of innovations.

In addition, DPHs were asked to provide their recommendations for renewal of DSRIP under the next Medicaid §1115 Waiver. These recommendations included:

- Align DSRIP projects with other initiatives and organizational goals.
- Consider projects that prepare DPHs for the future.
- Reduce the number of projects and narrow the focus of the program.
- Provide DPHs with clear metrics, instructions, and direction.
- Reevaluate the relevance of some measures to ensure consistency with current evidence.
- Allow for flexibility so that projects can be aligned with organization goals and characteristics. But increase standardization of some measures to reduce confusion and shifting goals.
- Improve measurement methods so that high performing DPHs are not penalized for small marginal improvements.
- Better measure time and effort required to complete projects.
- Provide CMS timely feedback and establish direct communication lines between CMS and DPHs.

Appendix B: Data Infrastructure and Use of Health Information Technology

Each of the initiatives described in the previous sections outlining activities to address delivery system transformation and alignment for Medi-Cal 2020 will need to be built on a robust data infrastructure that supports data use and sharing within the delivery system and with the state Medi-Cal program. In meeting opportunities to provide quality health care and services, the Medi-Cal program is changing from a quantity based reimbursement system to an integrated whole patient management system using value driven patient clinical data to demonstrate that California is reimbursing for clinical outcomes in a value driven system. Data infrastructure developments as part of the 1115 waiver will include the following:

Adoption of Health Information Technology (HIT) to Support Service Delivery

Over $2.5 billion federal funds have come to California professionals and hospitals through the Medicare and Medi-Cal Electronic Health Record (EHR) Incentive Programs. Additionally, DHCS is beginning a $38 million technical assistance program to assist providers in achieving meaningful use of the EHR technology in a CMS/DHCS program under the Medi-Cal EHR Incentive Program. The ongoing investment in EHR adoption and meaningful use provides the basis to further advance the use of HIT to support services for members. The 1115 Waiver Initiatives will provide programmatic incentives for use of HIT by incentivizing care coordination, targeting of specific populations, focusing on quality metrics. California has also supported adoption of EHRs for behavioral health services as has been funded in significant part through the California Mental Health Services Act. Work under the Waiver will specifically focus on inter-operability to support timely data transfer between data systems (e.g., primary care clinic EHRs and behavioral health EHRs, between hospital data systems and primary care, or between managed care plan Clinical Information Systems (CIS) and behavioral health EHRs) so that all primary care, mental health, substance use disorder treatment entities and managed care plans can assimilate and analyze the data sets from a variety of sources.

Although significant investment and transformation has occurred around adoption and use of EHRs, there are still significant gaps in the use of HIT to facilitate data sharing within the delivery system. The state has multiple organizations (over two dozen) supporting health information exchange (HIE) and yet a number of parts of the state do not have organizations or tools to support HIE. Challenges include linking of individual members between different and often disparate systems, the cost (effort, expertise, and system) of developing system interfaces, and the difficulty in maintaining up-to-date provider information to facilitate exchange. As part of the 1115 Waiver, DHCS will work with stakeholder internally and externally to address these issues for the Medi-Cal population with a focus on those individuals directly served by initiatives in the Waiver.

Incorporation of Clinical Data to Support Monitoring and Reporting

Currently the DHCS has invested significant funds to receive, standardize and analyze administrative data representing paid claims and capitated encounters to the health delivery system. While DHCS expects this investment to continue to be used, DHCS recognizes that the focus on value based purchasing, outcomes and care coordination cannot be supported by administrative data alone. Therefore, DHCS will evaluate methods for using clinical data and develop solutions that will make that data available to the department to monitor, manage and evaluate various Waiver Initiatives. The expanded data collection to include clinical data that is not included with a billing claim may include but is not limited to pharmacy data providing medication dosage, medication strength, and medication schedule, laboratory data documenting the diagnosis and the response to therapy, clinical findings such as blood pressure and physical findings documenting responses to treatment.

As is highlighted in the Medicaid Information Technology Architecture (MITA) Framework, clinical data is required to drive improved maturity in Medi-Cal activities. Clinical data originating from EHRs may be used in the clinical care environment to improve and document patient safety and direct resources to specific conditions. As the state Medicaid agency, DHCS will also use clinical data to evaluate the number of hospitalizations, emergency room visits, length of hospitalization, readmissions; assess cost of services and opportunities for reduction of services not contributing to improved health outcomes; and, evaluate the quality and cost for selected disease conditions and the effect of treatment on outcomes.

Medi-Cal employs HEDIS measures for its Managed Care Plans which include both administrative and hybrid measures. Hybrid measures cannot be calculated without clinical data and thus the DHCS is dependent on Managed Care Plans to use a sampling methodology to assess performance. Incorporation of clinical data to DHCS systems would allow DHCS to assess performance, perform more complex analysis around various member and provider demographics as well as outcome comparisons that can be adjusted for the various population mixes in each Manage Care Plan. This would allow the Department to use clinical data to provide outcome measures documenting the success and cost effectiveness of various treatments and interventions.

Appendix C: "Bridge to Reform" Evaluation Reports

Interim Evaluations attached in a separate file:

- DSRIP Interim Evaluation
- LIHP Interim Evaluation
- IHS Uncompensated Care Interim Evaluation
- Healthy Families Program Transition

Most Recent Operational Reports for Bridge to Reform demonstration:

- DY9 Annual Report
- DY 10 Quarter 2 Report

Appendix D: Proposed Medi-Cal 2020 Budget Neutrality

Attached in a separate file.

Appendix E: Updated "Bridge to Reform" Budget Neutrality

Attached in a separate file.

Interim Evaluation Report on California's Delivery System Reform Incentive Payments (DSRIP) Program

Prepared for:

California Department of Health Care Services and the Blue Shield of California Foundation

September 2014

UCLA CENTER FOR HEALTH POLICY RESEARCH

Interim Evaluation Report on California's Delivery System Reform Incentive Payments (DSRIP) Program

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September 2014

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List of Exhibits

Interim Evaluation Report on California's Delivery System Reform Incentive Payments (DSRIP) Program

Executive Summary

The findings presented in this interim report are based on preliminary data from DSRIP program years DY 6 through DY 8 (November 2010 – June 2013).

Several sources were used in this interim evaluation:

- Proposed DSRIP plans, and semi-annual and annual reports provided by the DPHs to the California Department of Health Care Services
- Data from the Office of Statewide Health Planning and Development (OSHPD)
- An extensive questionnaire created by UCLA and completed by representatives of all participating DPHs
- DPHs comments on the overall impact of DSRIP and recommendations for the DSRIP program in the next §1115 Medicaid waiver gathered from structured key informant interviews for Categories 1-4

This report includes the overall impact of Categories 1-4 as well as separate findings from each of those Categories. Category 5 is reported separately due to significant differences in the nature of those projects.

Findings

Overview of DSRIP Categories 1-4

DPHs varied in characteristics and choice of Categories 1 and 2 projects, the challenges they faced in implementing their projects and the solutions they devised to address such challenges. Despite these differences, the great majority of the project milestones were achieved. Specifically:

- Participating DPHs include five University of California and 12 County-owned and operated systems and include six multihospital systems. DPHs varied in size from 76,000 to 4,128 discharges and from 1.2 million to 130,000 outpatient visits in 2010.
- Many DPHs selected specific and related projects in Categories 1 and 2, including expanding primary care capacity and implementing and utilizing disease management registries for their Category 1 infrastructure development, and expanding medical homes for their Category 2 innovation and redesign initiatives.
- Nearly 50% of the implemented projects were ongoing prior to DPHs participation in DSRIP, though most were not implemented extensively or system-wide.
- DPHs cited consistency with organizational goals, availability of project champions among existing staff, and synergy with existing projects as principal reasons for selecting DSRIP projects.
- DPHs achieved nearly all (99%) of their proposed milestones in DY 7-8, covered in this interim report. This success was achieved with high levels of planning, resource investments, and many DPHs reported high level of overall difficulty in implementing projects.
- DPHs perceived a high level of impact on improving quality of care and health outcomes, two of the three components of the Triple Aim. The third component, cost containment/efficiency, had a lower perceived impact in part because not enough time had elapsed to assess the full effect of implemented projects.
- Category 1 infrastructure development and Category 2 innovation and redesign were perceived as having the greatest impact on the Categories 3, 4, and 5.

DSRIP Category 1

DPHs implemented a range of infrastructure development projects as part of their DSRIP plans. DPHs were required to implement at least two Category 1 projects from the project menu. Additional detail in implementation of Category 1 projects include:

- DPHs selected a total of 57 Category 1 projects, 11 of the 17 DPHs selected more than two projects, with four projects being the most projects a hospital selected. The most frequently selected projects included expand primary care capacity, implement and utilize disease management registry functionality, increase training of primary care workforce, and expand specialty care capacity.
- More than 75% of projects were ongoing or had been planned prior to DSRIP, but mostly with limited scope.
- Most projects were selected because of their consistency with organizational goals and/or synergy with existing projects.
- Over 98% of the 399 total proposed milestones in DY 6 through 8 were achieved.
- DPHs invested high levels of planning and resources, in some cases undertaking considerable levels of reorganization of care processes and personnel.
- Most projects received "medium" to "high" overall difficulty ratings.
- DPHs incorporated 75% of the project results into quality improvement initiatives and reported data to medical directors and administrators for 84% of Category 1 projects.
- More than half (53%) of Category 1 projects adopted an existing evidence-based model with moderate revision, but nonetheless required high levels of planning and resources.
- Introducing telemedicine, enhancing coding and documentation for quality data, and implementing and utilizing disease management registries were considered the three most difficult projects to implement overall.
- Staffing difficulties and the lack of standardized definitions for care and tracking processes were major challenges. DPHs solved these challenges by hiring and training staff and obtaining provider buy-in among other efforts.
- The greatest perceived impact was on improving quality of care. The overall perceived impact on improving health outcomes and increasing cost containment and efficiency were somewhat lower.

DSRIP Category 2

DPHs implemented Category 2 projects designed to expand medical home and the chronic care models, improve continuity and integration of care, enhance patient experience and engagement, and promote cohesive system change. Specifically:

- A total of 66 projects were implemented across the 17 DPHs for Category 2. Fifteen DPHs implemented more than the required two projects, and the greatest number of implemented projects was six.
- Thirteen DPHs implemented or expanded their medical homes. Other frequently implemented projects included the Chronic Care Model, the redesign of the patient

experience and primary care, the integration of physical and behavioral health care and the use of palliative care programs.

- The majority of Category 2 projects were either ongoing or planned prior to DSRIP, but with limited scope.
- Most organizations selected Category 2 projects for three main reasons: consistency with organizational goals (92% selected projects for this reason), synergy with existing projects (82%) and the availability of champions (77%). Lack of funding and lack of HIT were the most commonly cited reasons for not planning Category 2 projects prior to DSRIP.
- All but five of the 376 milestones for Category 2 projects were achieved from DY 6 to DY 8.
- Forty-four percent of Category 2 projects were implemented through the adoption of an existing evidence-based model with moderate modification.
- Staff received training during implementation for 83% of Category 2 projects and prior to implementation for 73% of projects.
- Among the 14 project types within Category 2, the DPHs reported that the cost containment, medication management, and real time acquired infection system projects required the greatest amount of planning.
- Category 2 projects related to palliative care, process improvement, and cost containment were the most demanding in terms of stakeholder engagement. Most Category 2 projects were rated "high" or "very high" in terms of level of difficulty in overall implementation.
- DPHs perceived that the majority of Category 2 projects had a high or very high impact on quality of care and improvement of health outcomes.
- The most commonly stated challenges for Category 2 projects included difficulties in tracking data from multiple systems and lack of an automated system for data abstraction. Solutions included developing EMRs that interfaced with multiple systems and developing record-keeping protocols.

DSRIP Category 3

In Category 3, DPHs were required to track a variety of measures relating to patient experience, care coordination, preventive care, and at-risk populations. DPHs were required to track all measures for Category 3, but measures were not held to performance standards. Other details related to Category 3 measures include:

- All DPHs were tracking some measures prior to DSRIP; the most commonly tracked measure was the 30-day Chronic Heart Failure readmission rate and the diabetes Hemoglobin A1c control measure (10 DPHs). CG-CAHPS was least frequently tracked prior to DSRIP (2 DPHs).
- Lack of HIT and lack of staff were the most commonly cited reasons for not tracking Category 3 measures prior to DSRIP.

- DPHs achieved all 119 milestones in DY 7 and all 340 milestones in DY 8.
- DY 8 CG-CAHPS results indicated scores were highest for ability of the doctors to communicate with patients (81.6%) but lowest for getting timely appointments, care, and information (44.9%).
- A substantial increase in the average rates of mammography screening (from 53.8% to 64.7%) were observed from DY 7 to DY 8, but other measures did not change or changed by a small percentage overall. The individual DPH rates indicated large percentage increases and declines in some rates.
- DPHs reported using Category 3 measures in quality improvement initiatives 80% of the time as well as using them to provide feedback to medical directors and administrators 75% of the time and providers 70% of the time.
- All Category 3 measures required a high level of planning and resources, with the optimal diabetes care composite measure requiring the highest level of planning and resources and reported as being the most difficult to track overall.
- Preventive measures such as pediatric asthma care, tobacco cessation, pediatrics body mass index, child weight screening, and influenza immunization also proved to be difficult to collect, largely due to the level of manual abstraction required.
- The most frequently cited challenges to tracking Category 3 measures were data collection and data abstraction. The implementation of EMRs across DPHs eased these main data challenges.
- Most DPHs reported that Category 3 measures were not anticipated to have a high impact on cost containment but were expected to have an important effect on improving quality of care and patient health outcomes.

DSRIP Category 4

All DPHs were required to implement severe sepsis detection and management and central-line associated bloodstream infection (CLABSI) prevention as well as two out of five other inpatient care projects. The findings related to Category 4 projects include:

- The two most frequently selected additional projects were surgical site infection (SSI) prevention and hospital-acquired pressure ulcer (HAPU) prevention.
- Nearly all hospitals identified consistency with organizational goals and synergy with existing projects as reasons for selecting the two additional projects.
- Seven out of the 17 hospitals had no sepsis intervention prior to DSRIP. All of the participating DPHs had a CLABSI program underway prior to DSRIP.
- Lack of identification of the intervention as a problem and lack of HIT infrastructure were the most frequently cited reasons for not implementing various inpatient care projects prior to DSRIP.

- Overall, rates of adherence to the protocols for stroke management were high at baseline and increased to 96% or higher in DY 8. Venous thromboembolism prevention and treatment adherence rates ranged from about 47% to 90% at baseline for five protocols related to therapy and prophylaxis. Adherence rates changed to nearly 70% to nearly 90% for the same protocols in DY 8.
- DPHs adopted existing models, extensively modified 12% of the projects, and designed a new model for 10% of projects.
- For 69% of Category 4 projects, hospital staff received training prior to implementation and for 82% of projects the staff received training during implementation.
- The DPHs reported high levels of effort required to implement Category 4 projects despite substantial work prior to DSRIP on some projects. In general the level of effort required for implementation overall was high to very high.
- The level of resources required, challenges in obtaining stakeholder engagement and reorganization of care processes all required especially high levels of effort.
- Consistent documentation, lack of resources for data collection, and time-consuming manual data abstraction proved to be some of the greatest challenges in obtaining data for Category 4 projects.
- Daily audits, monthly meetings, integration of protocols into the EMR systems, and staff training and engagement were some of the solutions identified by DPHs as most helpful in obtaining data, achieving milestones and improving sustainability for Category 4 projects.
- Measures and project results were integrated into quality improvement efforts for all Category 4 projects and nearly all Category 4 projects used data to provide administrative leadership and medical directors with feedback on results and progress.
- DPHs perceived that Category 4 projects had the greatest impact on improving quality of care and health outcomes, followed by increasing cost containment and efficiency.
- Preliminary analyses of hospital discharge data prior to DSRIP implementation indicated that the rates of mortality due to severe sepsis, surgical site infections, and hospital-acquired pressure ulcers were higher in DPHs than matched hospitals. However, the reverse was true for hospital-related falls and venous thromboembolisms.

DSRIP Category 5

Category 5 interventions were designed to improve the delivery of services to people living with HIV/AIDS (PLWHA) and facilitate the transition from Ryan White to the Low Income Health Program (LIHP) care sites. DPHs in ten counties implemented Category 5 interventions. Category 5A focused on improvements in infrastructure and program design, while Category 5B concentrated on improvements in clinical and operational outcomes. DPHs were required to select three (of seven) Category 5A interventions. All DPHs were required to report data on six HIV Core Clinical Performance Measures. In addition, DPHs were required to select at least one metric from Groups 2, 3 and Medical Case Management. Category 5 analysis was conducted with available data from DPH proposals and reports. Findings for this Category include:

- Empanel patients into medical homes, disease management registry, developing retention programs, and ensuring access to Ryan White wraparound services were most commonly selected Category 5A projects (6 DPHs). The interventions were successfully launched across the ten sites.
- The most commonly selected Category 5B, group 2 and 3 measures were hepatitis C and syphilis screening (4 DPHs).
- DPHs that implemented medical homes also selected enhanced Ryan White wraparound services, and DPHs implementing disease management registries often also selected development of formal retention programs.
- DPHs reported selecting Category 5A projects that aligned with the Federal Implementation Plan of the National HIV/AIDS Strategy. Projects were also selected because they were complementary to DSRIP Category 1-4 projects.
- DPHs reported significant increases in four of the six required Group 1 outcomes. Across the sites, the percentage of patients with at least two medical visits a year increased from 77.5% in the baseline period to 80.9%.
- Greater exposure to medical evaluation and management created opportunities to increase 5B outcomes. The proportion of patients who were on HAART therapy increased from 88.5% to 92.8%. Regular viral load monitoring increased from 57.6% to 70.7%, but receipt of CD4 T-cell counts grew only slightly from 70% to 70.2%. Viral load suppression grew to 86.1% of patients on ART from a baseline level of 84.6%. Among patients with CD4 T-cell counts below 200 cell/mm^3, the proportion receiving PCP prophylaxis rose from 75.9% to 83.0%.
- DPHs reported that empanelment of patients into medical homes with HIV expertise, implementation of a disease management registry, and development of retention programs were the three interventions with the greatest impact on retention.
- All five of the Category 5B measures with available outcome data showed significant increases. DPHs reported that disease management registries, clinical decision support

tools and linking patients to medical homes enabled them to increase screening for the targeted conditions such as sexually transmitted disease, tuberculosis (TB), and mental health issues. In addition to reaching a greater share of PLWHA in their care with screening, DPHs reported large increases in the percentage of PLWHA who received vaccinations, increasing the vaccination rate for pneumonia from 47% to 82% of patients, for hepatitis B from 19% to 34% and for influenza from 49% to 82% of all HIV patients.

- DPHs reported success in improving patient retention and adherence to medication. The major contributors to positive outcomes were empanelling patients into medical homes with HIV expertise, implementing a disease management registry and developing specific retention programs.
- DPHs faced many challenges, including short timelines, the need for staff training, physician compliance, and timeliness of inputting patient information in the electronic medical record system. The most frequently reported challenge was removing patient barriers to retention in care. DPHs also had concerns about sustainability of 5A programs after DSRIP funding ended. Despite the challenges, the DPHs reported success in implementing the interventions and improving patient outcomes.

Overall Impact of DSRIP and DPH Recommendations

DPHs reported on the overall impact of Categories 1 to 4 on their organizations. The summary of this impact includes:

- DSRIP led to systematic and major change and was considered as an investment in the future of DPHs. The focus of DSRIP on population-based measures and outpatient care was particularly valuable.
- DSRIP significantly transformed the operations and information technology in DPHs.
- DSRIP provided the resources and financial incentives to effectively implement the selected projects and obtain buy-in from executives and staff.
- DSRIP led to new collaborations between DPHs and sharing of innovations.

DPHs were asked to provide their recommendations for renewal of DSRIP under the next Medicaid §1115 Waiver. These recommendations included:

- Align DSRIP projects with other initiatives and organizational goals.
- Consider projects that prepare DPHs for the future.
- Reduce the number of projects and narrow the focus of the program.
- Provide DPHs with clear metrics, instructions, and direction.

- Reevaluate the relevance of some measures to ensure consistency with current evidence.
- Allow for flexibility so that projects can be aligned with organization goals and characteristics. But increase standardization of some measures to reduce confusion and shifting goals.
- Improve measurement methods so that high performing DPHs are not penalized for small marginal improvements.
- Better measure time and effort required to complete projects.
- Provide CMS timely feedback and establish direct communication lines between CMS and DPHs.

Future Analysis in the Final DSRIP Evaluation Report

The findings presented in this report are preliminary and represent the early experiences of DPHs during DY 6 to DY 8 and include selected areas of the evaluation. The final evaluation report will include all areas of the evaluation and will include evaluation of data from DY 9 and DY 10, in-depth analysis of key informant interviews with DPHs, and further analysis of DPH and non-DPH external data.

Introduction

In November 2010, California received approval for its §1115 Medicaid "Bridge to Reform" waiver. In preparation for health care reform under the Patient Protection and Affordable Care Act (ACA) of 2010, the waiver allowed California the flexibility to modify its Medicaid programs to implement innovative delivery reforms. The waiver included four main components: the Low Income Health Program (LIHP), which expanded eligibility for Medicaid-like coverage to low-income individuals prior to health reform; a program that moved seniors and persons with disabilities to Medicaid managed care organizations; programs to develop organized systems of care within the California Children's Services program; and the Delivery System Reform Incentive Payments (DSRIP) program, which was aimed at improving care delivery and performance of designated public hospitals and academic hospital systems throughout California through the use of financial incentives[1].

One of the main goals of California's DSRIP program was to incentivize innovation and integrated care delivery redesign at hospital systems serving a disproportionate share of low-income patients, particularly in anticipation of the influx of newly insured patients as a result of the ACA. Additional goals included creating and sustaining medical homes to manage chronic diseases, delivering proactive primary care services, and reducing health disparities. California was the first in the nation to implement a DSRIP program, supporting transformative change through a performance-based structure. Since the implementation of California's waiver, six additional states have created DSRIP programs, including Kansas, Massachusetts, New Jersey, New York, New Mexico, and Texas[2].

Participating DPHs

Participating institutions include all 17 designated public hospitals (DPHs) in California. Six DPHs are multi-hospital systems leading to 21 total hospitals. The following DPHs are participating in DSRIP:

- Alameda Health System
- Arrowhead Regional Medical Center
- Contra Costa Health Services
- Kern Medical Center
- Los Angeles County Department of Health Services (includes Los Angeles County University of Southern California, Harbor/University of California Los Angeles Medical Center, Olive View/ University of California Medical Center, and Rancho Los Amigos National Rehabilitation Center)

- Natividad Medical Center
- Riverside County Regional Medical Center
- San Francisco General Hospital
- San Joaquin General Hospital
- San Mateo Medical Center
- Santa Clara Valley Medical Center
- University of California, Davis Medical Center
- University of California, Irvine Medical Center
- University of California, Los Angeles Hospitals (includes University of California Los Angeles Medical Center – Ronald Reagan, and University of California Los Angeles Medical Center – Santa Monica)
- University of California, San Diego Health Systems
- University of California, San Francisco Medical Center
- Ventura County Medical Center

DSRIP Program Design

The first year of DSRIP implementation is referred to as Demonstration Year (DY) 6. DSRIP will end on October 31, 2015 or at the end of DY 10. DPHs have the potential to receive up to $3.3 billion dollars in federal funds over the 5 years of the waiver. DPHs' DSRIP proposals focused on four categories of projects: develop infrastructure, implement innovation and redesign, track population-focused measures, and implement urgent improvements in care. Ten DPHs elected to participate in Category 5 projects, which focused on ensuring that persons diagnosed with HIV have access to high-quality care, integrated and coordinated care, in the outpatient setting. Category 5 projects were implemented for a total of 18 months, from the start of DY 8 in July 2012 through the first six months of DY 9 and ending in December 2013.

Each approved project in the §1115 Medicaid waiver included multiple potential process and improvement measures; DPHs were required to select at least one measure of each type. Within each measure, DPHs were required to select an evidence-based metric and provide rationale and/or evidence to support the metric.

In their proposals, DPHs were required to submit a "Milestone and Metrics Table" for each Category 1 and Category 2 project, in which each milestone was specified as the improvement target for that specific year. For example, a milestone could be "Achieve at least a 10% or lower patient no-show rate for primary care medical homes" where the metric is the no-show rate and the milestone is 10% or lower[3].

In their proposals, DPHs were also required to include a narrative that described the goals of the program, the challenges faced by the particular system and community, and the delivery reform aimed at addressing the stated challenges. The baseline for the projects was required to begin no earlier than July 2009. DPHs were also required to note how each project reinforced and supported efforts in other categories within the DSRIP plan. Below are the further descriptions of each DSRIP category.

Category 1: Infrastructure Development

Category 1 projects focused on infrastructure development. These activities resulted in investments in technology, tools, and human resources to strengthen the ability of DPHs to serve populations and improve services. DPHs were required to select at least two Category 1 projects but had complete flexibility in which projects they selected. DPHs were required to provide reasons for their selections based on the needs and circumstance of their population, the relative priority of the project for the organization, and baseline status. The full and abbreviated Category 1 project names used in the rest of this report are provided in Exhibit 1.

Exhibit 1: Category 1 Projects

Full Project Name	Abbreviated Name
1. Expand Primary Care Capacity	Primary Care Capacity
2. Increase Training of Primary Care Workforce	Workforce Training
3. Implement and Utilize Disease Management Registry Functionality	Disease Registry
4. Enhance Interpretation Services and Culturally Competent Care	Cultural Competency
5. Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	REAL Data
6. Enhance Urgent Medical Advice	Urgent Medical Advice
7. Introduce Telemedicine	Telemedicine
8. Enhance Coding and Documentation for Quality Data	Quality Data
9. Develop Risk Stratification Capabilities/Functionalities	Risk Stratification
10. Expand Capacity to Provide Specialty Care Access in the Primary Care Setting	Specialty Care in Primary Setting
11. Expand Specialty Care Capacity	Specialty Care Capacity
12. Enhance Performance Improvement and Reporting Capacity	Performance Improvement

Category 2: Innovation and Redesign

Projects in Category 2 were aimed at implementing innovative models and redesign of care. Selection of Category 2 project was similar to Category 1 explained above. Category 2 projects full name and the abbreviated name used in the rest of this report are provided in Exhibit 2.

Exhibit 2: Category 2 Projects

Full Project Name	Abbreviated Name
1. Expand Medical Homes	Medical Homes
2. Expand Chronic Care Management Models	Chronic Care Management
3. Redesign Primary Care	Primary Care Redesign
4. Redesign to Improve Patient Experience	Patient Experience
5. Redesign for Cost Containment	Cost Containment
6. Integrate Physical and Behavioral Health Care	Physical and Behavioral Health Care Integration
7. Increase Specialty Care Access/Redesign Referral Process	Specialty Care Access/Redesign Referral Process
8. Establish/Expand a Patient Care Navigation Program	Patient Care Navigation Program
9. Apply Process Improvement Methodology to Improve Quality/Efficiency	Process Improvement
10. Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	Flow in the ED/Rapid Medical Evaluation
11. Use Palliative Care Programs	Palliative Care
12. Conduct Medication Management	Medication Management
13. Implement/Expand Care Transitions Programs	Care Transitions
14. Implement Real-Time Hospital-Acquired Infections (HAIs) System	Real-Time Hospital-Acquired Infections (HAIs) System

Category 3: Population-Focused Improvement

Category 3 required tracking specific measures of care delivery for high burden conditions in DPH systems focusing on population health improvement. Each DPH was required to gather six measures in DY 7, and to report all 16 measures during DY 8-10. DPHs without robust electronic health record systems were allowed to use a sampling approach to generate a statistically significant random sample using the methodology outlined in the Waiver Special Terms and Conditions. Category 3 measures are listed in Exhibit 3.

Exhibit 3: Category 3 Measures

Patient or Care Giver Experience
1. CG-CAHPS
Care Coordination
2. Diabetes, short term complications
3. Uncontrolled diabetes
4. Congestive heart failure
5. Chronic obstructive pulmonary disease
Preventive Health
6. Mammography screening
7. Influenza immunization
8. Child weight screening
9. Pediatrics body mass index
10. Tobacco cessation
At-Risk Populations
11. Diabetes: LDL control (<100 mg/dl)
12. Diabetes: HgA1c control (<8%)
13. 30-day CHF readmission rate
14. Hypertension: blood pressure control (<140/90 mmHg)
15. Pediatrics asthma care
16. Optimal diabetes care composite

Category 4: Urgent Improvement in Care

Category 4 projects were designed to make urgent improvements in the inpatient quality and safety and included specific evidence-based projects.[3] Each DPH was required to implement at least four projects including two required projects on severe sepsis detection and management and central-Line associated bloodstream infection prevention. DPHs were also required to select a minimum of two additional interventions from the following projects: surgical site infection prevention, hospital-acquired pressure ulcer prevention, stroke management, venous thromboembolism prevention and treatment, and falls with injury prevention. Improvement targets for Category 4 projects were based on baseline data starting no earlier than July 2009 or data based on 6-12 months of the project in DY 7. The state was tasked with setting a high performance level and a minimum performance level for central line insertion practices (CLIP) adherence, stroke management, and venous thromboembolism prevention and treatment, which will be used as guidelines to set targets for DY 9-10. Category 4 projects are provided in Exhibit 4.

Exhibit 4: Category 4 Projects

1. Severe Sepsis detection and Management (Mandatory Project)
2. Central Line-Associated Bloodstream Infection (CLABSI) Prevention (Mandatory Project)
3. Surgical Site Infection (SSI) Prevention
4. Hospital-Acquired Pressure Ulcer Prevention
5. Stroke Management
6. Venous Thromboembolism (VTE) Prevention and Treatment
7. Falls with Injury Prevention

Category 5: HIV Transition Projects

Category 5 projects are aimed at strengthening the ability of DPHs to serve individuals diagnosed with HIV, and are focused on outpatient services. Category 5 proposals were required to demonstrate the infrastructure, programs and services that must be in place in order for HIV-positive individuals to receive high-quality, coordinated care. Category 5A focused on improvements in infrastructure and program design, while Category 5B concentrated on improvements in clinical and operational outcomes. DPHs were required to select three Category 5A interventions.

Category 5B projects were designed to focus on achieving discrete patient outcomes across several domains. All DPH systems were required to report data on six HIV Core Clinical Performance Measures for individuals enrolled in LIHP who access care through the DPH system and were also required to select and track four additional Performance Measures. For the additional measures, DPHs were required to select at least one measure from Groups 2, 3 and Medical Case Management. Hospital systems reported measures through the Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB). Upon collecting baseline data, DPHs were required to achieve performance improvement targets by the end of the Category 5 timeline in order to receive funding for each measure.

The following DPHs participated in Category 5 projects:

1. Alameda Health System
2. Contra Costa Regional Medical Center
3. Kern Medical Center
4. Los Angeles Department of Health Services
5. Riverside County Regional Medical Center
6. San Francisco General Hospital
7. San Mateo Medical Center
8. Santa Clara Valley Medical Center

9. University of California, San Diego Health Services
10. Ventura County Medical Center

Exhibit 5: Category 5A Projects

1. Empanel patients into medical homes with HIV expertise
2. Implement a Disease Management Registry module suitable for managing patients diagnosed with HIV
3. Build clinical decision support tools to allow for more effective management of patients diagnosed with HIV
4. Develop retention programs for patients diagnosed with HIV who inconsistently access care
5. Enhance data sharing between DPHs and County Departments of Public Health to allow for systematic monitoring of quality of care, disease progression, and patient and population level health outcomes
6. Launch electronic consultation system between HIV primary care medical homes and specialty care providers
7. Ensure access to Ryan White wraparound services for new LIHP enrollees

Exhibit 6: Category 5B Required Core Clinical Performance Measures

Required Measures	Optional Measures		
Group 1	**Group 2**	**Group 3**	**Medical Case Management**
1. CD4 T-Cell Count	1. Adherence Assessment and Counseling	1. Chlamydia Screening	1. Care Plan
2. HAART	2. Cervical Cancer Screening	2. Gonorrhea Screening	2. Medical Visits
3. Medical Visits	3. Hepatitis B Screening	3. Hepatitis/HIV Alcohol Counseling	
4. PCP Prophylaxis	4. Hepatitis B Vaccination	4. Influenza Vaccination	
5. Viral Load Monitoring	5. Hepatitis C Screening	5. MAC Prophylaxis	
6. Viral Load Suppression	6. HIV Risk Counseling	6. Mental Health Screening	
	7. Lipid Screening	7. Pneumococcal Vaccination	
	8. Oral Exam	8. Substance Abuse Screening	
	9. Syphilis Screening	9. Tobacco Cessation and Counseling	
	10. TB Screening	10. Toxoplasma Screening	

DPH Reporting

In order to receive funding under DSRIP, DPHs are required to submit reports to the State, which must include progress reports and the incentive amounts requested by each DPH. DPHs are required to submit two semi-annual reports and one year-end report per demonstration year. With the exception of DY 6, the first reporting period occurs from July 1 through December 31 of the demonstration year, with the report due March 31 and final incentive payments disbursed by April 30. The second reporting period occurs from January 1 through June 30 of the demonstration year, with the report due in September and the payment disbursed by October 31. DPHs must also submit an annual, year-end report by October 31. The year-end reports must include information from the two semi-annual reports, a year-end

narrative and descriptions of the DPHs' involvement in collaborations. Each report must include data that supports milestone achievement.

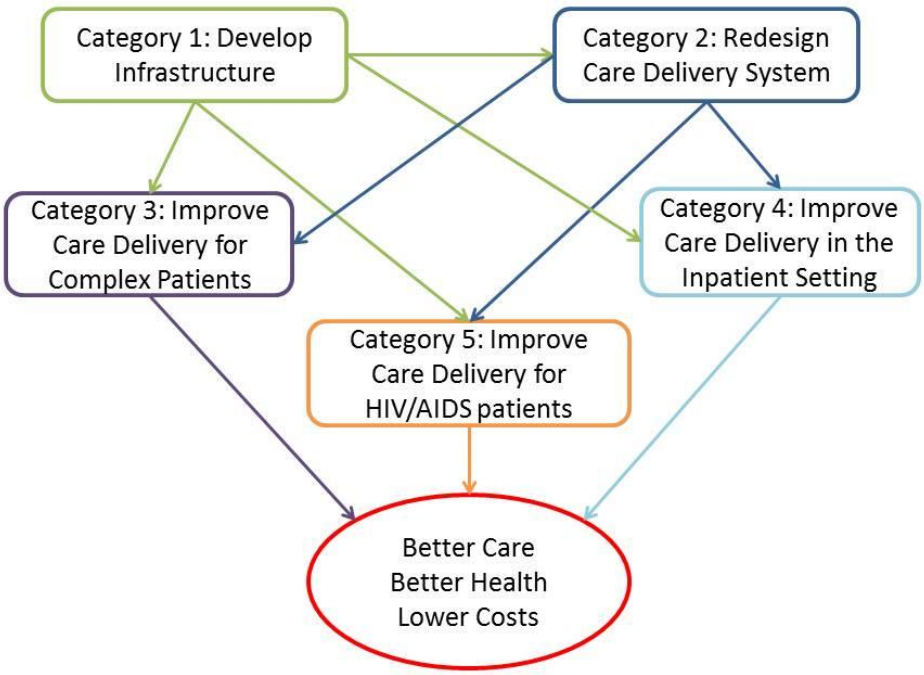
DPHs must report achievement on the designated milestones to receive funding. Each milestone is given an achievement value between 0 and 1. These achievement values are then summed to give a total achievement value for each "milestone bundle" for a particular length of time (full calculation available in *Attachment P* of the Waiver Special Terms and Conditions).

Achievement	Achievement Value
Full achievement	1
≥75%	0.75
74% to 50%	0.5
49% to 25%	0.25
≤24%	0

UCLA Evaluation

The University of California, Center for Health Policy Research (UCLA) was selected by the California Department and Health Care Services (DHCS) to evaluate the DSRIP program. The evaluation is designed to examine the progress of DPHs in implementing DSRIP projects, the process of implementation and challenges faced by DPHs, and whether DSRIP projects impacted the Triple Aim of improving quality of care and patient outcomes, and increased cost containment or efficiency. This interim evaluation report covers DY 6, DY 7 and DY 8. The final evaluation report to be completed in late 2015 will cover the available data for the entire program including DY 9 and 10. UCLA examines the implementation of each Category as well as impact of categories on each other as indicated in the conceptual framework in Exhibit 7.

Exhibit 7: Conceptual Framework for UCLA's Evaluation of the DSRIP Program



Research Questions

The following research questions are addressed to the degree possible and depending on availability of data in this interim period:

- What were the predominant types of infrastructure and system redesign projects selected by DPHs? Why were these projects chosen?
- Did infrastructure and system redesign projects improve the ability of DPHs to enhance care delivery in the inpatient setting and for complex populations? How were these improvements accomplished?
- Did any projects have a greater impact on improving health, care delivery, or efficiency than others?
- What were the major challenges experienced by DPHs in implementing Categories 1-5 projects? What was the impact of these challenges on program sustainability?
- What were the lessons learned and innovations by DPHs in implementation of projects in Categories 1-5? How were implementation challenges addressed?
- Above and beyond the DSRIP milestones and requirements, did the Category 5 projects lead to smoother transitions for patients transitioning into LIHP, and in what ways?

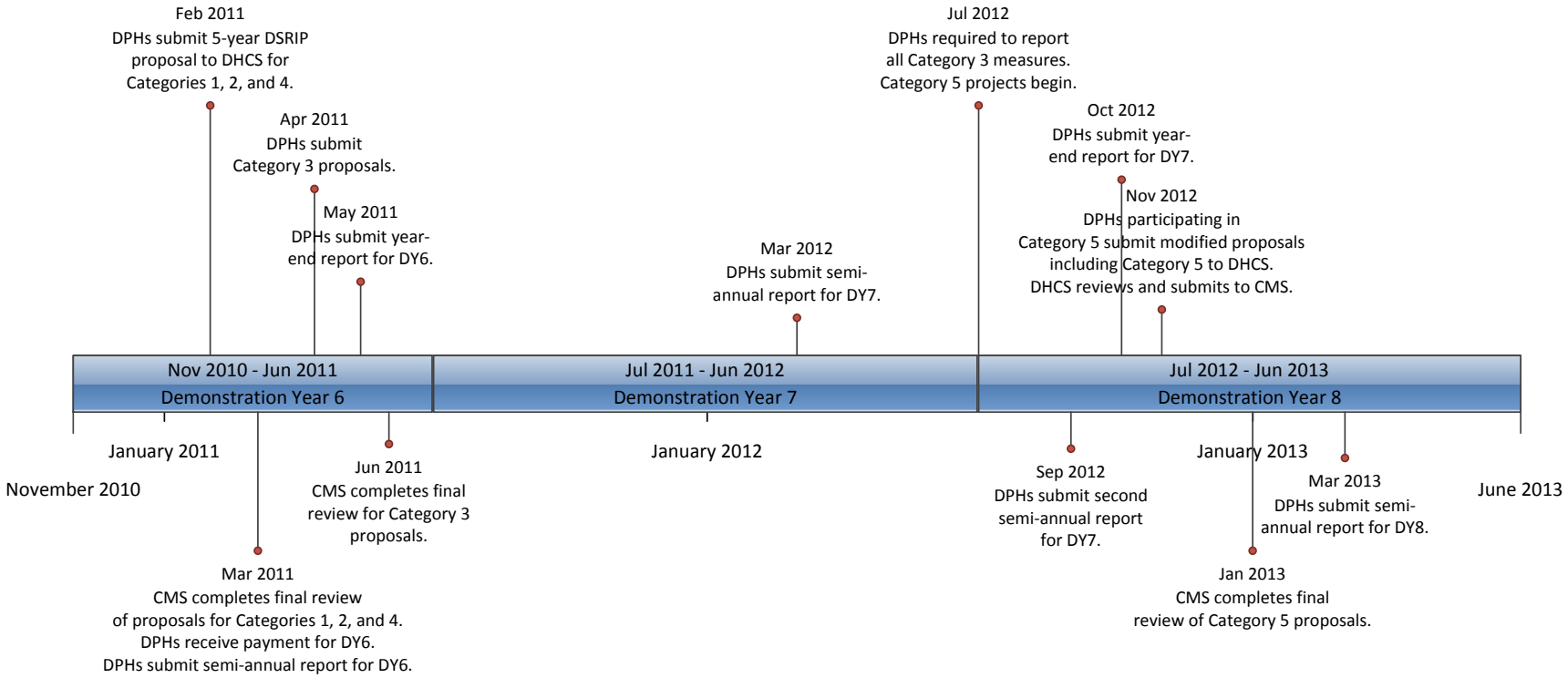
- Did the Category 5 projects lead to improved health outcomes for HIV-positive LIHP enrollees? What impact has the provision of preventive care and screening services had on health outcomes for HIV-positive LIHP enrollees?
- How has the implementation of Category 5A projects improved coordination of services for patients diagnosed with HIV? How has the implementation of Category 5A projects improved retention and compliance for patients diagnosed with HIV?
- What trends are reported across DPHs on the obstacles to meeting performance improvement targets?

Data Sources

UCLA used four data sources in this interim report:

- The DSRIP plans and annual DPH reports from DY 6 through DY 8. A timeline of plan and report submissions is presented in Exhibit 8.
- An extensive questionnaire completed by representatives of all participating DPHs. The questionnaire included open-ended and categorical closed-ended questions for a systematic set of responses from all respondents.
- Structured key informant interviews conducted with all DPHs. Interviews were used to gather additional data to answer the evaluation questions, particularly when DPH reports did not sufficiently illustrate lessons learned and barriers or challenges to implementation of the program overall or for specific projects. Key informant interviews were conducted by telephone with the individuals most knowledgeable about the specific areas of interest such as medical directors, administrators of the DSRIP projects and/or quality improvement initiatives, and clinicians. Limited data from these interviews were available and are used for this report.
- Data from the Office of Statewide Health Planning and Development (OSHPD) to describe the context in which DPHs deliver care in California and identify benchmarks for Category 4 DSRIP indicators and measures.

Exhibit 8: Timeline of DSRIP Plans and Reports Used in Interim Report



Overview of Categories 1-4

This chapter provides an overview of the implementation and impact of DSRIP Categories 1-4 overall. Category 5 is reported separately due to significant differences in the nature of those projects. However, the discussion of the impact of projects from one category to another includes the impact on Category 5 projects.

DPH Characteristics

The 17 DPHs participating in DSRIP include five University of California (UC) systems and 12 County-owned and operated systems (Exhibit 9). These DPHs vary widely in size, structure, and other characteristics. Six of the DPHs had multiple acute care hospitals within their systems, and all said that DSRIP projects were consistently implemented across their facilities. The Los Angeles County Department of Health Services (LACDHS) was the largest system, with three acute care hospitals, more than 76,000 discharges and 1.2 million outpatient visits. In terms of payer mix, the county-owned DPHs tended to have a larger percentage of discharges and outpatient visits covered by Medi-Cal and less coverage from third-party payers than DPHs in the UC system. The DPHs in the UC system had higher case mix averages than the non-UC hospitals, an indication of the higher level of care complexity provided by UC DPHs. Most of the participating systems also share some similarities. All DPHs have multiple primary care facilities participating in DSRIP. Sixteen of the DPHs (except for San Mateo Medical Center), are teaching hospitals and have residents on staff (data not shown).

Exhibit 9: Characteristics of Designated Public Hospitals Participating in DSRIP

Designated Public Hospital	Number of Hospitals*	Total Hospital Beds	FY 2010 Total Discharges	FY 2010 Outpatient Visits	Total Non-Pediatric General Acute Care Beds	Percentage of Discharges With Medi-Cal as Payer Source	Percentage of Discharges with Third-Party Payer Source	Percentage of Outpatient Visits With Medi-Cal as Payer Source	Percentage of Outpatient Visits with Third-Party Payer Source	Number of Primary Care Facilities Participating in DSRIP	Case Mix**
County-Owned DPHs											
Alameda County Medical Center	1	475	13,816	424,224	236	51	3	39	3	4	1.04
Arrowhead Regional Medical Center	1	456	24,325	384,516	260	48	5	44	6	4	1.04
Contra Costa Regional Medical Center	1	163	9,658	486,551	123	54	9	51	13	10	0.91
Kern Medical Center	1	222	11,878	147,603	173	61	11	55	8	4	0.95
Los Angeles County Department of Health Services	3	2,034	76,549	1,236,594	1,305	51	7	35	7	23	1.21
Natividad Medical Center	1	172	7,904	194,084	138	60	16	36	12	2	0.86
Riverside Medical Center	2	439	21,194	130,000	341	38	16	50	15	4	1.04
San Francisco General Hospital	1	509	15,625	614,152	395	52	16	39	14	10	1.18
San Joaquin General Hospital	1	196	8,601	220,458	181	63	8	50	9	3 to 6***	1.03
San Mateo Medical Center	1	509	4,128	303,953	93	39	13	36	8	9****	1.19
Santa Clara Valley Medical Center	1	574	23,433	823,341	484	55	10	54	12	7	1.11
Ventura County Medical Center	2	272	13,893	860,589	213	42	24	31	38	17	1.01
University of California DPHs											
University of California, Davis Medical Center	1	619	29,190	930,372	605	34	28	9	63	18	1.6
University of California, Irvine Medical Center	1	422	16,389	412,552	345	27	32	20	37	5	1.53
University of California, Los Angeles Hospitals	2	800	38,327	834,944	723	17	45	8	57	20	1.62
University of California, San Diego Health System	2	600	23,706	482,693	479	26	32	23	42	8	1.58
University of California, San Francisco Medical Center	2	580	29,244	953,070	635	23	43	13	48	5	1.85

Source: UCLA analysis of 2010 hospital financial and utilization data from the California Office of Statewide Health Planning and Development

*Does not include rehabilitation or psychiatric facilities.

**Case mix is a measure of the relative cost or resources needed to treat the mix of patients in each designated public hospital during the calendar year. Higher scores indicate greater level of complexity. Some of the factors that go into calculating case mix include: principal and secondary diagnoses, age, procedures performed, the presence of co-morbidities and/or complications, discharge status, and gender. A detailed explanation is available here: http://www.oshpd.ca.gov/HID/Products/PatDischargeData/CaseMixIndex/default.asp

***San Joaquin General Hospital reported most measures from three primary care clinics, but reported mammography screenings from six clinics.

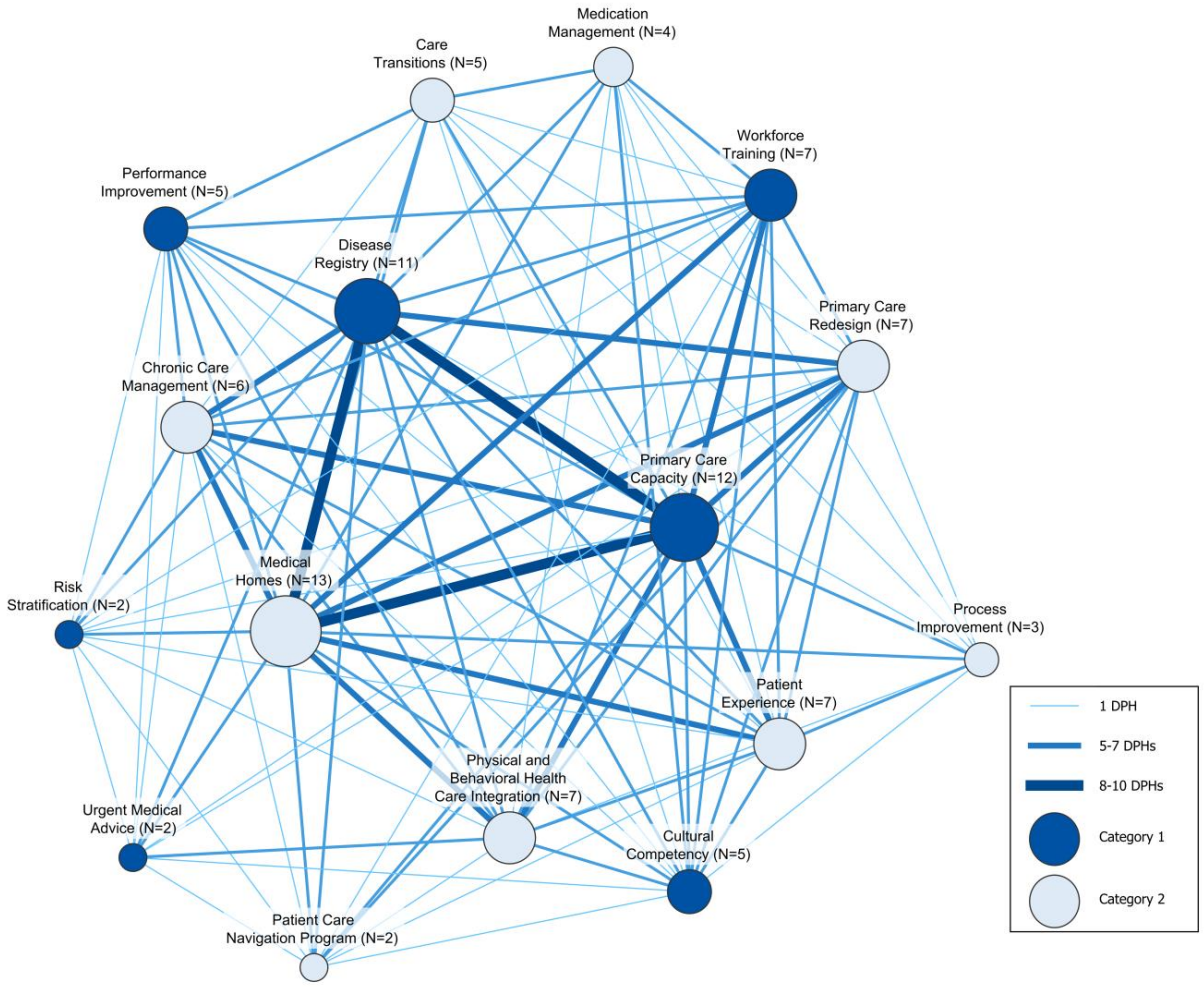
****San Mateo Medical Center had 10 clinics participating in DSRIP until 2013 when one clinic closed down. It now has nine clinics participating in DSRIP.

Project Selection

Participating DPHs had to track all Category 3 measures. Category 4 included two required projects and two optional projects. However, DPHs could choose from 12 projects in Category 1 and 14 projects in Category 2.

The following diagram highlights the projects that were most frequently and concurrently chosen by DPHs in Categories 1-2 (Exhibit 10). The dark circles represent Category 1 projects and the light circles represent Category 2 projects. The larger circles represent projects most frequently selected by DPHs (the number of DPHs that selected each project is denoted by N). For example, the Category 1 disease registry project was selected by 11 DPHs and is represented by a large dark circle but risk stratification was selected by 2 DPHs and is represented by a small dark circle. The lines between circles identify which projects were concurrently selected and the thickness of the line represents how many DPHs concurrently implemented the same project. For example, between 8 -10 DPHS selected both disease management and medical home projects, but disease registry and chronic care management projects were concurrently selected by 5-7 DPHs. The diagram indicates that the DPHs that selected implementing and utilizing disease management registries and expanding primary care capacity as Category 1 projects most frequently selected expanding medical home projects in Category 2. The second group of most frequently concurrent projects included workforce training from Category 1 with chronic disease management, physical and behavioral health integration, and improving patient experiences from Category 2. The pattern of selection among the remaining projects is less pronounced or clear.

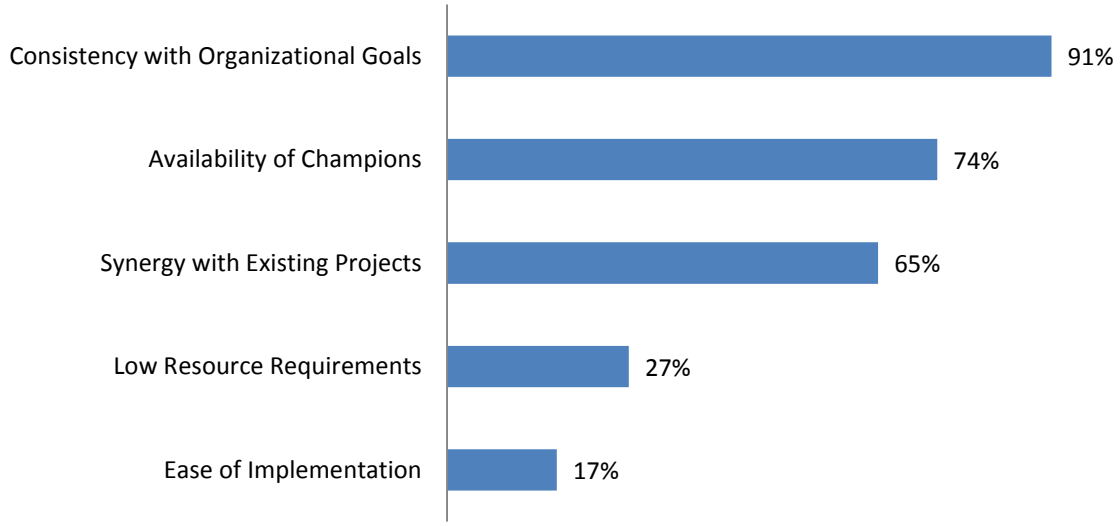
Exhibit 10: Selection Frequency of Concurrent Category 1-2 DSRIP Projects



Source: UCLA analysis of designated public hospital (DPH) reports.
Notes: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

DPHs reported the reasons for selecting the projects included in their DSRIP plans. The three most common reasons were consistency with organizational goals, availability of project champions among existing staff, and synergy with existing projects (Exhibit 11). DPHs least frequently reported ease of implementation as a reason for selecting projects.

Exhibit 11: Reasons for Selecting Categories 1, 2, 4 DSRIP Projects

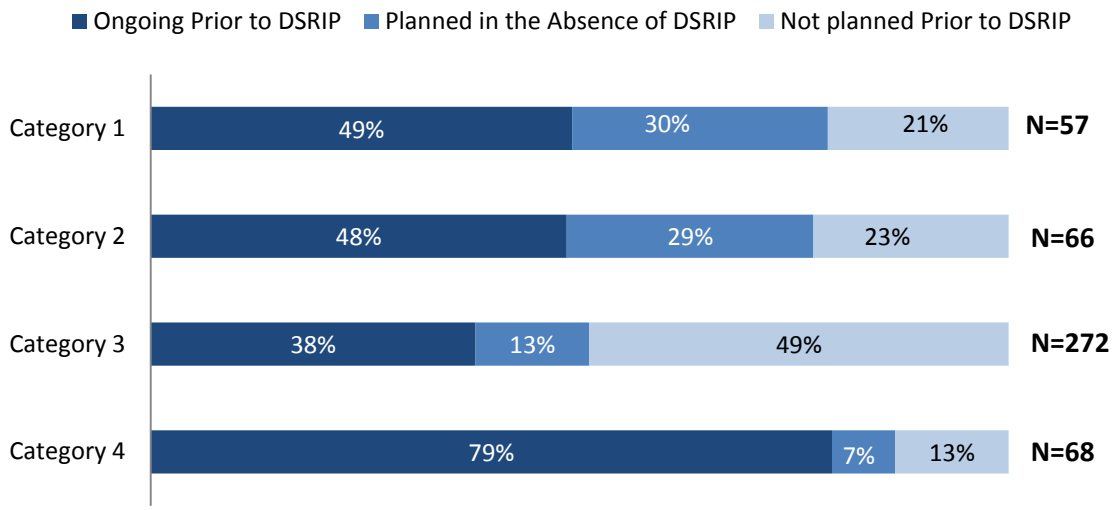


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on a total of 157 projects selected by DPHs in Categories 1, 2, and 4. Category 3 was excluded because all projects were required. Total is greater than 100% because DPHs were allowed to select more than one reason per project.

Status of Category 1-4 Projects Prior to DSRIP

Many DPHs were implementing projects similar to those in DSRIP prior to their participation in the program (Exhibit 12). For example, of the 57 projects implemented in Category 1 during DSRIP, nearly half were ongoing prior to DSRIP. In most cases, participation in DSRIP substantially increased the scope of the existing work. Thirty percent of Category 1 projects were planned prior to DSRIP, but most were not attainable without DSRIP funding or had unidentified timelines. A large proportion (49%) of Category 3 measures were not planned prior to DSRIP.

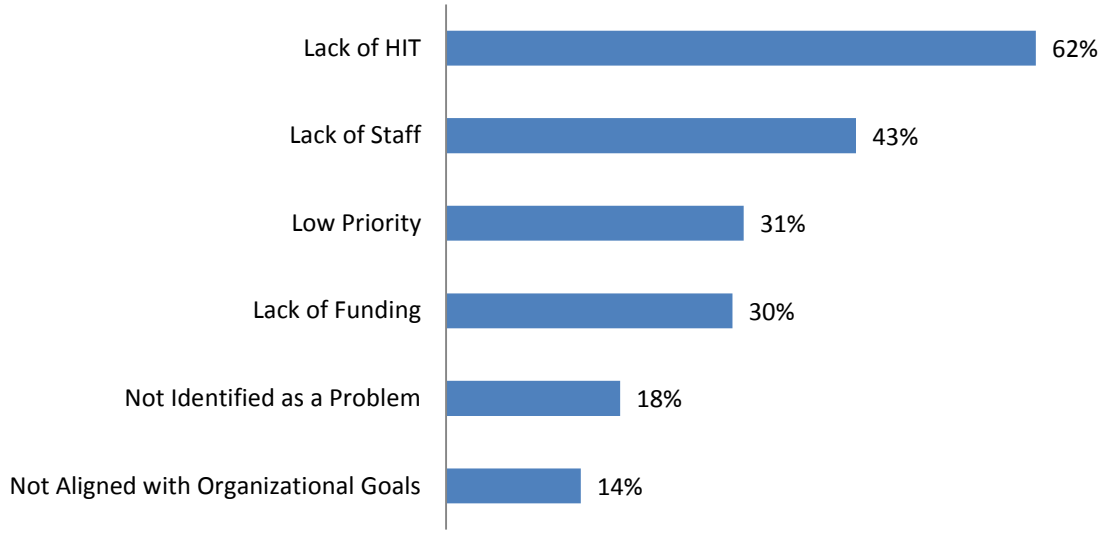
Exhibit 12: Status of Categories 1-4 Projects in DPHs Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).
Note: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

DPHs also reported on the reasons for not implementing specific DSRIP projects prior to their participation in the program. Lack of health information technology (HIT) was the most commonly cited reason for not having planned DSRIP-related projects (Exhibit 13), in part because many of those projects were Category 3 projects that were heavily dependent on availability of such technology. The least frequently cited reasons for not selecting DSRIP projects prior to the program were not identifying the related project topics as a problem (18%) or lack of alignment with organizational goals (14%).

Exhibit 13: Reasons That Category 1-4 Projects Were Not Planned Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of projects selected that were not implemented or planned prior to DSRIP (n=169). Total is greater than 100% because DPHs were allowed to select more than one reason per project.

Participation in External Initiatives

DPHs were asked to report if they were participating in CMS-related quality initiatives or other state or federal initiatives in addition to DSRIP. Many of the initiatives reported were focused on inpatient care and patient safety and related most closely to Category 4 projects. Nearly half of DPHs surveyed noted they were participating in the CMS Hospital Engagement Network initiative, started in 2012 as part of the CMS Partnership for Patients campaign, aimed at improving the quality and safety of health care. These networks provide learning collaboratives and technical assistance to reduce hospital-acquired conditions and readmissions[4]. Almost all of the DPHs surveyed stated that they are currently participating in the Meaningful Use EHR Incentive Program, which provides financial incentives to hospitals and providers for the "meaningful use" of EHR technology[5, 6].

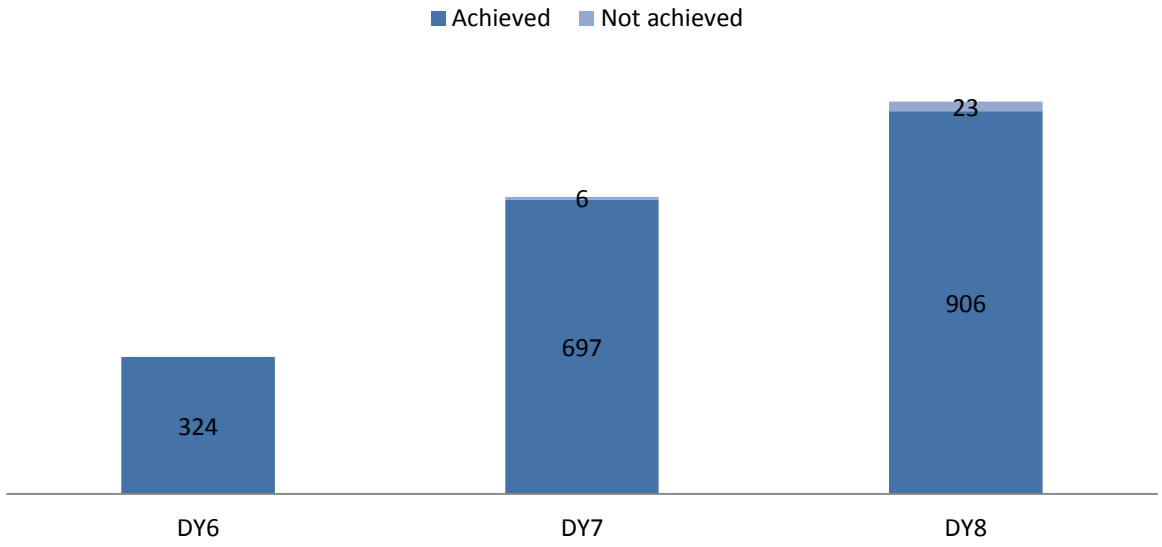
Approximately one-third of DPHs reported they had or are currently participating in the CMS Hospital Quality Initiative, a voluntary initiative where hospitals report several core quality process measures to CMS. Only a few hospitals noted they had received a CMS Health Care Innovation Award. These awards, which support innovative care models, supported projects such as a patient navigation center, a prenatal care project, and a community health worker partnership. A couple of hospitals surveyed noted participation in an Accountable Care

Organization (ACO) initiative. Other initiatives mentioned by DPHs in the surveys included the CAHP/SNI collaboratives for sepsis and central-line associated bloodstream infections.

Outcomes

DPHs achieved 1,927 of the 1,956 milestones they proposed in demonstration years 6 through 8, an achievement rate of 99% (Exhibit 14). The number of milestones nearly tripled from DY 6 to DY 8 and the number of milestones not achieved increased from 6 in DY 7 to 23 in DY 8. Part of the increase in the number of total milestones from DY 7 to DY 8 is due to the full implementation of Category 3 measurement activities in DY 8. These numbers differ from those reported in the Safety Net Institute's (SNI) previous DSRIP annual reports. The completion of an additional 25 milestones in DY 6 and 2 milestones in DY 7 are reported here. The differences are primarily due to the timing of when the SNI reports were released. DPHs have the ability to carry forward the available incentive funding associated with that milestone bundle until the end of the following Demonstration year.

Exhibit 14: Number of Milestones Achieved in Categories 1-4, by Demonstration Year



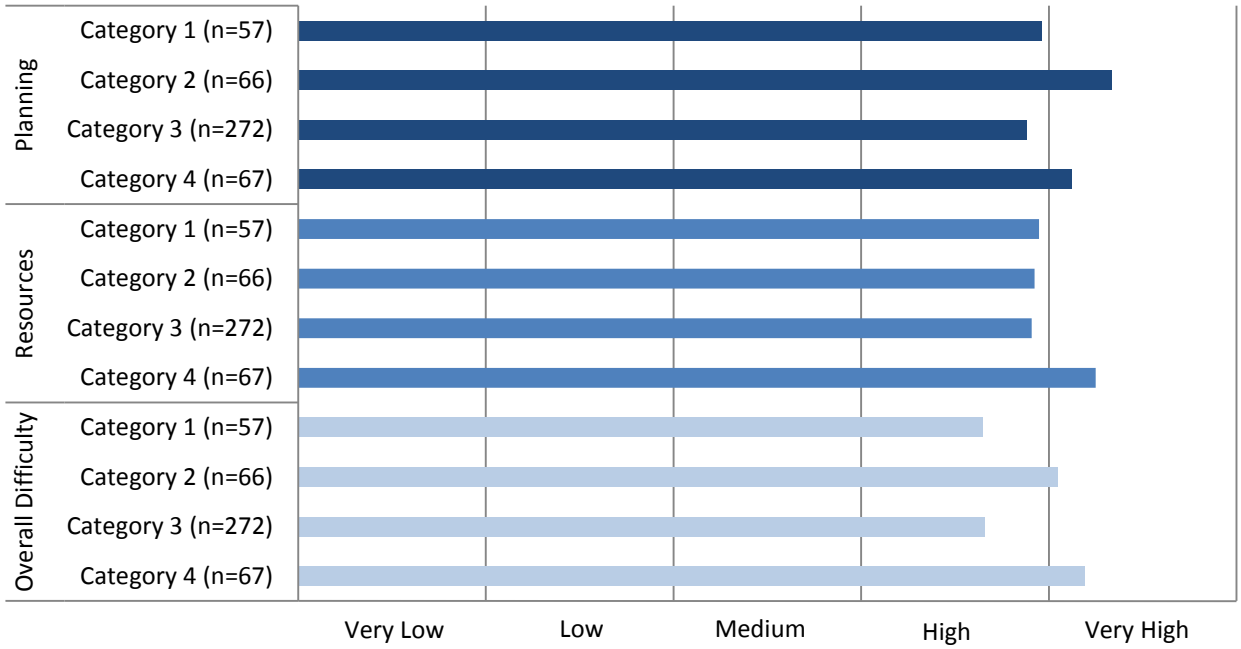
Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

Implementation

DPHs reported on the level of effort and difficulty of implementing Category 1-4 projects (Exhibit 15). DPHs reported that Category 2 required the highest level of planning followed by Category 4, on average. Category 4 required the highest level of resources and was reported as

the most difficult set of projects to implement. In contrast, Category 1 and 3 were considered the least difficult projects or measures.

Exhibit 15: Amount of Effort and Overall Level of Difficulty in Implementing Categories 1-4

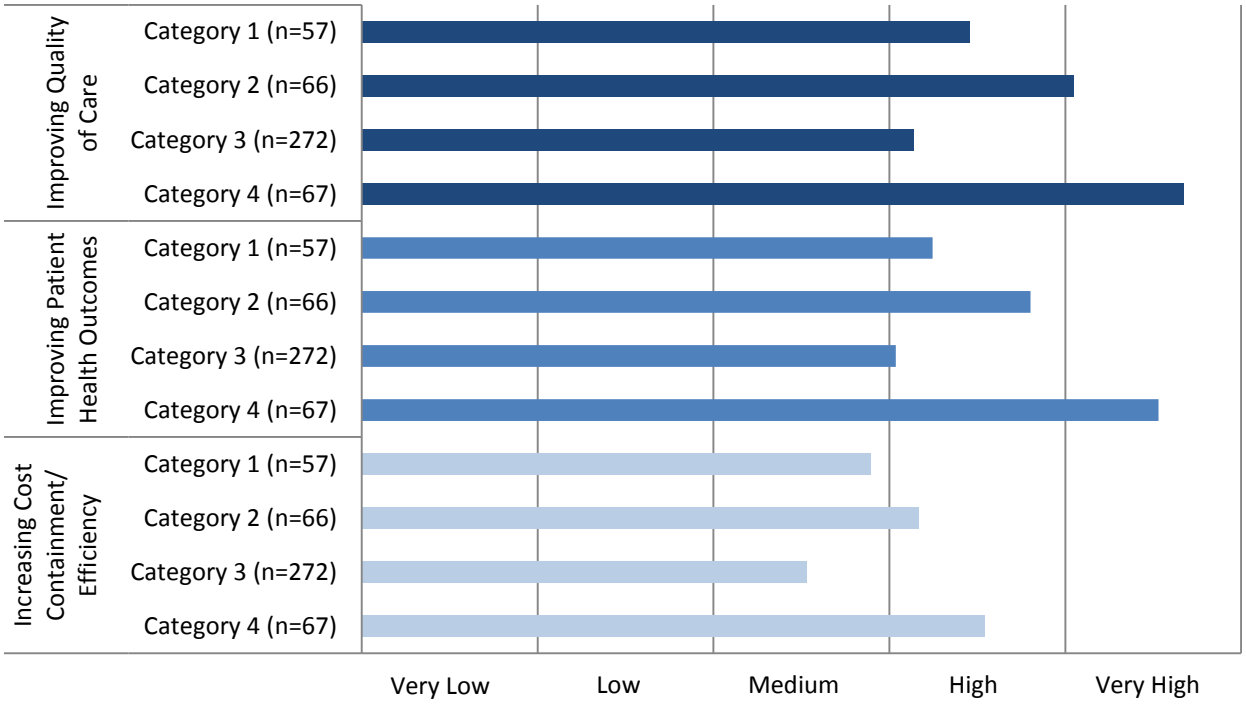


Source: UCLA survey of designated public hospitals (DPHs).
Note: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Perceived Impact on Triple Aim

DPHs were asked to report their perceptions of the impact of DSRIP projects on the Triple Aim of improving quality of care, patient health outcomes, and cost containment/efficiency. DPHs rated Category 4 projects as having the highest perceived impact on quality of care and Category 3 projects the lowest (Exhibit 16). The same pattern was observed for health outcomes and cost containment/efficiency.

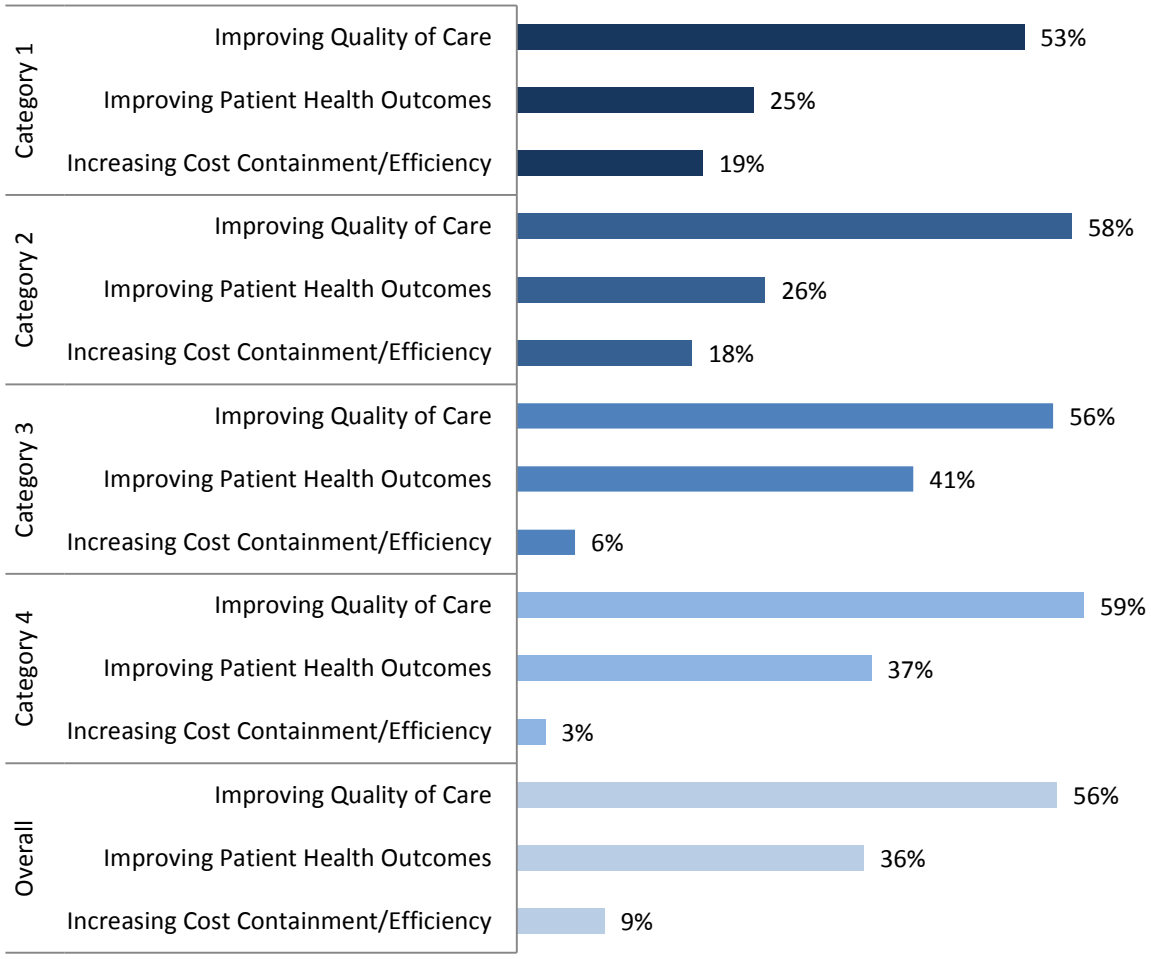
Exhibit 16: Perceived Impact of Categories 1-4 on Triple Aim of Quality of Care, Health Outcomes, and Increasing Cost Containment/Efficiency



Source: UCLA survey of designated public hospitals (DPHs).
Note: The total number of projects implemented in the category across all DPHs is provided in parentheses.

In addition, DPHs were also asked to rank each Category 1-4 projects in terms of impact on the Triple Aim. Overall, DPHs reported that 56% of DSRIP projects had the greatest impact on improving quality of care (Exhibit 17). Fewer (36%) of projects had the greatest impact on improving patient outcomes and only 9% of projects had the greatest impact on increasing cost containment/efficiency. The same analysis by category showed similar results with some variation. For example, 41% of Category 3 projects were perceived to have the greatest impact on improving patient outcomes and 6% were considered to have the greatest income on increasing cost containment/efficiency.

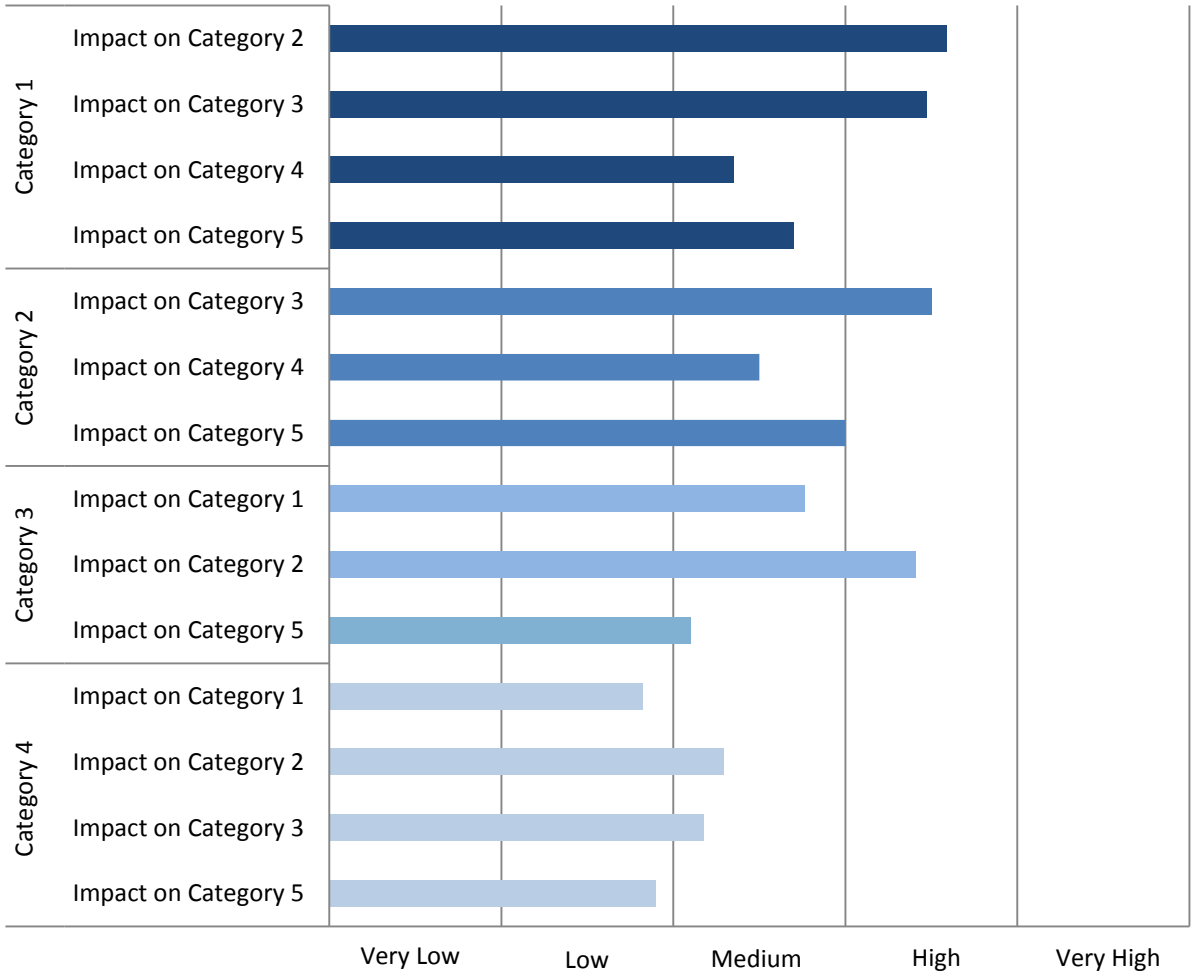
Exhibit 17: Percentage of Category 1-4 Projects Perceived to Have the Greatest Impact on Quality of Care, Health Outcomes, and Cost Containment/Efficiency



Source: UCLA survey of designated public hospitals (DPHs).
Notes: DPHs were asked to rank the relative impact of projects on the Triple Aim of quality of care, health outcomes, and cost containment/efficiency. The percentages in the chart show the proportion of projects for which each of the triple aims ranked as the highest-impact.

DPHs were asked whether implementation of projects in each category impacted projects in other categories. DPHs reported that Category 1 projects had a high impact on implementation of Category 2 and 3 projects and measures, but a medium impact on Category 4 and 5 projects (Exhibit 18). Category 2 projects also had a high impact on implementation of Category 3 projects but less of an impact on the other two categories. Category 3 measures had the most impact on the implementation of Category 2, but were not anticipated to impact Category 4 projects. Category 4 projects had medium or low impact on other categories.

Exhibit 18: Impact of Categories 1-4 on One Another and on Category 5



Source: UCLA survey of designated public hospitals (DPHs).
Note: Data for the impact of Category 2 on Category 1 and Category 3 on Category 4 was not available at the time of publication.

Summary

Seventeen DPHs of varied sizes and affiliations implemented a large number of projects through the DSRIP program from DY 6 through DY 8. Many DPHs opted to focus on specific and related projects in Categories 1 and 2, including expanding primary care capacity and implementing and utilizing disease management registries for their Category 1 infrastructure development, and expanding medical homes for their Category 2 innovation and redesign initiatives. Nearly half of the projects that DPHs implemented were ongoing prior to their participation in DSRIP, though most were not implemented extensively or system-wide. DPHs cited consistency with organizational goals, availability of project champions among existing staff, and synergy with

existing projects as principal reasons for selecting DSRIP projects, although DSRIP appeared to have rearranged priorities and focal areas in some cases.

DPHs achieved nearly all (99%) of their proposed milestones in the three years covered in this interim report. This success was achieved with high levels of planning, resource investment, and overall implementation difficulty. DPHs reported a high level of perceived impact on quality of care and health outcomes, two of the three components of the Triple Aim. The third component, cost containment/efficiency, rated lower in part because not enough time had elapsed to be able to see the full effect of program initiatives. DPHs reported synergies in implementation of DSRIP projects in different categories. Category 1 (infrastructure development) and Category 2 (innovation and redesign) were perceived as having the greatest impact on the other categories.

Category 1: Infrastructure Development

Category 1 projects are focused on infrastructure development. Project options for participating DPHs ranged from staff and physical space expansions to health information technology development to enhanced data collection strategies and new care delivery channels such as telemedicine and video interpretation services (Exhibit 1).

Project Selection

None of the projects in Category 1 were mandatory, but each DPH was required to implement at least two projects. Eleven of the 17 DPHs selected more than two Category 1 projects (Exhibit 19). The most frequently implemented projects were expansion of primary care capacity (12 DPHs), implementation and utilization of disease management registry functionality (11), increased training of primary care workforce (7), and expanded specialty care capacity (6).

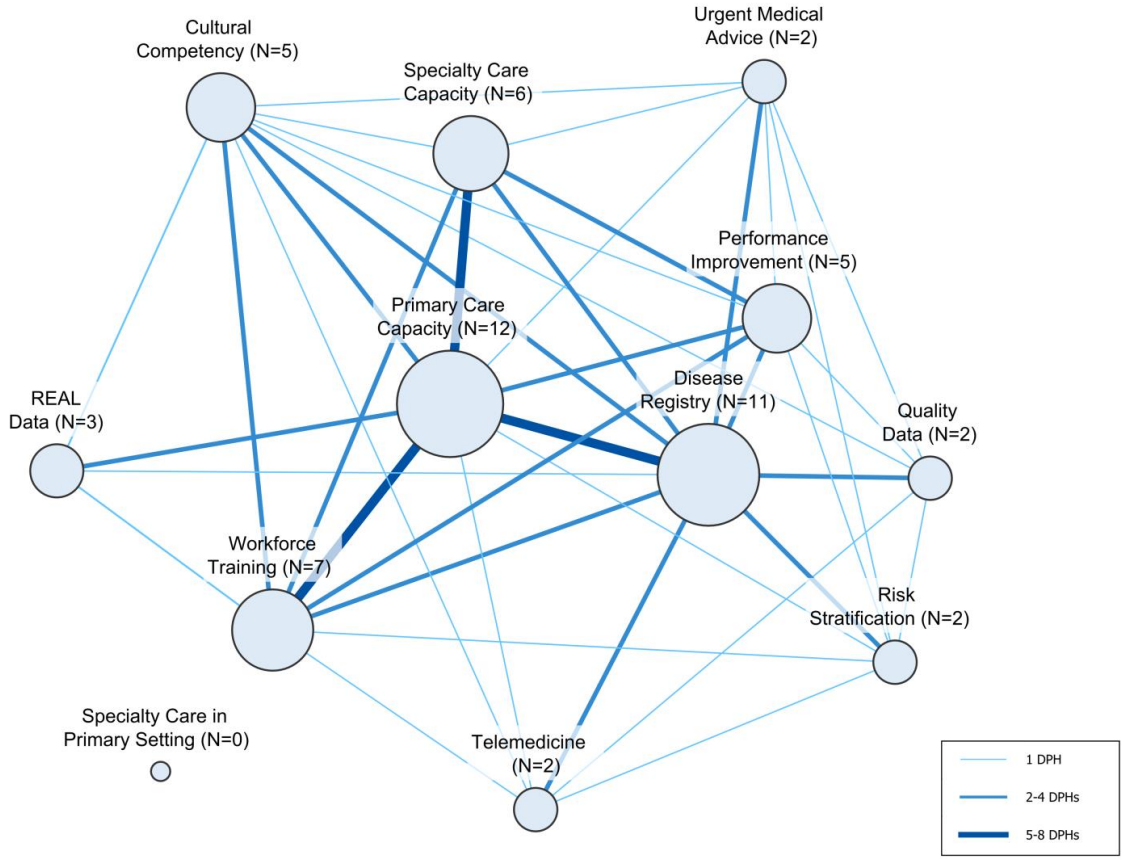
Exhibit 19: Projects Selected, by Designated Public Hospital, Category 1

Designated Public Hospital	Expand Primary Care Capacity	Increase Training of Primary Care Workforce	Enhance Interpretation Services and Culturally Competent Care	Implement and Utilize Disease Management Registry Functionality	Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities	Enhance Urgent Medical Advice	Introduce Telemedicine	Enhance Coding and Documentation for Quality Data	Develop Risk Stratification Capabilities/Functionalities	Expand Capacity to Provide Specialty Care Access in the Primary Care Setting	Expand Specialty Care Capacity	Enhance Performance Improvement and Reporting Capacity	Total
Alameda Health System	✓			✓							✓	✓	4
Arrowhead Regional Medical Center	✓	✓		✓							✓		4
Contra Costa Health Services	✓	✓	✓		✓								4
Kern Medical Center	✓		✓	✓		✓					✓		5
Los Angeles County Department of Health Services				✓		✓		✓	✓			✓	5
Natividad Medical Center	✓		✓										2
Riverside County Regional Medical Center	✓	✓		✓							✓		4
San Francisco General Hospital	✓	✓									✓	✓	4
San Joaquin General Hospital	✓			✓									2
San Mateo Medical Center	✓				✓								2
Santa Clara Valley Medical Center	✓			✓									2
University of California, Davis Medical Center				✓	✓								2
University of California, Irvine Medical Center	✓	✓		✓			✓		✓				5
University of California, Los Angeles Hospitals		✓									✓		2
University of California, San Diego Health System			✓	✓			✓	✓					4
University of California, San Francisco Medical Center	✓			✓								✓	3
Ventura County Medical Center		✓	✓									✓	3
Total	**12**	**7**	**5**	**11**	**3**	**2**	**2**	**2**	**2**	**0**	**6**	**5**	**57**

Source: UCLA analysis of designated public hospital reports.

Exhibit 20 indicates how frequently Category 1 projects were selected and which projects were most frequently selected concurrently. For example, primary care capacity (selected by 12 DPHs) and disease registry (selected by 11 DPHs) were concurrently selected by 5-8 DPHs. Also, DPHs that selected primary care capacity also frequently (5-8 DPHs) selected projects to expand specialty care capacity and workforce training. The project to expand capacity to provide specialty care access in the primary care setting was not implemented by any of the DPHs.

Exhibit 20: Selection Frequency of Concurrent Category 1 DSRIP Projects

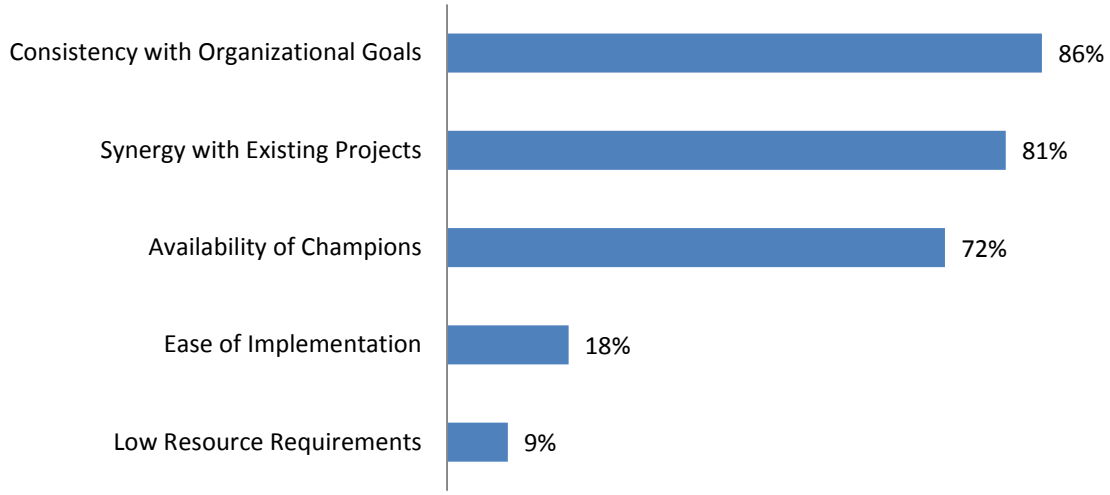


Source: UCLA analysis of designated public hospital (DPH) reports.
Note: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

DPHs reported the reasons for selecting Category 1 projects (Exhibit 21). Eighty-six percent of the selected projects were chosen because of their consistency with organizational goals, and 81% because of their synergy with existing projects. In contrast, ease of implementation and

low resource requirements were least frequently cited as reasons for selecting Category 1 projects.

Exhibit 21: Reasons for Selecting Category 1 Projects

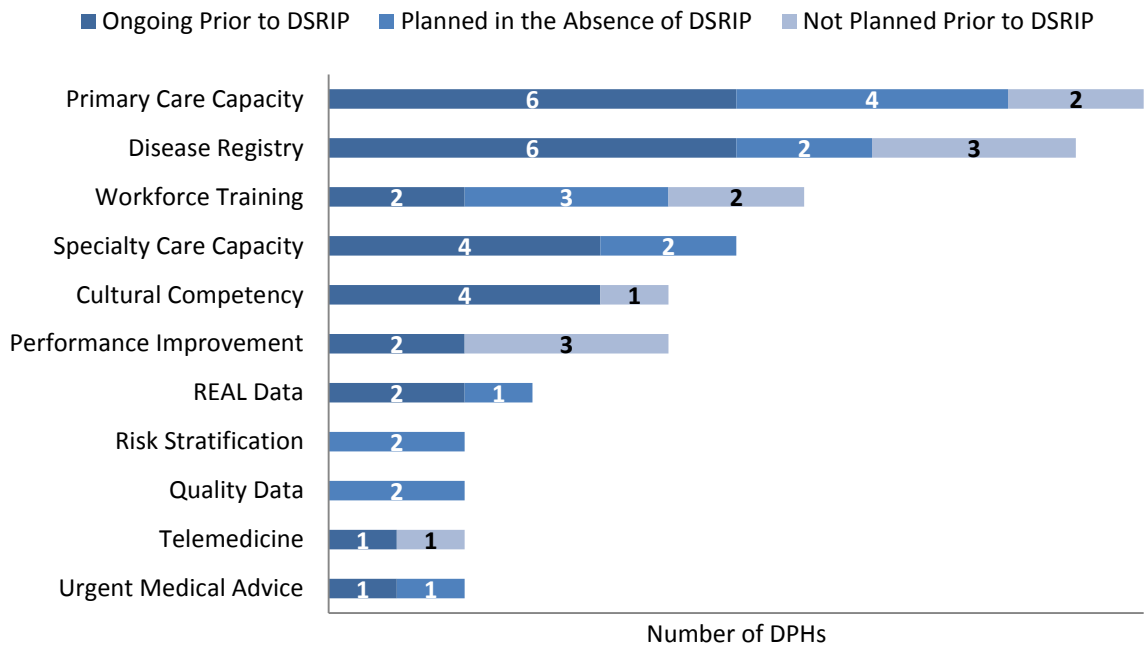


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 1 projects (n=57). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Status of Category 1 Projects Prior to DSRIP

DPHs were asked to report on whether the Category 1 projects they selected were ongoing prior to DSRIP or previously planned. At least half of the DPHs that implemented the four most frequently selected projects – primary care capacity, disease registry, workforce training, and specialty care capacity –had similar ongoing or planned projects prior to DSRIP (Exhibit 22). These ongoing projects were frequently limited in scope or lacked resources for implementation in the near future, and DSRIP funding provided the impetus for expanding these efforts.

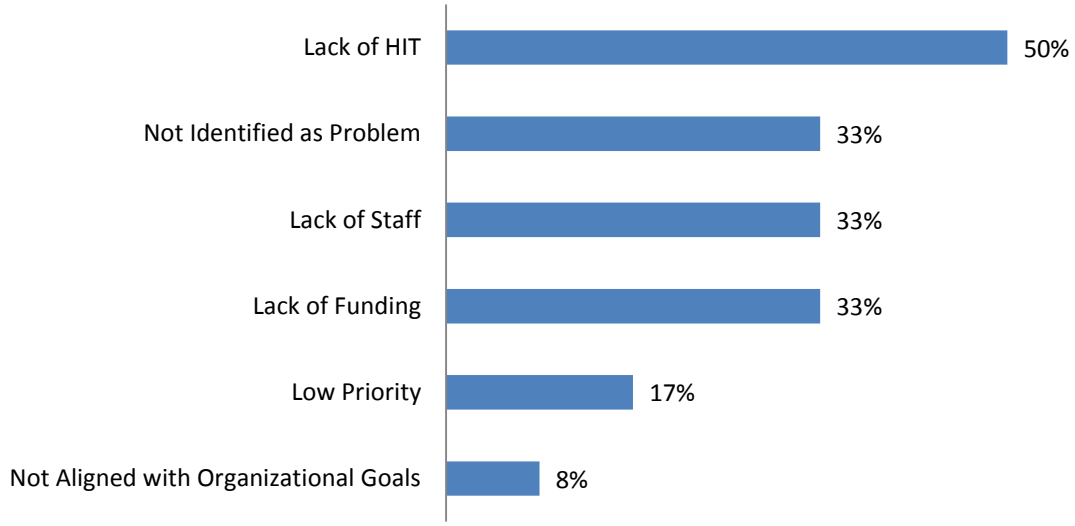
Exhibit 22: Status of Category 1 Projects in DPHs Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).
Note: The Specialty Care in Primary Setting project was not included because it was not implemented by any of the DPHs.

DPHs were also asked to report on the reasons for not previously planning or implementing the selected Category 1 projects. Half (50%) reported lack of HIT infrastructure as one reason (Exhibit 23). Other reasons included not having previously identified these as problem areas (33%), low priority (17%), or lack of alignment with organizational goals (8%).

Exhibit 23: Reasons That Category 1 Projects Were Not Planned Prior to DSRIP



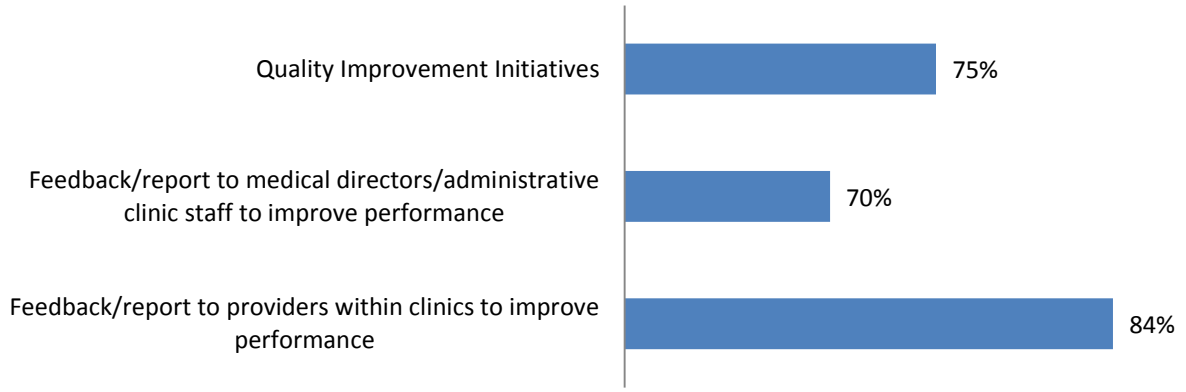
Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of projects selected that were not implemented or planned prior to DSRIP (n=12). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Outcomes

Category 1 project milestones increased from 104 in DY 6, to 153 in DY 7, and 142 in DY 8. DPHs achieved all milestones in DY 6 and nearly all in DY 7 and DY 8. Only 3 and 4 milestones were not achieved in DY 7 and DY 8, respectively.

DPHs reported on how they used the information from Category 1 projects. DPHs reported that they incorporated this information most frequently in quality improvement activities (75%) and in feedback to medical directors or administrators (84%; Exhibit 24). The results were less frequently incorporated in performance improvement feedback given directly to providers (70%).

Exhibit 24: The Proportion of Category 1 Projects that Used Project Measures for Quality Improvement Initiatives and Feedback

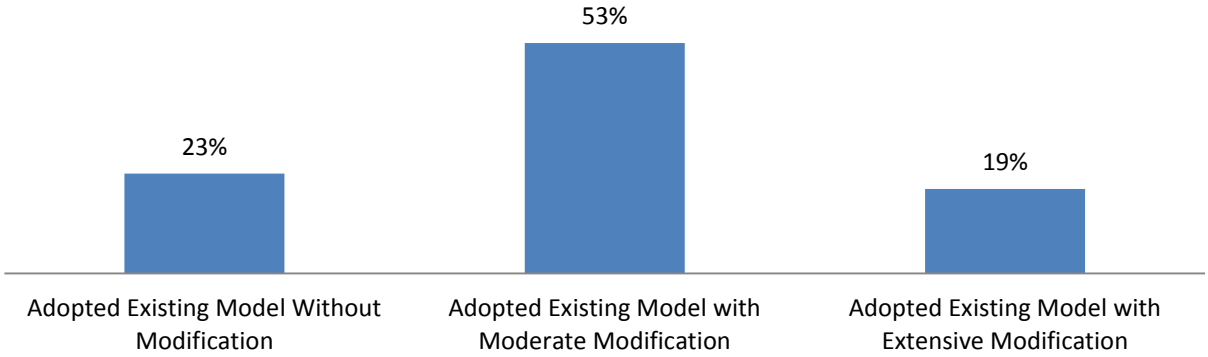


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 1 projects selected by DPHs (n=57). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Implementation

DPHs were asked to indicate the extent to which the selected Category 1 projects were based on existing evidence-based models. DPHs reported that they adopted existing models with moderate modification to fit the DPHs' needs for 53% of the projects in Category 1 (Exhibit 25). They also reported adopting models with extensive modification for another 19% of the projects.

Exhibit 25: The Proportion of Category 1 Projects That Used Evidence-Based Models, by Degree of Modification to the Model



Source: UCLA survey of designated public hospitals (DPHs).
Note: Analysis is based on the total number of Category 1 projects selected by DPHs (n=57). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could implement more than one model to complete a project.

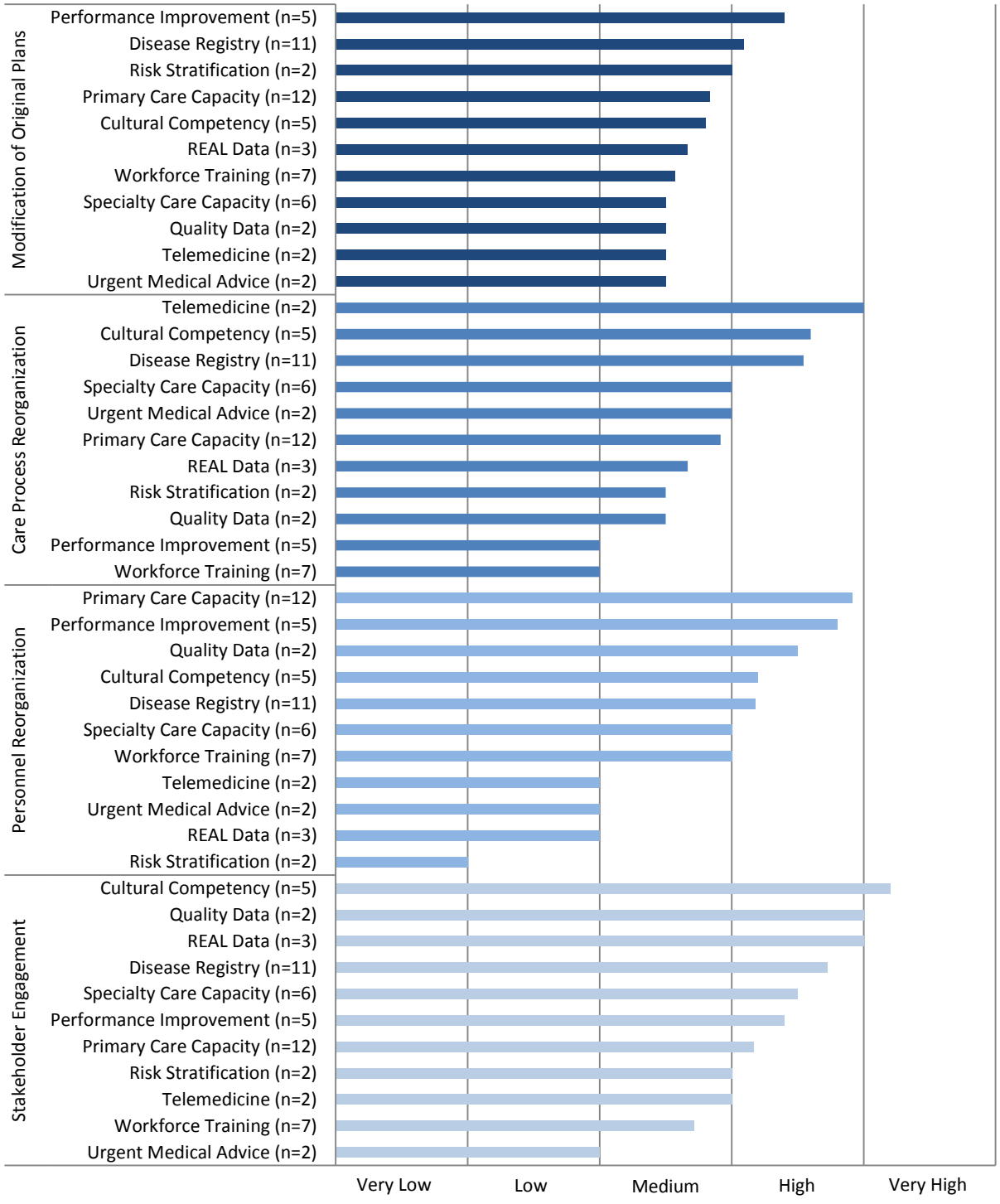
DPHs reported on the level of staff training to complete Category 1 projects. DPHs trained staff during implementation for 70% of Category 1 projects (Exhibit 26). Forty percent of Category 1 projects also required training of staff prior to implementation, and only 25% of projects did not involve any training or orientation.

Exhibit 26: Timing of Staff Training in Relation to DSRIP Implementation for Category 1 Projects

Source: UCLA survey of designated public hospitals (DPHs).
Note: Analysis is based on the total number of Category 1 projects selected by DPHs (n=57). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could conduct multiple phases of staff training depending on the needs of the project.

DPHs reported on how much revision, redesign, or modification of original project plans was required to successfully implement Category 1 projects on a scale of one to five, indicating very low to very high level of revision (Exhibit 27). DPHs reported that the majority of selected Category 1 projects required a medium level of modification to the original plan. However, performance improvement and disease registry projects required high levels of modification. DPHs also reported on the level of reorganization of care processes and personnel. The reorganization of care processes was high for telemedicine, cultural competency, and disease registry projects. The reorganization of personnel was high for primary care capacity, performance improvement, and three other projects. DPHs also reported on the level of effort required to engage internal stakeholders, such as identifying program champions or obtaining buy-in from opinion leaders and staff required to implement Category 1 projects. The projects requiring the highest levels of effort were cultural competency, enhanced coding and documentation for quality data, collecting accurate REAL data to reduce disparities, as well as three other projects.

Exhibit 27: Level of Modification of Original Plans, Reorganization of Personnel and Care Processes, and Stakeholder Engagement for Category 1 Projects

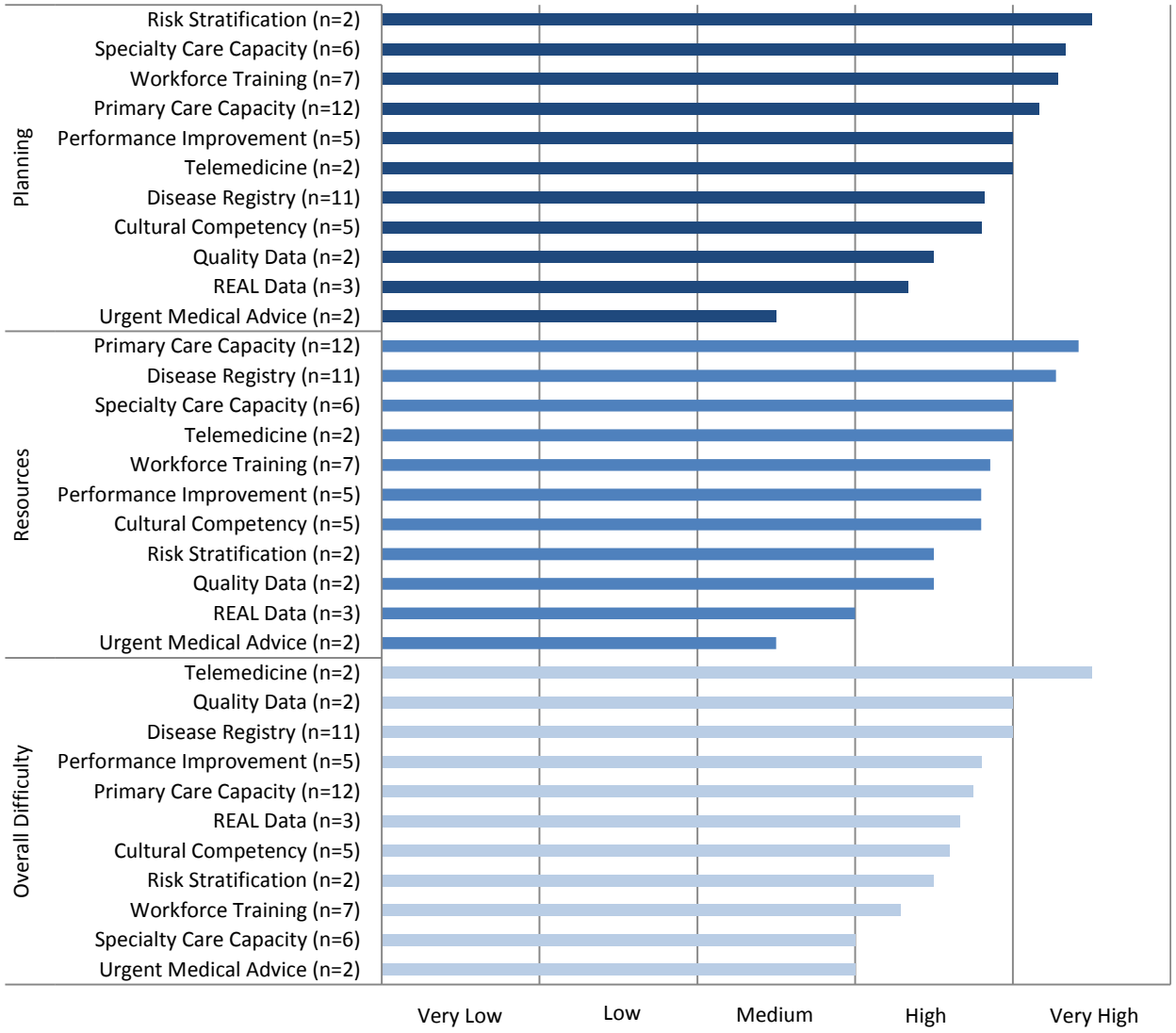


Source: UCLA survey of designated public hospitals (DPHs).

Notes: The Specialty Care in Primary Setting project was not included because it was not implemented by any of the DPHs. The Ns for each category represent the total number of projects implemented in the category across all DPHs.

DPHs reported that the level of planning, resources and overall difficulty for implementing Category 1 projects was either very high or high for the majority of the projects implemented (Exhibit 28). For example, the level of planning required to develop risk stratification capabilities/functionalities was reported by most DPHs to have required the highest level or planning. Furthermore, expanding primary care capacity was reported to require the highest amount of resources. Telemedicine was reported to be the most difficult project to implement overall.

Exhibit 28: Amount of Effort and Overall Level of Difficulty in Implementing Category 1 Projects



Source: UCLA survey of designated public hospitals (DPHs).

Notes: The Specialty Care in Primary Setting project was not included because it was not implemented by any of the DPHs. The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Top Challenges and Solutions to Implementation

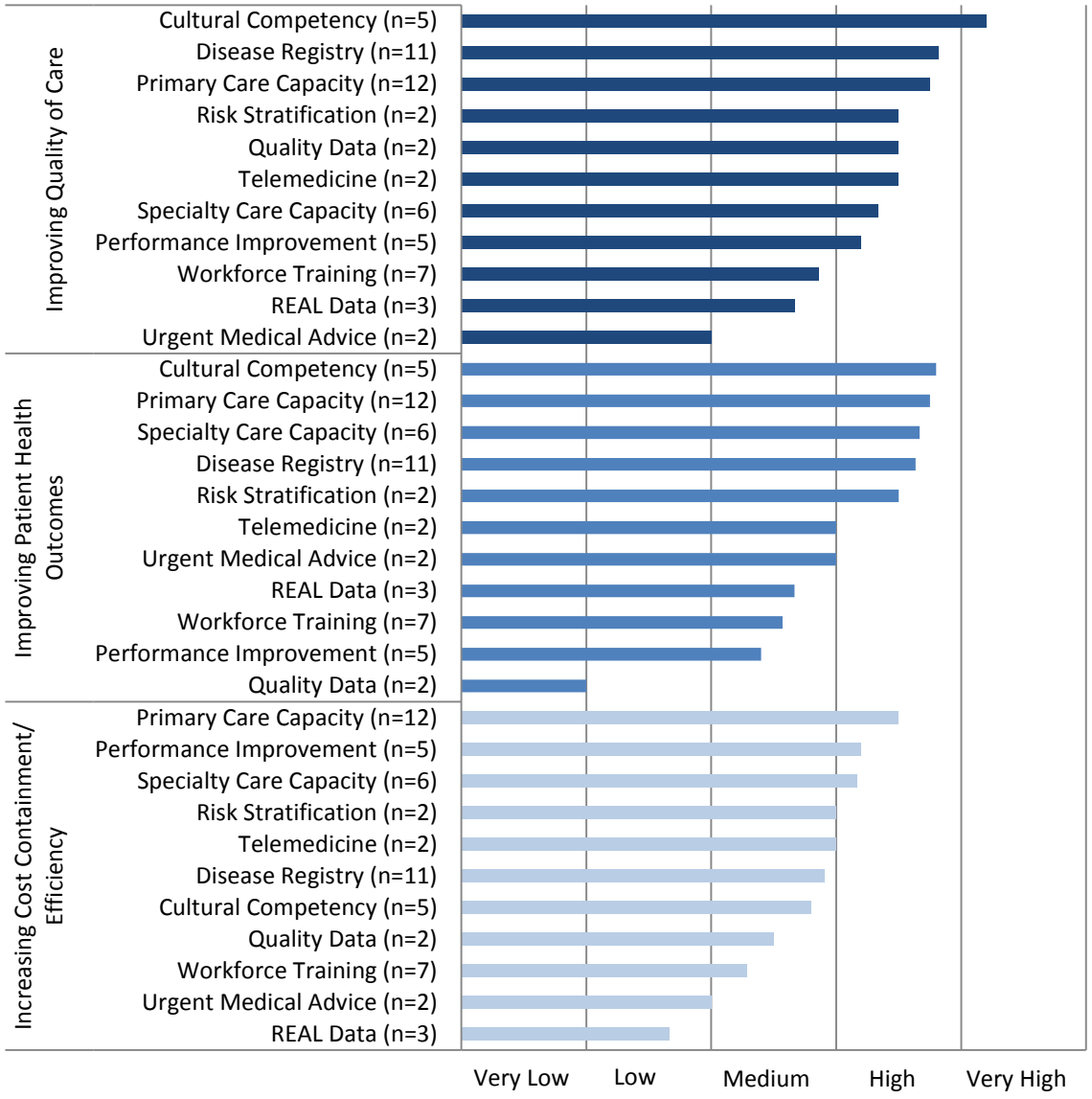
DPHs cited the top two challenges in implementing the selected Category 1 projects and reported the solutions used to address these challenges.

The most commonly reported challenges were related to staffing, including recruitment, retention, turnover, training, buy-in, and difficulty identifying the appropriate people for given tasks. In response, DPHs hired additional staff, improved benefits and contracts, identified project leaders and champions and empowered them to complete tasks, increased training, and reorganized existing staff. The second most commonly reported challenges were lack of standardized definitions for data collection and formalized, consistent care and tracking processes to ensure provider buy-in and compliance. In response, DPHs engaged stakeholders more directly by involving them in change processes, formed workgroups to establish standards and definitions, worked on obtaining provider buy-in through focusing on employee satisfaction and providing cues to action such as reminders about new technologies, and used existing data sources to monitor compliance.

Perceived Impact on Triple Aim

DPHs were asked to assess the potential impact of each Category 1 project on the triple aim of improving quality of care, improving patient health outcomes, and increasing cost containment/efficiency using a five point scale from very low to very high. The average rating for each measure for each aim is reported in Exhibit 29. Overall, cultural competency was reported to have the highest impact on quality of care, followed by other projects such as implementation of disease registry and expanded primary care. Cultural competency was also perceived to have a high impact on health outcomes. Expanding primary care capacity was anticipated to have the highest impact on cost containment/efficiency. DPHs acknowledged that the full impact of Category 1 projects would not be known until after DSRIP projects were completed and data were available.

Exhibit 29: Perceived Impact of Category 1 Projects on Triple Aim of Improving Quality, Patient Health Outcomes, and Increasing Cost Containment/Efficiency



Source: UCLA survey of designated public hospitals (DPHs).

Notes: The Specialty Care in Primary Setting project was not included because it was not implemented by any of the DPHs. The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Future Analyses

Further analyses of the implementation of Category 1 projects from the DPH reports and UCLA surveys will be provided in the final report. The final report will include complete key informant

interview data to provide context and depth to implementation decisions of DPHs and challenges they faced. Data from DY 6 -DY 10 DPH reports will be analyzed to explore specific challenges or other implementation issues provided in those reports. The potential of DSRIP projects in achieving the Triple Aim will be assessed by examining the available literature on the anticipated outcomes of the DSRIP projects selected by DPHs. The funding levels of different projects and milestones across the DPHs will be provided.

Summary and Conclusions

DPHs implemented 57 Category 1 projects designed to develop infrastructure, promote innovation, and redesign and improve care delivery. The most frequently selected projects included expanding primary care capacity, implementing and utilizing disease management registry functionality, increasing training of primary care workforce, and expanding specialty care capacity. More than 75% of Category 1 projects were ongoing or had been planned prior to DSRIP. Program participation served to enhance and expand existing work in many cases, and most projects were selected because of their consistency with organizational goals and/or synergy with existing projects.

Over 98% of the 399 total proposed milestones in demonstration years 6 through 8 were achieved. DPHs incorporated 75% of the project results into quality improvement initiatives and reported data to medical directors and administrators for 84% of Category 1 projects.

To attain this level of success, DPHs undertook considerable levels of reorganization of care processes and personnel, and often required additional work to engage internal stakeholders. More than half (53%) of Category 1 projects required the adoption of an existing evidence-based model with moderate revision, but nonetheless required high levels of planning and resources. Introducing telemedicine, enhancing coding and documentation for quality data, and implementing and utilizing disease management registries were considered the three most difficult projects to implement overall.

The top challenges cited by DPHs in implementing Category 1 projects related to staffing problems and the lack of standardized definitions and care and tracking processes. DPHs solved these challenges by hiring and training staff and obtaining provider buy-in among other efforts.

DPHs considered many Category 1 projects to have had a high impact on improving quality of care, most prominently the projects to enhance interpretation services and culturally competent care, implement and utilize disease management registries, and expand primary care capacity. The overall perceived impact on improving health outcomes and increasing cost

containment and efficiency were somewhat lower. Results varied by project and DPHs acknowledged that it was too early to gauge long-term impacts.

Category 2: Innovation and Redesign

Projects in Category 2 aim at implementing innovative models of care by implementing and expanding medical homes and the Chronic Care Model, improving continuity and integration of care, enhancing patient experience and engagement, and promoting cohesive system change. The individual projects are highlighted in Exhibit 2.

Project Selection

DPHs were required to select at least any two Category 2 projects from 14 possible projects. Overall, a total of 66 projects were implemented across 17 DPHs (Exhibit 30). Fifteen DPHs implemented more than the required two projects, and the most number of implemented projects was six.

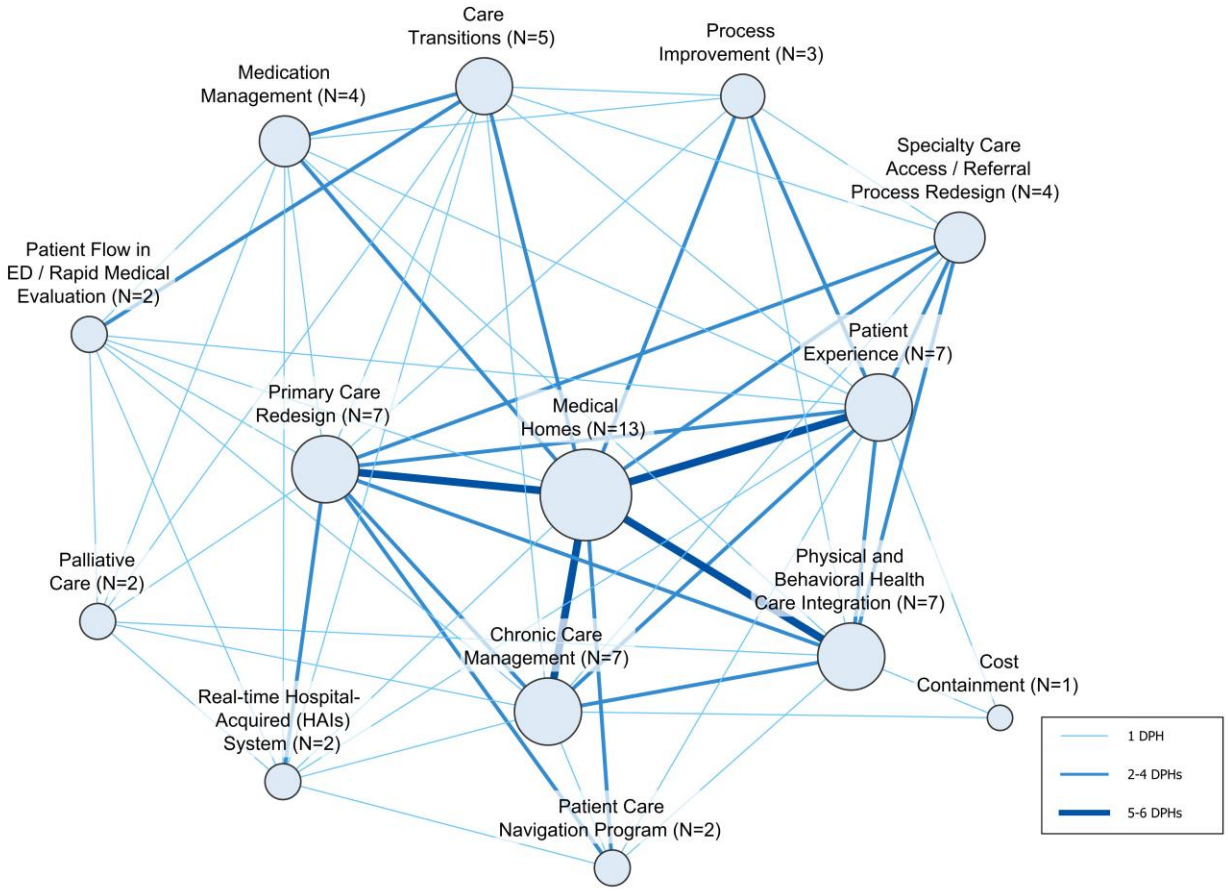
Exhibit 30: Projects Selected, by Designated Public Hospital, Category 2

Designated Public Hospital	Expand Medical Homes	Expand Chronic Care Management Models	Redesign Primary Care	Redesign to Improve Patient Experience	Redesign for Cost Containment	Integrate Physical and Behavioral Health Care	Increase Specialty Care Access/Redesign Referral Process	Establish/Expand a Patient Care Navigation Program	Apply Process Improvement Methodology to Improve Quality/Efficiency	Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation	Use Palliative Care Programs	Enhance Performance Improvement and Reporting Capacity	Conduct Medication Management	Implement/Expand Care Transitions Programs	Implement Real-Time Hospital-Acquired Infections (HAIs) System	Total
Alameda Health System	✓	✓		✓						✓				✓		5
Arrowhead Regional Medical Center	✓	✓	✓													3
Contra Costa Health Services	✓			✓		✓						✓				4
Kern Medical Center	✓		✓			✓		✓								4
Los Angeles County Department of Health Services	✓	✓				✓										3
Natividad Medical Center				✓					✓							2
Riverside County Regional Medical Center	✓	✓	✓	✓			✓									5
San Francisco General Hospital	✓					✓	✓									3
San Joaquin General Hospital	✓		✓													2
San Mateo Medical Center	✓		✓	✓		✓	✓		✓							6
Santa Clara Valley Medical Center		✓		✓	✓	✓										4
University of California, Davis Medical	✓								✓			✓	✓			4
University of California, Irvine Medical	✓	✓	✓	✓				✓							✓	6
University of California, Los Angeles Hospitals	✓											✓	✓			3
University of California, San Diego Health System			✓							✓	✓	✓	✓	✓		6
University of California, San Francisco Medical Center	✓						✓						✓			3
Ventura County Medical Center		✓				✓					✓					3
Total	**13**	**7**	**7**	**7**	**1**	**7**	**4**	**2**	**3**	**2**	**2**	**4**	**5**	**2**		**66**

Source: UCLA analysis of designated public hospital reports.

Exhibit 31 identifies Category 2 projects that were most frequently selected by DPHs and those projects selected concurrently most frequently. Medical home projects were most commonly selected by 13 of the 17 DPHs. DPHs that selected medical home projects concurrently selected primary care redesign, chronic care management models, physical and behavioral health care integration, and patient experience projects.

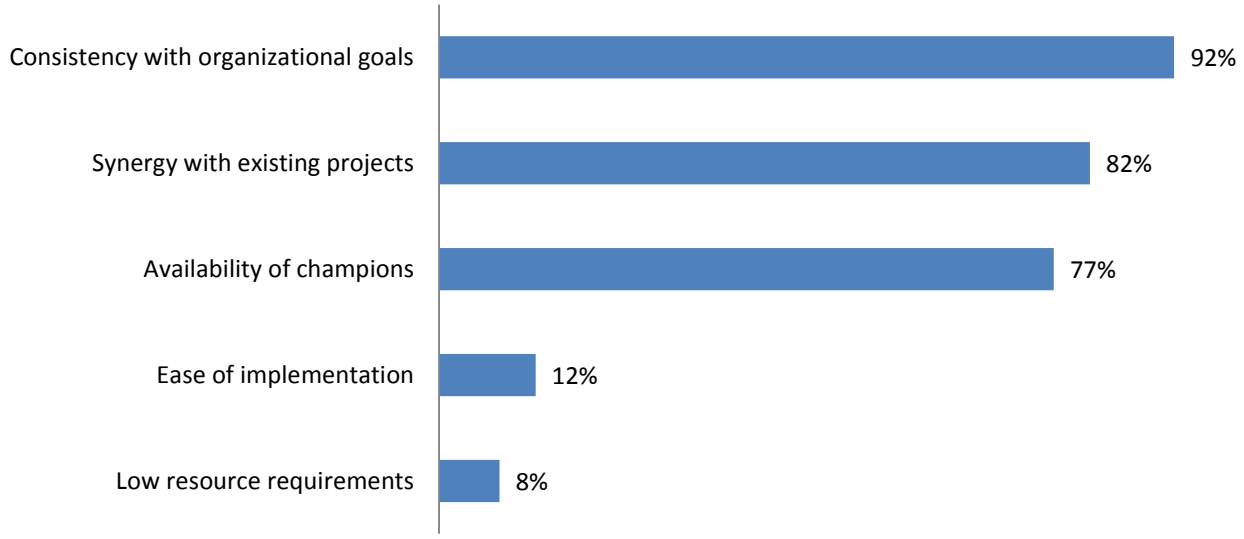
Exhibit 31: Selection Frequency of Concurrent Category 2 DSRIP Projects



Source: UCLA analysis of designated public hospital (DPH) reports.
Note: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

DPHs reported the top reasons for selecting Category 2 projects (Exhibit 32). Ninety-two percent of the selected projects were chosen because of their consistency with organizational goals, 82% because of their synergy with existing projects, and 77% were selected because of the availability of champions. Ease of implementation and low resource requirements were infrequently cited as reasons for selecting Category 2 projects.

Exhibit 32: Reasons for Selecting Category 2 Projects

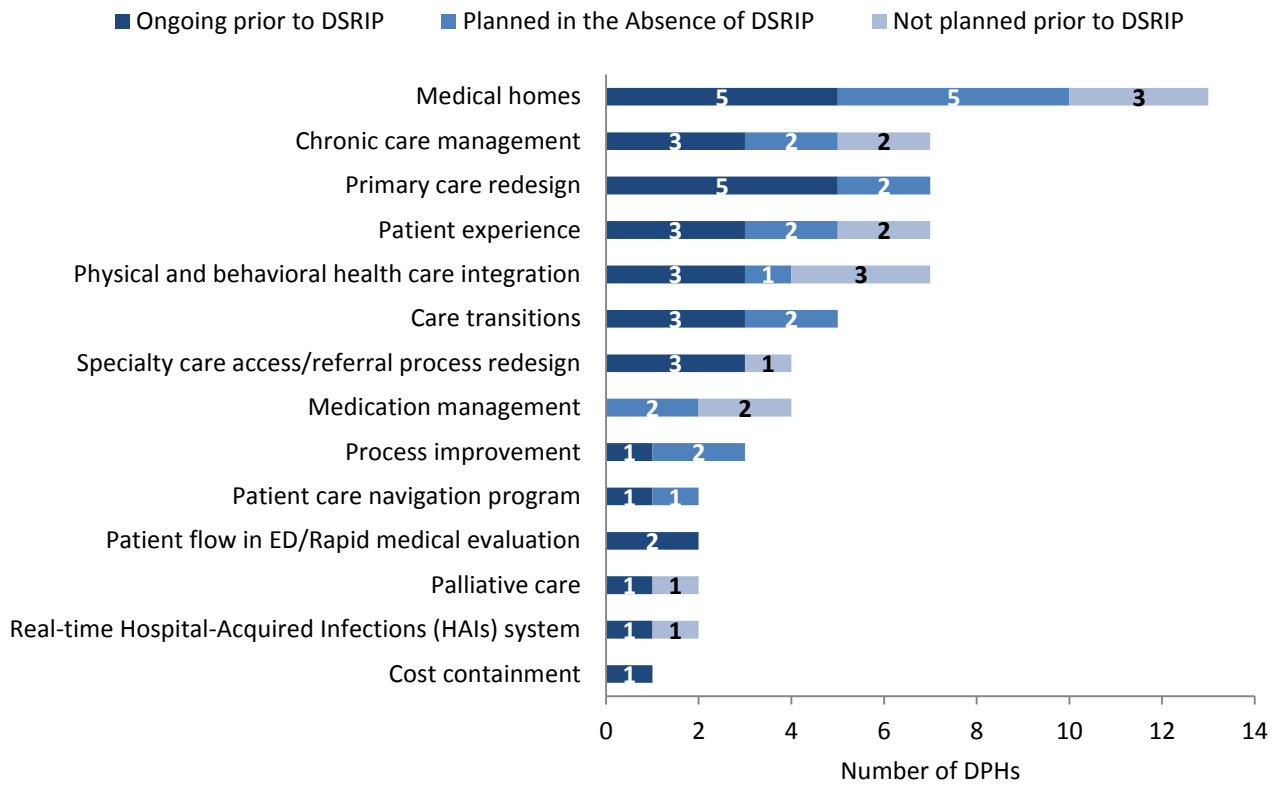


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 2 projects (n=66). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Status of Category 2 Projects Prior to DSRIP

DPHs reported on whether the Category 2 projects they selected were ongoing prior to DSRIP or previously planned (Exhibit 33). The majority of Category 2 projects in participating DPHs were either ongoing or planned prior to DSRIP. For instance, among the 13 DPHs implementing medical home projects, five had ongoing medical home projects and another five had planned such projects prior to DSRIP. However, most of these projects were either pilot programs and/or had not been implemented comprehensively or system-wide.

Exhibit 33: Status of Category 2 Projects Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).

DPHs reported the reasons that Category 2 projects had not been planned prior to DSRIP. For 53% of the projects, DPHs listed lack of funding as a reason, followed by lack of HIT (47%), and lack of staff (47%; Exhibit 34).

Exhibit 34: Reasons that Category 2 Projects Were Not Planned Prior to DSRIP

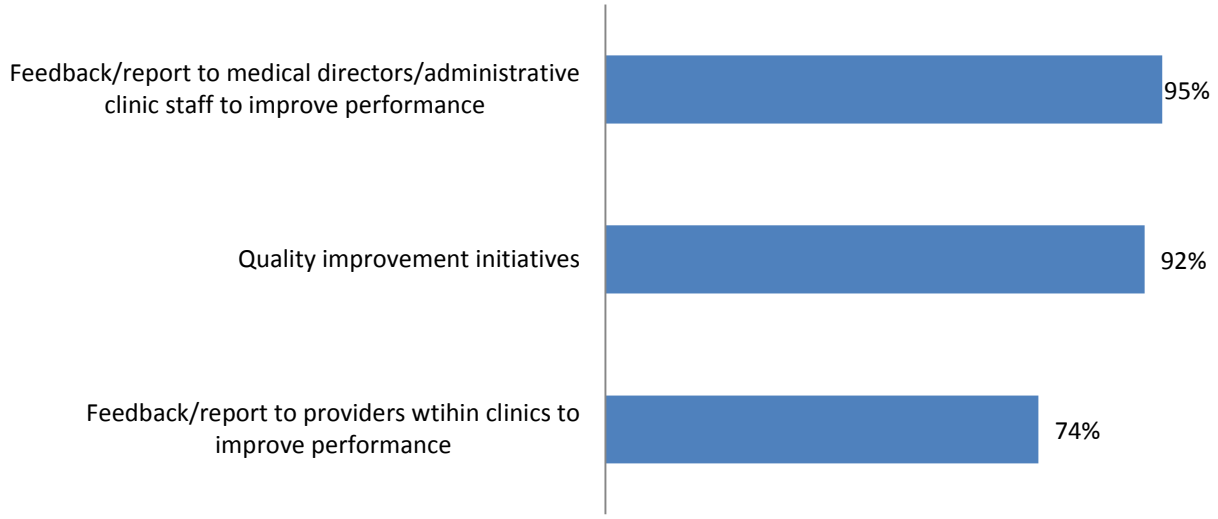
Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of projects selected that were not implemented or planned prior to DSRIP (n=15). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Outcomes

DPH annual reports indicated that almost all of the milestones for Category 2 projects planned by DPHs were achieved, including 93 milestones in DY 6, 147 in DY 7, and 136 in DY 8. Only three milestones in DY 7 and two in DY 8 were not fully achieved. DY 7 had the largest number of milestones (144 out of 147) planned and achieved for Category 2 projects.

DPHs were asked if they incorporated Category 2 project results or information into quality improvement activities or performance improvement (Exhibit 35). Based on DPHs' responses, 95% of all Category 2 projects used project measures to provide feedback and reports to medical directors and/or administrative and clinic staff to improve performance. Over ninety percent of the projects used project measures to provide information for quality improvement initiatives.

Exhibit 35: The Proportion of Category 2 Projects that Used Project Measures for Quality Improvement Initiatives and Feedback

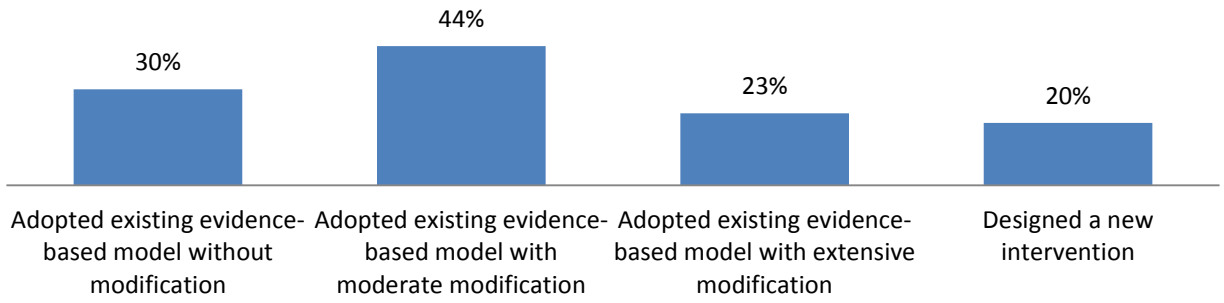


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 2 projects selected by DPHs (n=66). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Implementation

DPHs reported whether the Category 2 projects were based on evidence-based models and whether the DPHs modified these models. The majority of DPHs adjusted selected models to fit the individual needs of their organization. Over 40% of DPHs adopted an existing evidence-based model of care with moderate modification and more than 20% of DPHs adopted a model with extensive modifications (Exhibit 36). Another 20% of DPHs developed brand-new interventions for Category 2 projects.

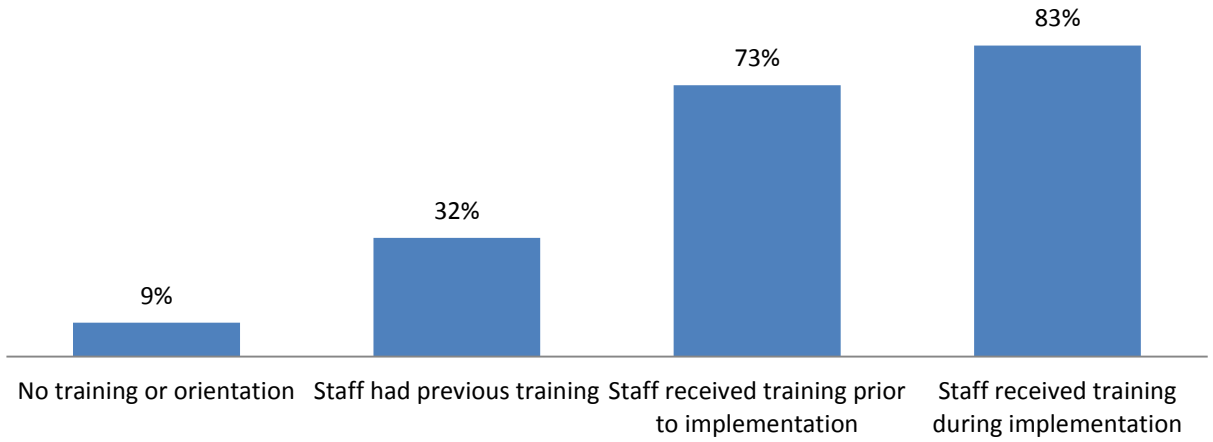
Exhibit 36: The Proportion of Category 2 Projects That Used Evidence-Based Models, by Degree of Modification to the Model



Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 2 projects selected by DPHs (n=66). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could implement more than one model to complete a project.

DPHs were also asked to assess the training initiatives related to quality and process improvements that were provided to staff prior to or during implementation of Category 2 projects (Exhibit 37). Examples of trainings given include Lean and Six Sigma. Training most frequently (83%) occurred during and prior (73%) to the implementation of DSRIP projects. Only 9% of the projects did not involve any staff training or orientation.

Exhibit 37: Timing of Staff Training in Relation to DSRIP Implementation for Category 2 Projects



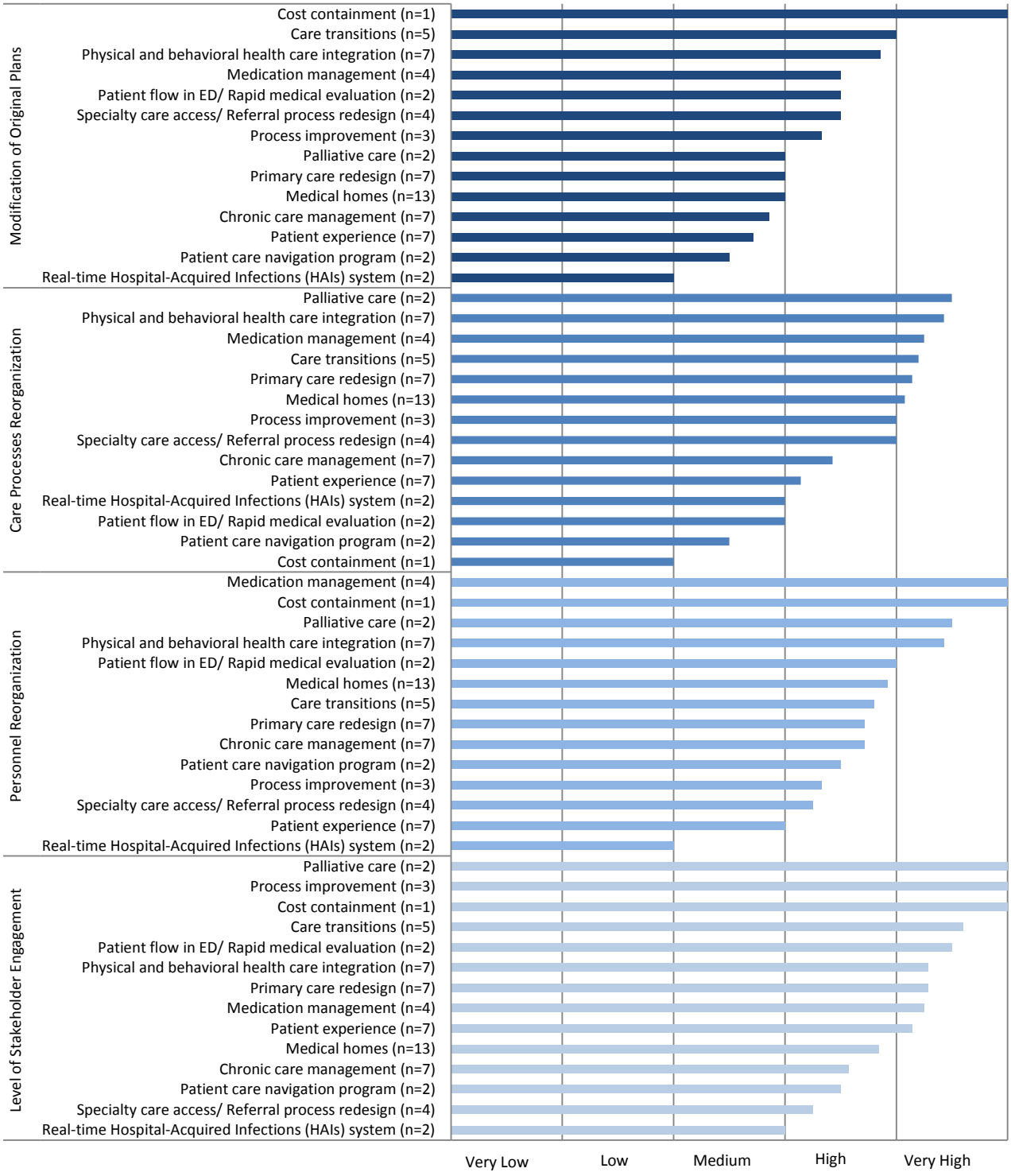
Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 2 projects selected by DPHs (n=66). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could conduct multiple phases of staff training depending on the needs of the project.

DPHs were asked how much revision, redesign, or modification of project plans from their original form was required to successfully implement Category 2 projects, using a scale from one to five, with five indicating a very high level of modification (Exhibit 38). One DPH participated in the cost containment project and gave a rating of "very high" for the amount of modification of the original plan required for this project. Also rated as having "high" demands related to plan modification were projects in the areas of: care transitions, physical and behavioral health care integration, medication management, patient flow in emergency department/rapid medical evaluation, specialty care access/referral process redesign, and process improvement.

When DPHs were asked to rate the level of reorganization of care processes required to implement Category 2 projects, they reported that the majority of projects required a "high" or "very high" level of care process reorganization. Projects focused on palliative care, physical and behavioral health care integration, medication management, care transition, primary care redesign, and medical homes required the highest level of care process reorganization. DPHs also rated the level of reorganization of personnel required to implement Category 2 projects. Projects requiring the highest level of personnel reorganization were medication management, cost containment, palliative care, and physical and behavioral health care integration.

DPHs rated the level of effort to engage internal stakeholders (e.g., identify and select a champion; obtain buy-in from opinion leaders, front-line staff, and others; collaborate on implementation) for the implementation of Category 2 project. They reported that projects related to palliative care, process improvement, and cost containment were the most demanding in terms of stakeholder engagement, and required a "very high" level of stakeholder engagement. Nevertheless, all the other projects except for the real-time hospital-acquired infections system project required high levels of effort to engage internal stakeholders.

Exhibit 38: Level of Modification of Original Plans, Reorganization of Personnel and Care Processes, and Stakeholder Engagement for Category 2 Projects



Source: UCLA survey of designated public hospitals (DPHs).

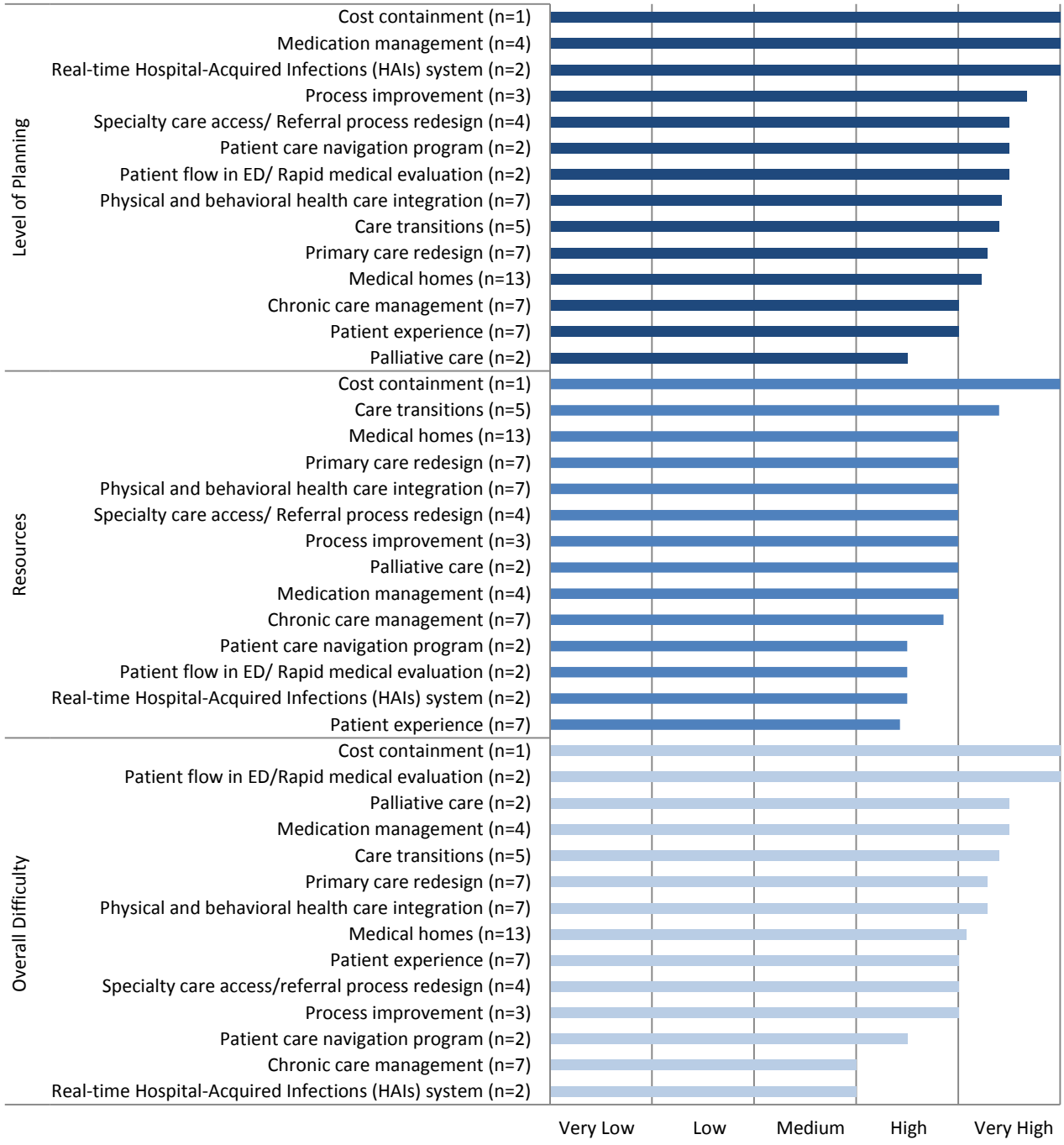
Notes: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

DPHs were asked to rate the amount of planning required to implement Category 2 projects (Exhibit 39). Among the 14 project types within Category 2, the DPHs reported that the cost containment, medication management, and real-time hospital-acquired infections system projects required the greatest amount of planning (e.g., extensive and long-term formal planning). Notably, they rated all projects as having a "high" or "very high" level of planning requirement.

DPHs rated the amount of resources (e.g., personnel, cost, time, training) required to implement Category 2 projects. The DPHs that participated in cost containment and care transition projects reported that they required a "very high" level of resources to implement these projects. The other projects required at least a "high" level of resources.

Finally, we asked DPHs to rate each Category 2 project in terms of the overall level of difficulty in implementation. Among the 14 project types in Category 2, the cost containment and patient flow in the emergency department/rapid medical evaluation projects received the highest rankings for overall difficulty in implementation. However, these project types were implemented by only one or two DPHs, respectively. All the other projects except for the chronic care management and real-time hospital-acquired infections system projects were rated as having a "high" or "very high" level of difficulty in terms of overall implementation.

Exhibit 39: Amount of Effort and Overall Level of Difficulty in Implementing Category 2 Projects



Source: UCLA survey of designated public hospitals (DPHs).

Notes: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Top Challenges and Solutions to Implementation

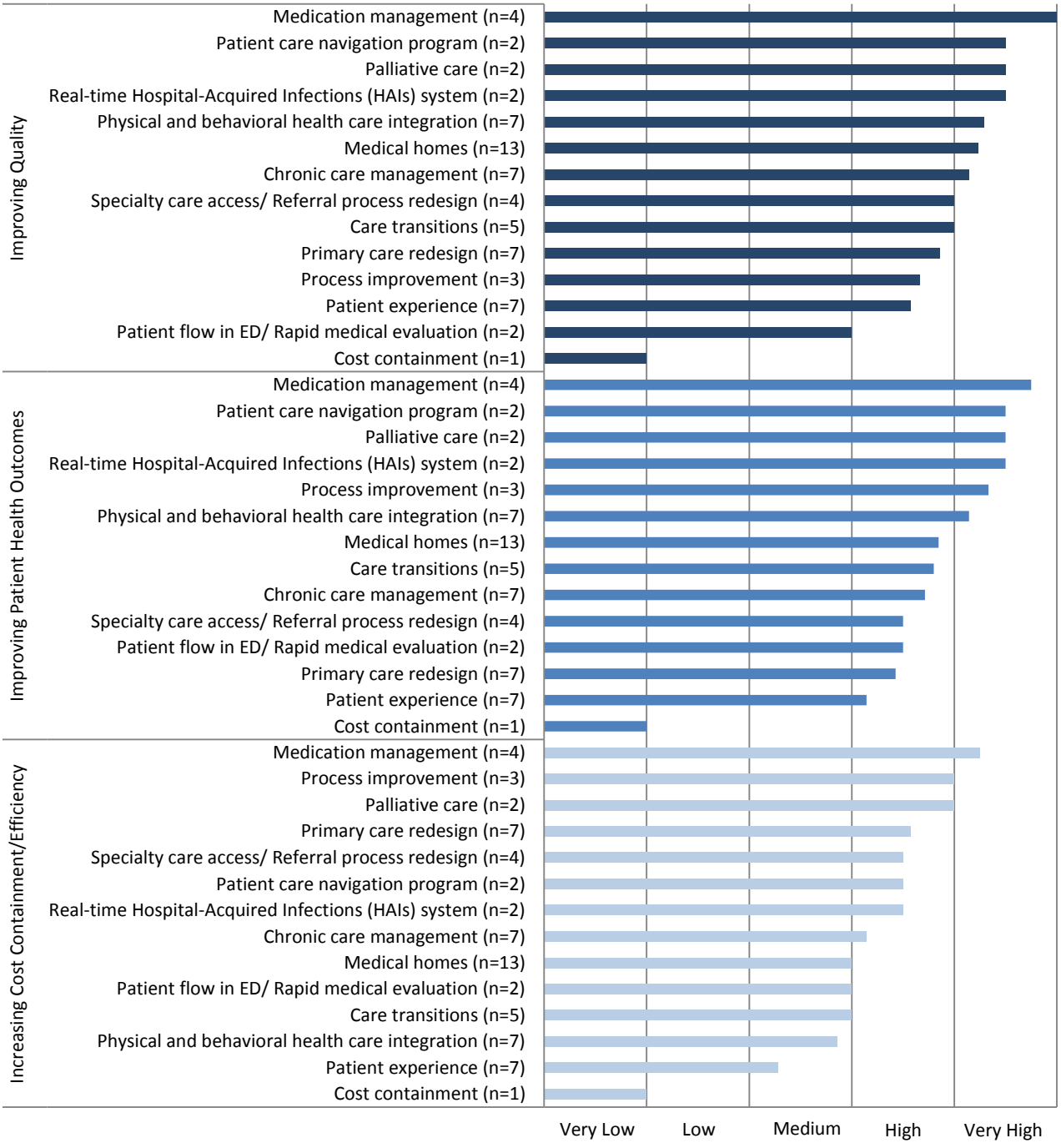
DPHs reported many challenges in obtaining data, achieving milestones and improving sustainability for Category 2 projects. Nevertheless, these challenges were resolved through a variety of creative solutions. For example, difficulties in tracking data from multiple systems, lack of an automated system for data abstraction, and a lack of timely/real-time data were resolved by developing EMRs that interfaced with multiple systems, training staff to document data consistently, developing record-keeping protocols and using real-time data tracking tools.

Challenges to achieving milestones and sustainability beyond DSRIP included the existence of competing priorities in primary care clinics; staffing difficulties, including recruitment, retention, training, and buy-in; and involving and engaging patients. The challenges were resolved by hiring more mid-level practitioners and other staff, utilizing LEAN projects to streamline processes, implementing staff engagement interventions, increasing staff training forming workgroups to establish standards and definitions, focusing on employee satisfaction and providing cues, and using existing data sources to monitor compliance.

Perceived Impact on Triple Aim

DPHs were asked to report their perceptions of the impact of Category 2 projects on improving quality of care and patient health outcomes, as well as increasing cost containment or efficiencies (Exhibit 40). The medication management projects were rated as having the highest impact across all three aims. Conversely, the cost containment project was rated as having the lowest impact on all Triple Aim, although only one DPH implemented this project and DY 8 and DY 9 milestones were not fully achieved. In general, DPHs reported that nearly all of the projects had a "high" or "very high" impact on quality of care and improving health outcomes.

Exhibit 40: Perceived Impact of Category 2 Projects on Triple Aim of Improving Quality, Patient Health Outcomes, and Increasing Cost containment/Efficiency



Source: UCLA survey of designated public hospitals (DPHs).
Notes: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Future Analyses

Further analyses of the implementation of Category 2 projects from the DPH reports and UCLA surveys will be provided in the final report. The final report will include complete key informant interview data to provide context and depth to implementation decisions of DPHs and challenges they faced. Data from DY 6 -DY 10 DPH reports will be analyzed to explore specific challenges or other implementation issues provided in those reports. The potential of DSRIP projects in achieving the Triple Aim will be assessed by examining the available literature on the anticipated outcomes of the DSRIP projects selected by DPHs. The funding levels of different projects and milestones across the DPHs will be provided.

Summary

DPHs implemented a range of innovation and redesign projects as part of their DSRIP programs. A total of 66 projects were implemented across the 17 DPHs for Category 2. Fifteen DPHs implemented more than the required two projects, and the greatest number of implemented projects was six. The most frequently selected projects included medical homes (13 DPHs), primary care redesign, chronic care management models, physical and behavioral health care integration, and patient experience improvement. Many Category 2 projects were either ongoing or planned prior to DSRIP. However, these previously existing projects were either not planned or implemented comprehensively prior to DSRIP. Most projects (92%) were selected because of their consistency with organizational goals, synergy with existing projects and availability of champions. Over 98% of the total proposed milestones from DY 7 (147) through DY 8 (136) were achieved.

DPHs prepared for sustaining Category 2 achievements by incorporating project results into quality improvement initiatives and reporting outcomes to medical providers and administrators. To attain high levels of success, DPHs dedicated high levels of planning and resources, in some cases undertaking considerable levels of reorganization of care processes and personnel. Most projects received "high" to "very high" overall difficulty ratings except for the chronic care management project and the implementation of real-time hospital-acquired infections systems project. The analysis indicates that DSRIP provided essential resources (e.g. funding, information systems, and needed staff) needed to launch and accelerate these projects. DPHs reported the widespread adoption or adaptation of existing, evidence-based models and 44% of DPHs modified these models moderately. Based on their responses, DPHs invested extensively in staff training for the implementation of Category 2 projects. Staff received training during implementation for 83% of Category 2 projects and prior to implementation for 73% of projects.

Almost all of the projects in Category 2 were perceived to have a high or very high impact on the improving quality of care and patient health outcomes. Most projects were reported to have a medium to high impact on increasing cost containment and efficiency. Most DPHs cautioned that it was too early to gauge long-term impacts in these three areas.

Top challenges cited by DPHs in implementing Category 2 projects were staffing difficulties and the lack of standardized definitions and data collection. Solutions included developing EMRs that interfaced with multiple systems and developing record-keeping protocols.

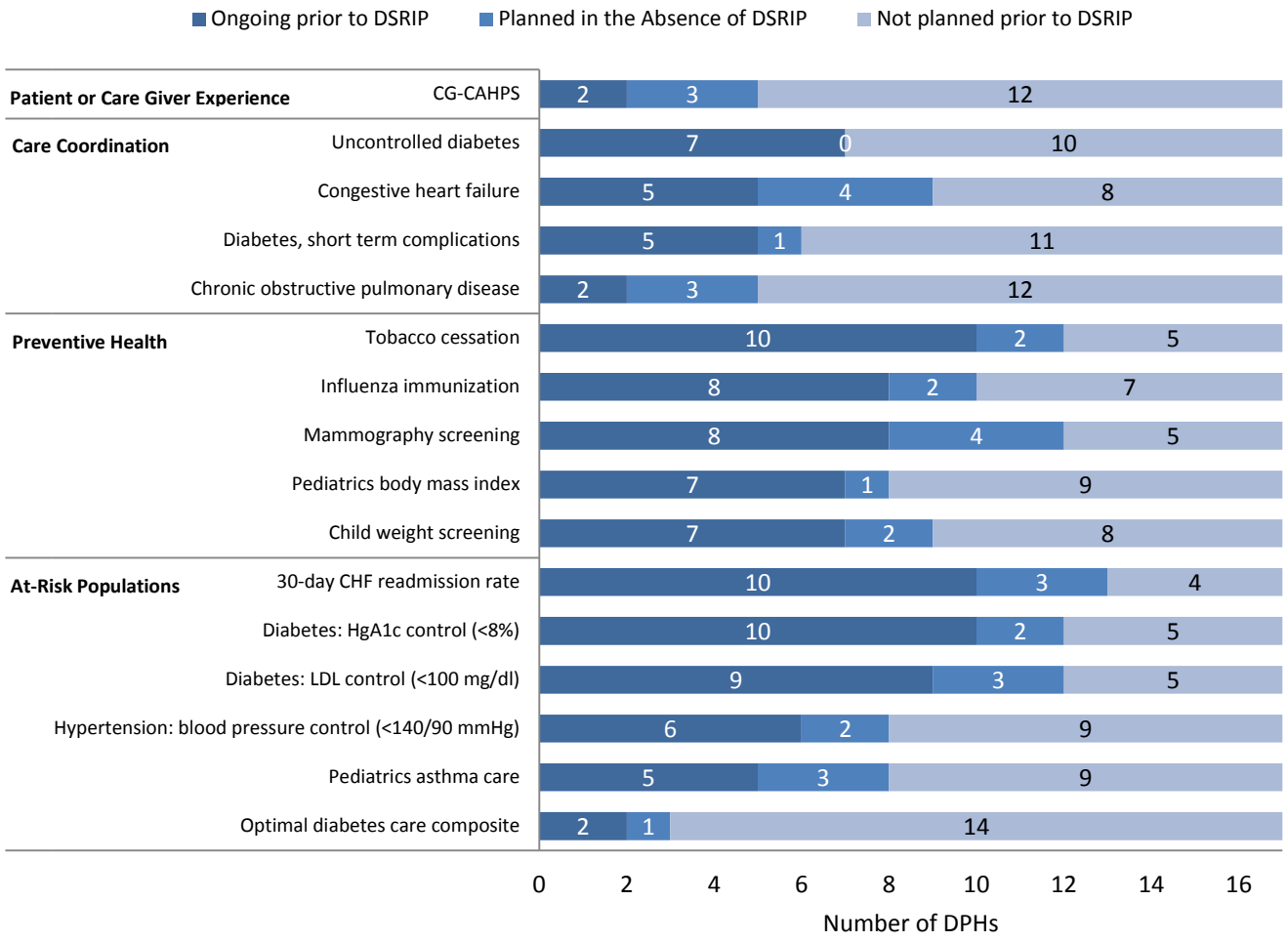
Category 3: Population-Focused Improvement

Category 3 measures are focused on tracking population-focused improvements in California DPHs. DPHs were required to track and report 16 measures in four different areas of patient care including patient or caregiver experience, care coordination, preventive health, and at-risk populations. Payment for this category was tied only to reporting these measures and DPHs were not held to specific performance standards.

Status of Category 3 Measures Prior to DSRIP

Exhibit 41 indicates the number of DPHs that were tracking Category 3 measures prior to DSRIP, had planned to do so but had not begun tracking these measures, or were not planning such activities. All DPHs had gathered some Category 3 measures prior to DSRIP. However, these measures were either not tracked system-wide or differed in some respect from what is tracked under DSRIP. Furthermore, if DPHs had plans to track a given measure, their timeline was frequently uncertain.

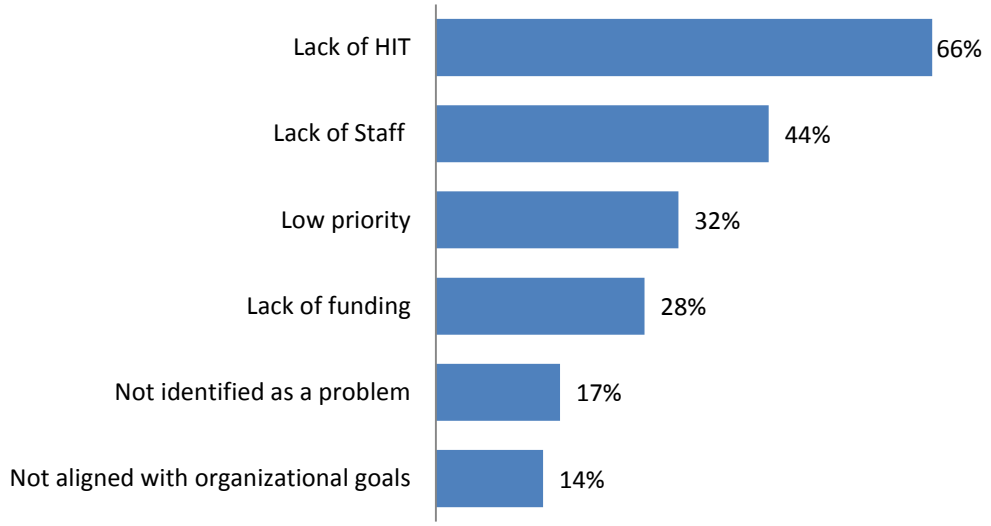
Exhibit 41: Status of Category 3 Measures in DPHs Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).

DPHs reported the reasons for not tracking Category 3 measures prior to DSRIP. The most frequently cited reasons (66%) were lack of sufficient HIT, followed by lack of staff (44%), and perceiving the measures as a low priority (32%; Exhibit 42).

Exhibit 42: Reasons Category 3 Measures Were Not Gathered Prior to DSRIP



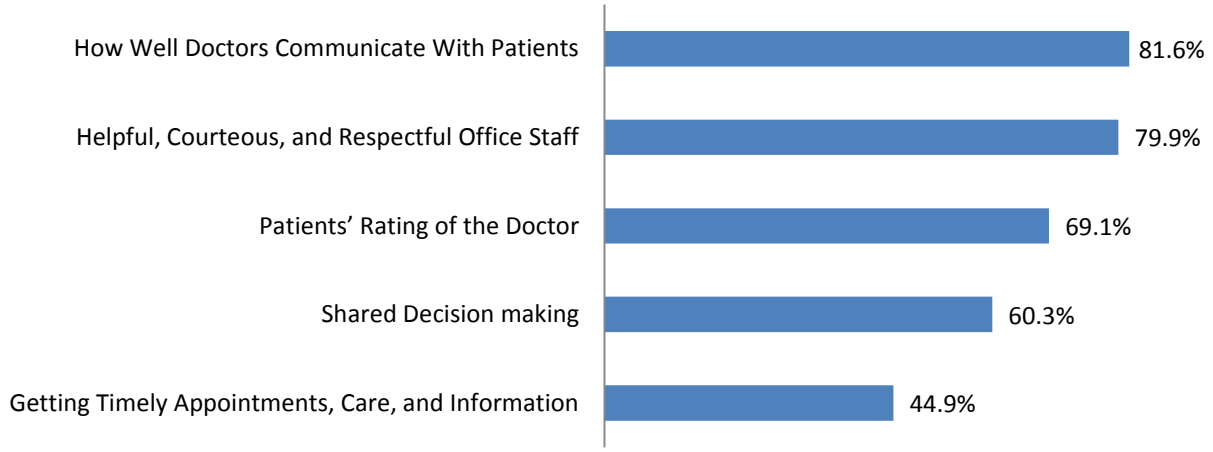
Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of measures that were not gathered prior to DSRIP (n=133). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Outcomes

DPHs had to achieve 119 milestones in DY 7 and 340 milestones in DY 8. DPHs reported that they achieved all these Category 3 milestones in their respective annual reports (data not shown).

DPHs began reporting the results of their CG-CAHPS surveys in their DY 8 reports. On average, patients receiving care in the outpatient setting scored the ability of their doctors to communicate with them (81.6%) and the helpfulness, courtesy, and respectfulness of office staff (79.9%) as highest. The lowest score was given to the ability to get timely appointments, care, and information (44.9%). Side-by-side comparisons of individual DPH rates are available in the SNI DY 8 report.

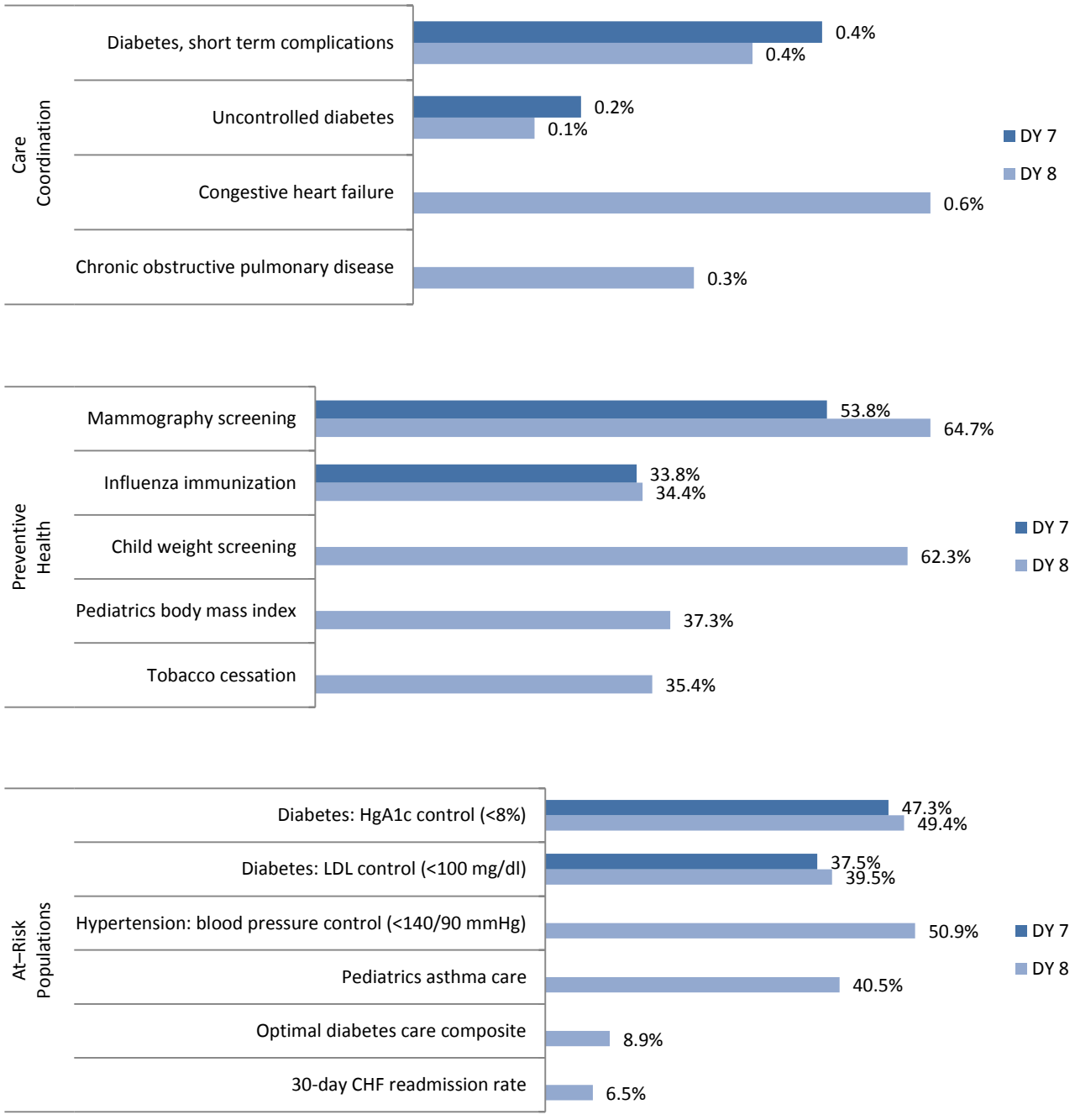
Exhibit 43: Category 3 Patient or Caregiver Experiences (CG-CAHPS) Survey Results, DY 8



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

DPHs also reported data for the remaining Category 3 measures for DY 7 and DY 8 (Exhibit 53). Measure definitions are provided in Appendix 1 (Category 3). Of the six measures that were reported in both years, the average rates remained similar or indicated a small increase from DY 7 to DY 8 (Exhibit 44). The largest average rate increase was reported for mammography screening, increasing from 53.8% to 64.7%. An additional nine measures were reported in DY 8 for the first time. Of these, child weight screening (62.3%) was most frequently measured. However, the rates reported by individual DPHs varied widely. For example, the rate of mammography screening ranged from a 28% decline in one DPH to 95% increase in another DPH. Similarly, the rates of three measures -- influenza immunizations (a decline of 67% to an increase of 50%), diabetes LDL control (a decline of 45% to an increase of 417%), and diabetes HgA1c control (a decline of 47% to an increase of 269%) -- also ranged widely.

Exhibit 44: Trends in Selected Category 3 Measures, DY 7 and DY 8

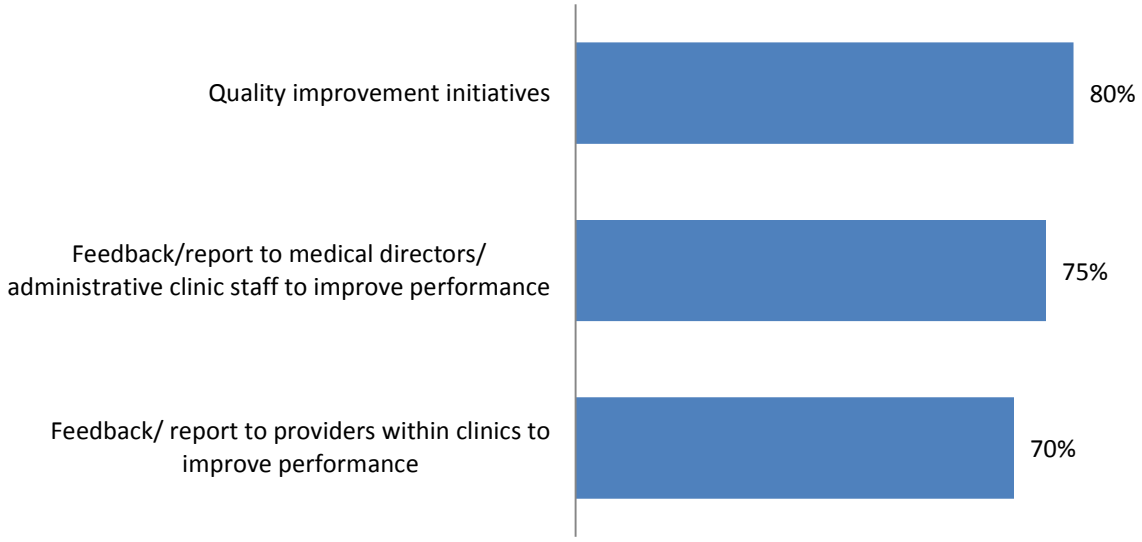


Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

Note: Six measures were reported in both DY 7 and DY 8 and an additional 9 were first reported in DY 8. Patient or caregiver experience (CG-CAHPS) data are reported in previous exhibit.

DPHs reported on whether and how they used Category 3 measures in various operations or activities. Category 3 measures were used most frequently in quality improvement initiatives (80%; Exhibit 45). These measures were also used to improve performance by sending feedback to medical directors or administrators (75%) as well as to clinicians providing direct care (70%).

Exhibit 45: The Proportion of Category 3 Project Measures Used for Quality Improvement Initiatives and Feedback

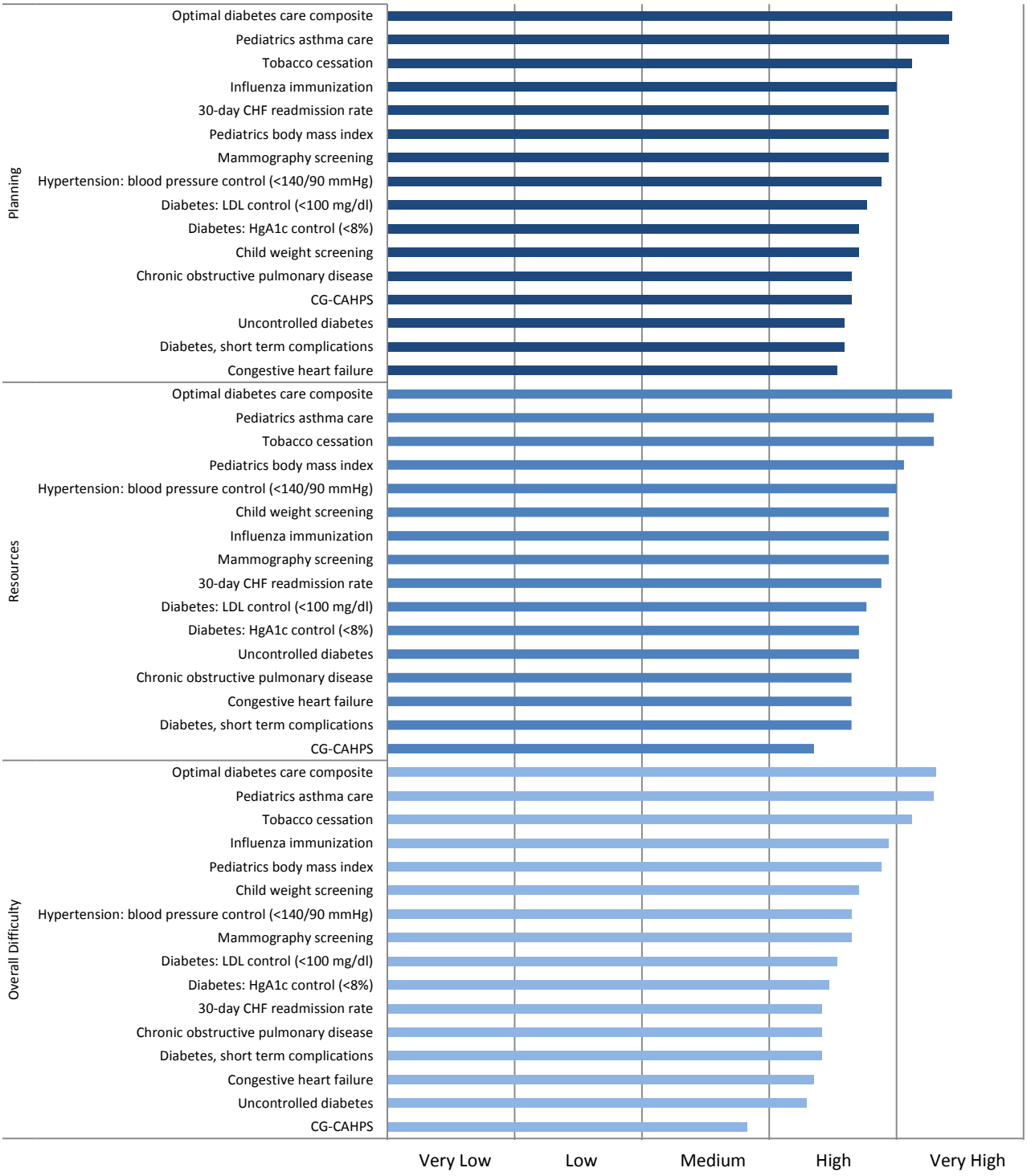


Source: UCLA survey of designated public hospitals (DPHs).
Note: Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Implementation

DPHs reported on the level of effort and resources required to gather Category 3 measures using a five point scale from very low to very high. The average rating for each measure is reported in Exhibit 46. The data indicate that all measures required a high level of planning and resources. Three measures required very high levels of effort including the diabetes care composite, pediatric asthma care, and tobacco cessation. Similarly, tracking nearly all measures was reported to require a high or very high level of difficulty. Only tracking CG-CAHPS was reported to have a medium level of difficulty. DPHs reported using outside vendors to collect the CG-CAHPs measures, which required fewer personnel and resources on the part of the DPHs.

Exhibit 46: Amount of Effort and the Overall Level of Difficulty in Gathering Category 3 Measures



Source: UCLA survey of designated public hospitals (DPHs).

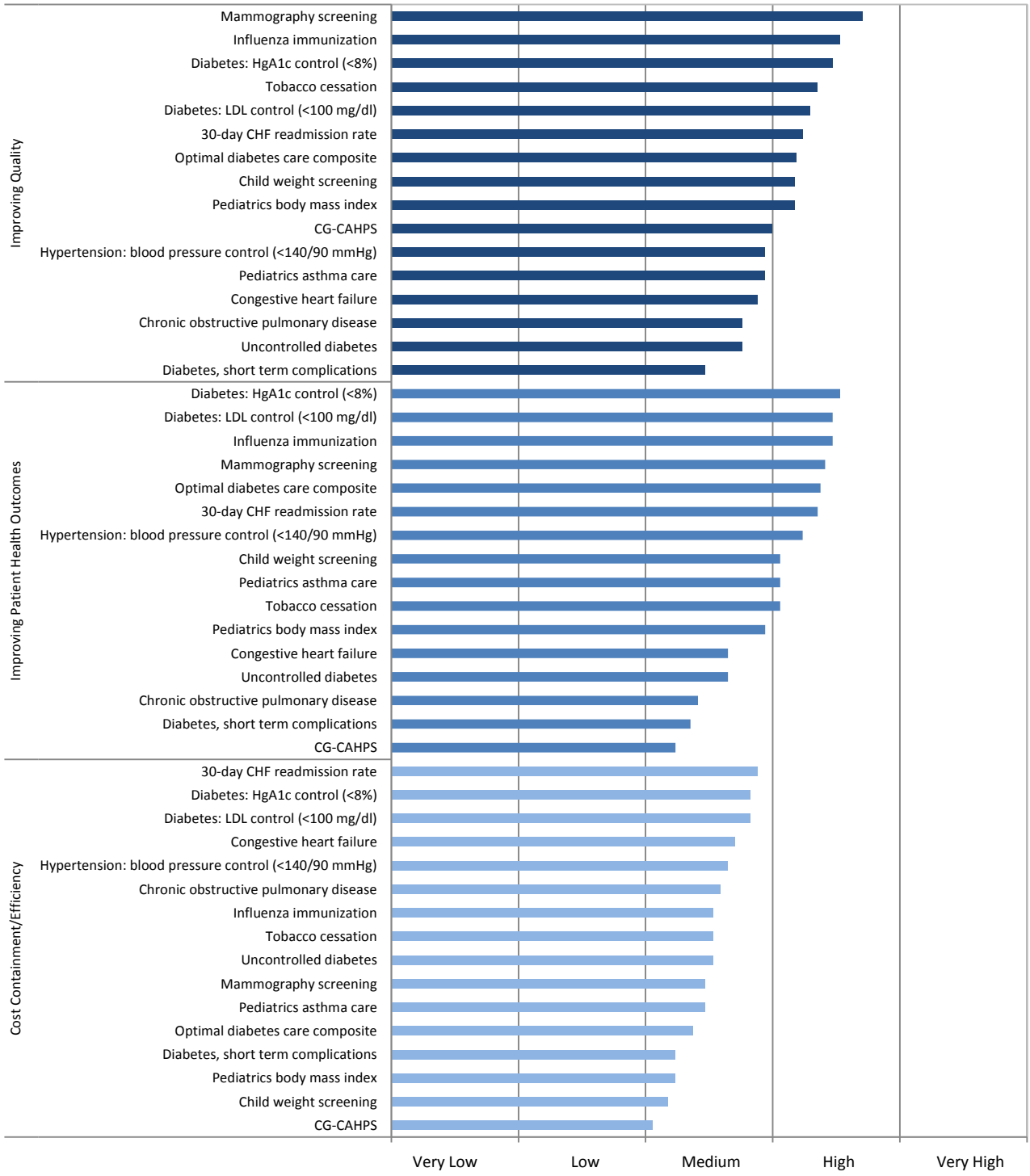
Top Challenges and Solutions to Implementation

DPHs reported the top two challenges in tracking each Category 3 measure. The most frequently cited challenges related to data collection and abstraction issues, which were generally resolved by implementing electronic medical records if they were not available before DSRIP or accelerating the process of implementation. The second most frequently cited challenge was inconsistency in data collection methods, which was resolved by additional staff training and by improving documentation. The third most frequently cited reason was lack of sufficient staff for manual chart abstraction and data reporting, particularly before full implementation of EMRs or when EMRs lacked specific data. These challenges were resolved by hiring and training additional staff to complete the required tasks.

Perceived Impact on Triple Aim

DPHs were asked to assess the potential impact of each Category 3 measure on the Triple Aim of improving quality, patient outcomes and cost containment/efficiency using a five point scale from very low to very high. The average rating for each measure for each aim is reported in Exhibit 47. Overall, several Category 3 measures were anticipated to have a high impact on improving quality of care and patient health outcomes. However, no measures were expected to have a high or very high impact on cost containment/efficiency. Furthermore, the perceived impact of measures varied by each aim. For example, most DPHs perceived that mammography screening would have the highest impact on improving quality but a slightly lower impact on patient outcomes and a medium impact on cost containment/efficiency.

Exhibit 47: Perceived Impact of Category 3 Measures on Triple Aim of Improving Quality, Patient Health Outcomes, and Increasing Cost containment/Efficiency



Source: UCLA survey of designated public hospitals (DPHs).

Future Analyses

Additional analyses of the trends in Category 3 measures in DY 9 and DY 10 will be provided in the final report. Furthermore, the trends in Category 3 measures reported by DPHs will be compared to publicly available data for other comparable California hospitals when available. The final report will also include complete key informant interview data to provide context and depth to implementation decisions of DPHs and challenges they faced. Data from DY 6 -DY 10 DPH reports will be analyzed to explore specific challenges or other implementation issues provided in those reports.

Summary

The findings indicate that CG-CAHPS data were infrequently (2 DPHs) tracked prior to DSRIP. Preventive health measures and at-risk population measures, however, were tracked by more than half of DPHs. Care coordination measures were tracked by fewer than half of DPHs. However, most of these measures were not tracked uniformly or at the same scope as under DSRIP. The most frequently cited reason for not tracking Category 3 measures was lack of HIT (66%).

DPHs reported achieving all of the milestones in DY 7 and DY 8, even though the milestones nearly doubled in this timeframe. The available results from CG-CAHPS indicated scores were highest for ability of the doctors to communicate with patients (81.6%) and lowest for getting timely appointments, care, and information (44.9%).

Of the remaining measures, a substantial increase in the average rates of mammography screening (from 53.8% to 64.7%) were observed from DY 7 to DY 8, but other measures did not change or changed by a small percentage overall. However, the individual DPH rates indicated large percentage increases and declines in some rates. DPHs reported using Category 3 measures in quality improvement initiatives 80% of the time as well as using them to provide feedback to medical directors and administrators 75% of the time and providers 70% of the time.

DPHs reported use of extensive resources and high level of difficulty for tracking most of the Category 3 measures. Top challenges in implementation included a lack of EMR systems, inconsistencies in data collection methods, and lack of clear instructions on gathering data. DPHs responded to these challenges by implementing EMRs, training staff, and improving documentation. Overall, several Category 3 measures were anticipated to have a high impact on improving quality of care and patient health outcomes. However, no measures were expected to have a high or very high impact on cost containment/efficiency. Most DPHs

perceived that mammography screening would have the highest impact on improving quality, diabetes control of HgA1c would have the highest impact on patient outcomes, and 30-day CHF readmission rates would have the highest impact on cost containment or efficiency.

Category 4: Urgent Improvement in Care

Category 4 projects were designed to make evidence-based urgent improvements in the inpatient care setting. Each DPH was required to implement at least four projects related to inpatient care for Category 4. DPHs were required to select two projects: severe sepsis detection and management and central-line associated bloodstream infection (CLABSI) prevention. DPHs were also required to select a minimum of two out of five other projects, including: surgical site infection (SSI) prevention, hospital-acquired pressure ulcer (HAPU) prevention, stroke management, venous thromboembolism (VTE) prevention and treatment, and falls with injury prevention. Improvement targets for Category 4 projects were based on baseline data starting no earlier than July 2009 or data based on 6-12 months of the project in DY 7. DHCS was tasked with setting a high performance level and a minimum performance level for central line insertion practices (CLIP) adherence, stroke management, and VTE, which are to be used as guidelines to set targets for DY 9-10.

Project Selection

Exhibit 48 presents the selection of projects by the DPHs. As required, all 17 DPHs are working on the sepsis and CLABSI projects. Twelve DPHs selected the SSI project, and 12 selected the HAPU project. Six DPH selected the VTE project. The stroke intervention and falls projects were the least frequently selected, with three DPHs selecting the stroke project and only one selecting the falls project.

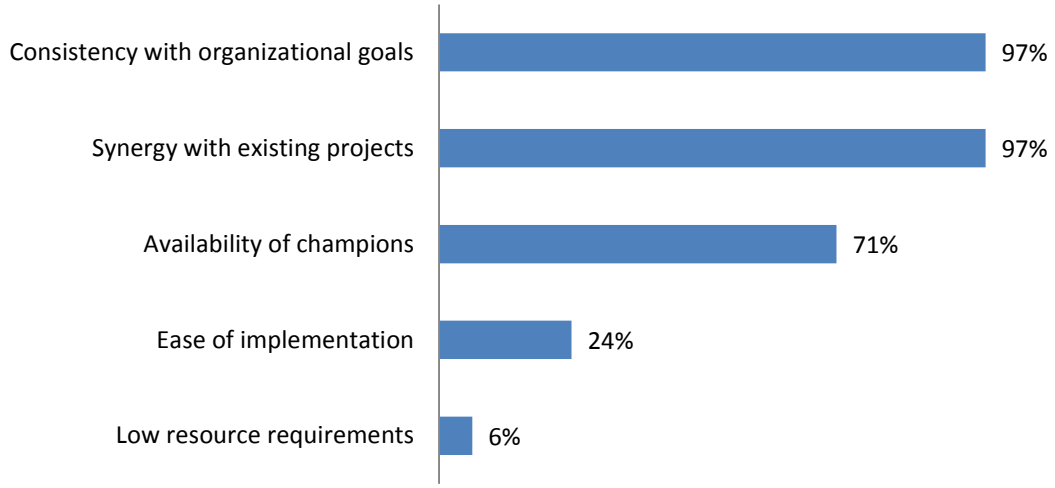
Exhibit 48: Projects Selected, by Designated Public Hospital, Category 4

	Severe Sepsis Detection and Management	Central Line-Associated Bloodstream Infection Prevention	Surgical Site Infection Prevention	Hospital-Acquired Pressure Ulcer Prevention	Stroke Management	Venous Thromboembolism Prevention and Treatment	Falls with Injury Prevention
Alameda Health System	✓	✓	✓	✓			
Arrowhead Regional Medical Center	✓	✓		✓	✓		
Contra Costa Health Services	✓	✓		✓		✓	
Kern Medical Center	✓	✓		✓		✓	
Los Angeles County Department of Health Services	✓	✓	✓			✓	
Natividad Medical Center	✓	✓		✓		✓	
Riverside County Regional Medical Center	✓	✓	✓		✓		
San Francisco General Hospital	✓	✓	✓			✓	
San Joaquin General Hospital	✓	✓	✓		✓		
San Mateo Medical Center	✓	✓	✓				✓
Santa Clara Valley Medical Center	✓	✓	✓	✓			
University of California, Davis Medical Center	✓	✓	✓	✓			
University of California, Irvine Medical Center	✓	✓		✓		✓	
University of California, Los Angeles Hospitals	✓	✓	✓	✓			
University of California, San Diego Health System	✓	✓	✓	✓			
University of California, San Francisco Medical Center	✓	✓	✓	✓			
Ventura County Medical Center	✓	✓	✓	✓			
Total	**17**	**17**	**12**	**12**	**3**	**6**	**1**

Source: UCLA analysis of designated public hospital reports.

For the projects selected, nearly all DPHs identified consistency with organizational goals and synergy with existing projects as reasons for choosing the project (Exhibit 49). Neither ease of implementation (24%), nor low resource requirements (6%), appeared to be key considerations in choosing projects.

Exhibit 49: Reasons for Selecting Optional Category 4 Projects

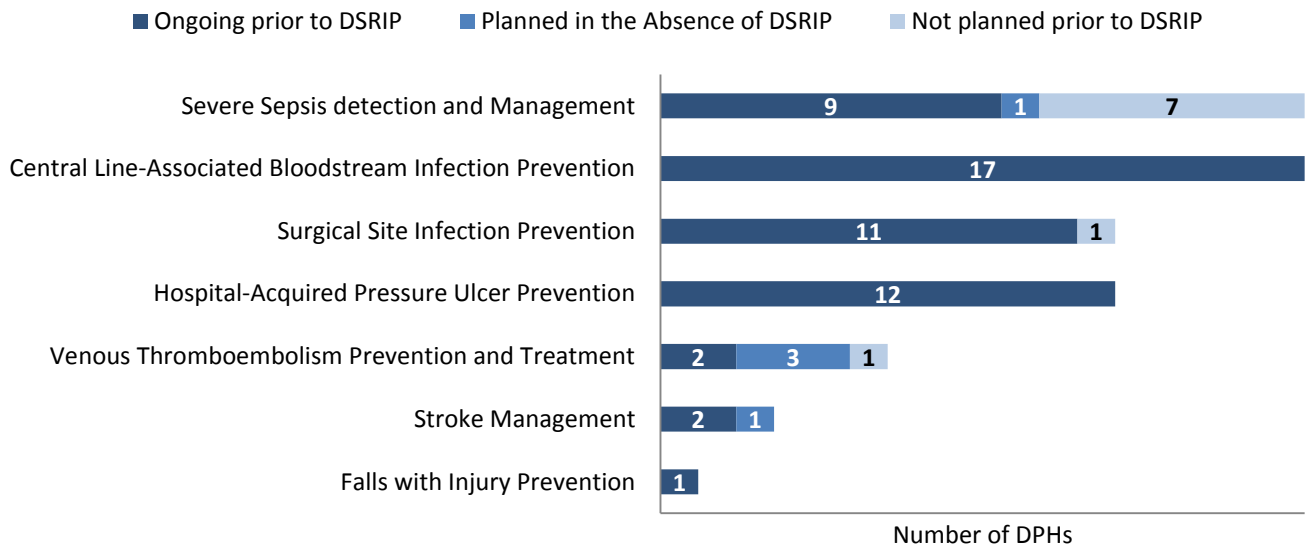


Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 4 projects (n=68). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Status of Category 4 Projects Prior to DSRIP

For almost all of the projects, DPHs that selected the project were either working on or planning a project prior to DSRIP (Exhibit 50). The one notable exception to this pattern was the sepsis project, a mandatory project, where seven of the 17 DPHs indicated that no project had been implemented or planned prior to DSRIP. This is in sharp contrast to the other mandated project, CLABSI, in which all 17 DPHs indicted they had projects underway prior to DSRIP. For all the optional projects, DPHs indicated prior work was underway with two exceptions, with one DPH that chose SSI prevention and one that chose VTE indicating that no work had been planned prior to DSRIP.

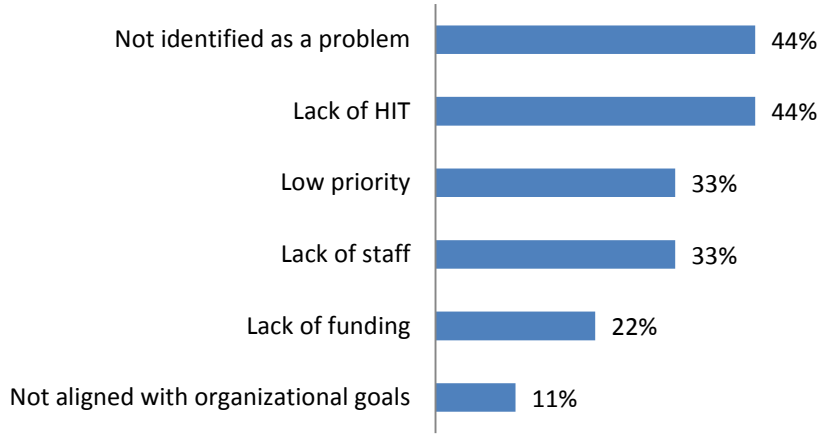
Exhibit 50: Status of Category 4 Projects in DPHs Prior to DSRIP



Source: UCLA survey of designated public hospitals (DPHs).

DPHs offered a wide range of reasons why projects had not been planned or underway prior to DSRIP (these responses are largely about the sepsis project) (Exhibit 51). Lack of identification of the project as a problem (44%) and lack of HIT infrastructure to identify or manage the project (44%) were the two reasons most frequently cited, with low priority relative to other areas, lack of staff and lack of funding also cited as reasons.

Exhibit 51: Reasons that Category 4 Projects Were Not Planned Prior to DSRIP



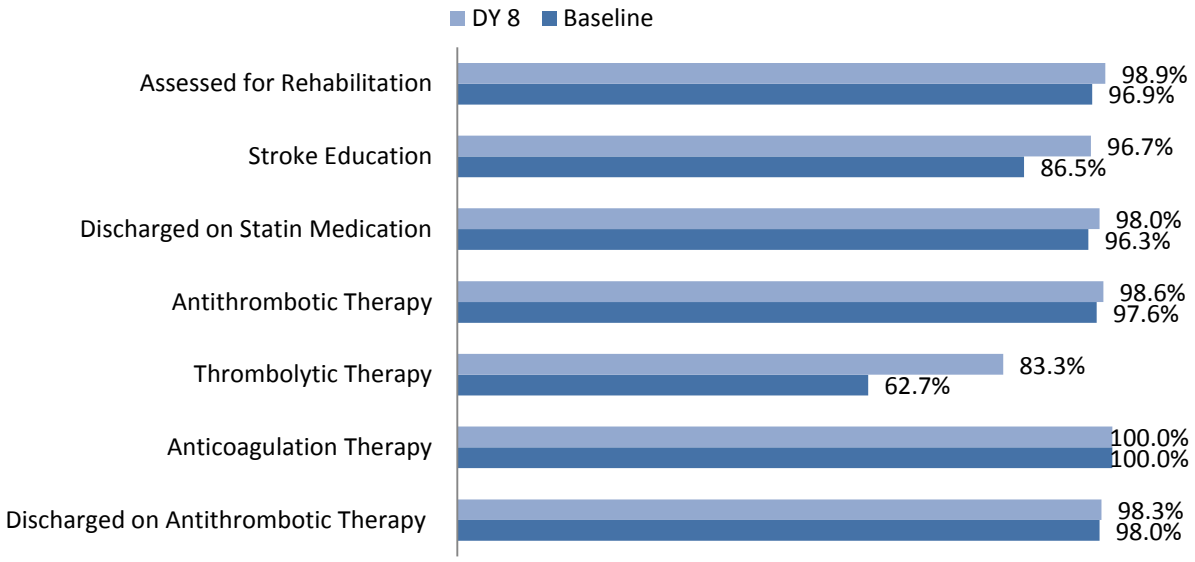
Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of projects selected that were not implemented or planned prior to DSRIP (n=9). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

Outcomes

Each of the projects in Category 4 required implementing a bundle of improvements, and DPHs were required to report baseline adherence to the protocol and adherence in DY 8. Data were available for baseline and DY 8 for the components of the stroke bundle (Exhibit 52), VTE bundle (Exhibit 53), and CLABSI central line insertion bundle (Exhibit 54). Data were not available for the baseline sepsis bundle but DY 8 rates of adherence were available (Exhibit 54). Overall, rates of adherence were high at baseline and increased for all measures in DY 8 over baseline. Adherence rates for six of seven stroke measures, four of five VTE measures and the central line bundle were over 90% in DY 8. The three measures with the lowest baseline compliance (between 45% and 80%) increased by 10-20 percentage points, with the largest gain for the measure with lowest compliance (Venous Thromboembolism Warfarin Discharge Instructions). Process measures have shown consistent improvement across sites.

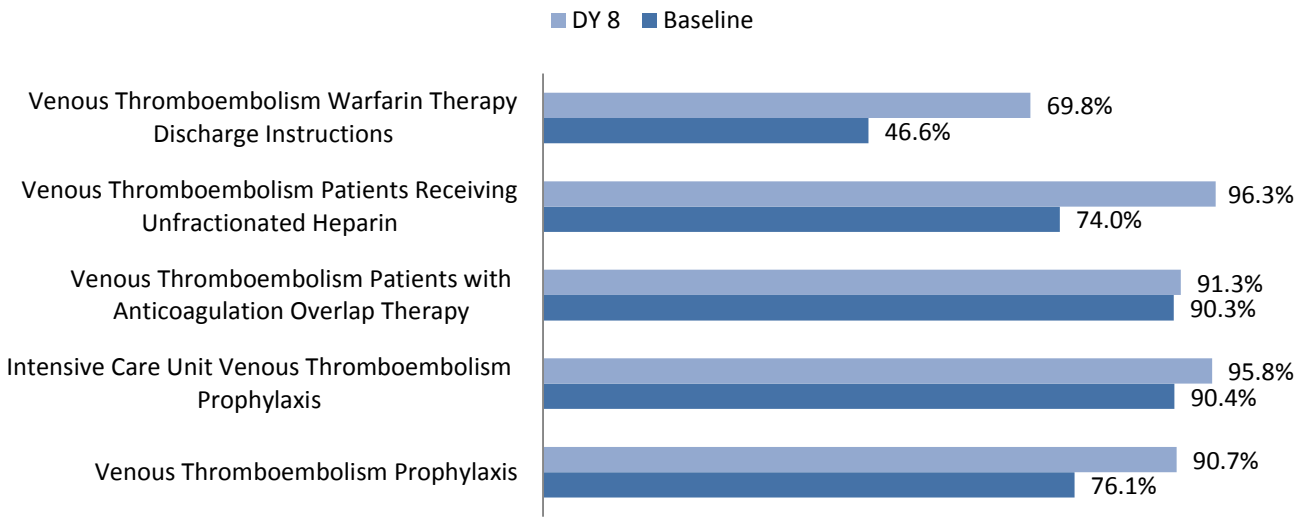
Rates reported by individual DPHs varied widely. VTE bundle rate changes between DY 7 and DY 8 ranged from a 24% decrease for one DPH to a 552% increase for another DPH, while overall average rate changes for each measure ranged between 1% and 50%. The CLABSI central line insertion bundle adherence rate between DY 7 and DY 8 ranged from a 2% decrease for one DPH to a 117% increase for another DPH, an overall average rate increase of 7% for all DPHs combined. Side-by-side comparisons of individual DPH rates are available in the SNI DY 8 report.

Exhibit 52: Stroke Management Adherence Rates Reported by DPHs, Baseline and DY 8



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

Exhibit 53: Venous Thromboembolism Prevention and Treatment Adherence Rates Reported by DPHs, Baseline and DY 8



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

Exhibit 54: Category 4 Process Measures Reported by DPHs, Baseline and DY 8

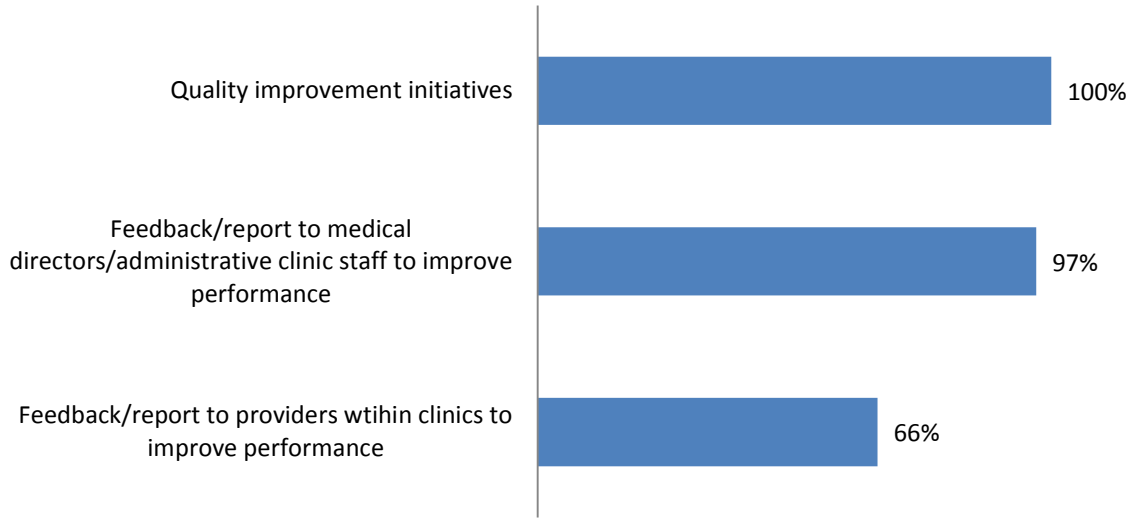
Measure	Baseline	DY 8
Sepsis Bundle – PHS Data Definition	NA	56.9%
Sepsis Bundle – ICD-9 Coded Data Definition (785.52 & 995.92)	NA	59.8%
Central Line Insertion Practices – Adherence Rate	89.3%	95.3%

Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.

Note: Data not available for sepsis bundle measures in the baseline period.

DPHs reported on whether and how they incorporated Category 4 project results or project information into quality improvement initiatives, feedback or reports to medical directors or administrative leadership to improve performance, or feedback to providers within clinics to improve performance (Exhibit 55). All DPHs planned to incorporate project results into quality improvement. For 97% of the projects, DPHs planned on providing feedback to medical directors or administrative leadership. The largest area of variation was in the intention to provide direct feedback to providers within clinics, where DPHs indicated they would be doing this for two-thirds of the projects.

Exhibit 55: The Proportion of Category 4 Projects that Used Project Measures for Quality Improvement Initiatives and Feedback



Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 4 projects selected by DPHs (n=68). Total is greater than 100% because DPHs were allowed to select more than one response option per project.

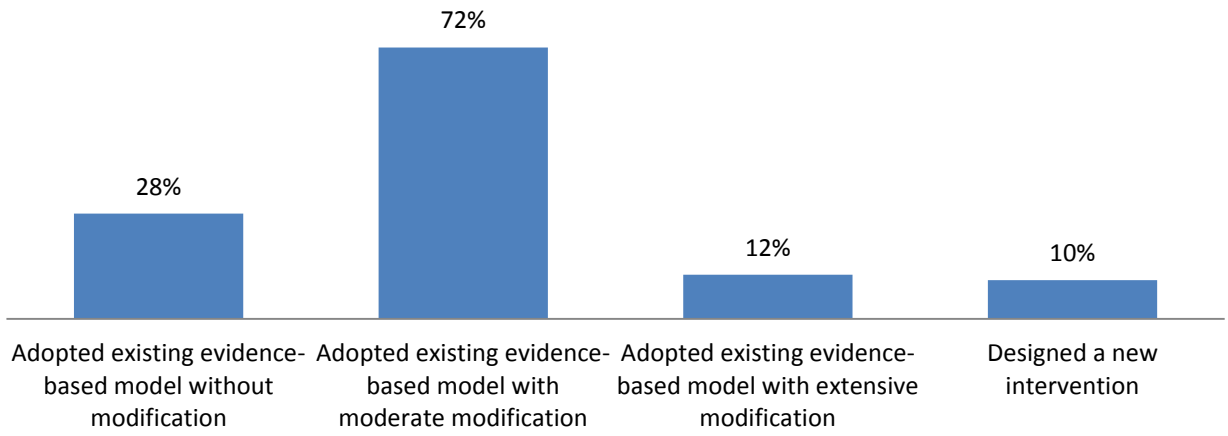
Implementation

The DPHs reported high levels of effort required to implement the Category 4 projects despite substantial work prior to DSRIP on the projects required or selected. For each project, DPHs reported the extent to which, in implementing the project, they adopted an existing model without modification, adopted an existing model with moderate modification, adopted an existing model with extensive modification, or designed a new project, and indicated the degree of staff training required for the project. They were also asked to rate the level of effort required for planning, personnel reorganization, care process reorganization, obtaining stakeholder engagement, and selecting and implementing measurement, and the overall level of difficulty in implementing the project using a five-point scale from "very low" to "very high." Additionally, DPHs reported the extent of revision, redesign, or modification of plans from their original form for successful implementation.

Exhibit 56 presents the responses to the question about evidence-based models and Exhibit 57 presents the responses about training. Overwhelmingly DPHs adopted an existing model for the project but found the models required at least moderate levels of modification. For 12% of the projects, modifications were described as extensive and in 10%, a new intervention was designed. Consistent with findings from the implementation research literature, simply

adopting an intervention without any adaption to local circumstances was not generally sufficient.

Exhibit 56: The Proportion of Category 4 Projects That Used Evidence-Based Models, by Degree of Modification to the Model



Source: UCLA survey of designated public hospitals (DPHs).

Notes: Analysis is based on the total number of Category 4 projects selected by DPHs (n=68). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could implement more than one model to complete a project.

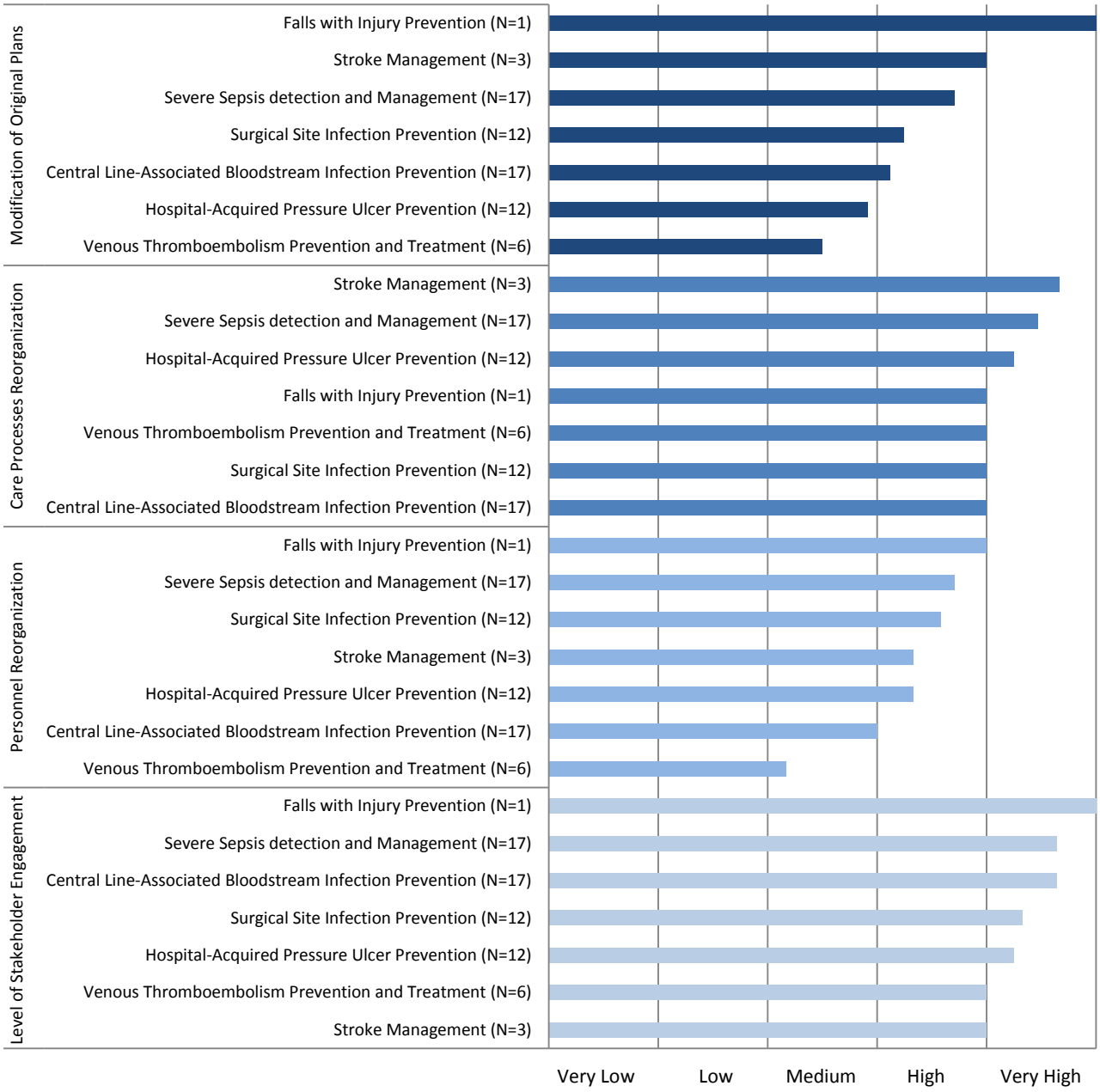
With respect to training (Exhibit 57), nearly 60% of DPHs reported staff had some previous training relevant to the project, but 69% reported intervention-related training prior to the intervention, and 82% reported training during the intervention.

Exhibit 57: Timing of Staff Training in Relation to DSRIP Implementation for Category 4 Projects

Source: UCLA survey of designated public hospitals (DPHs).
Notes: Analysis is based on the total number of Category 4 projects selected by DPHs (n=68). Total is greater than 100% because DPHs were allowed to select more than one response option per project. DPHs could conduct multiple phases of staff training depending on the needs of the project.

Challenges in obtaining stakeholder engagement and reorganization of care processes required especially high levels of effort or were most frequently characterized as very hard. The exceptions were the degree to which plans needed to be modified for the VTE and HAPU projects, where effort was characterized as moderate, and personnel reorganization for the VTE and CLABSI projects (Exhibit 58). In general the level of effort required for each component of the implementation and implementation overall was "high" to "very high" (Exhibit 59).

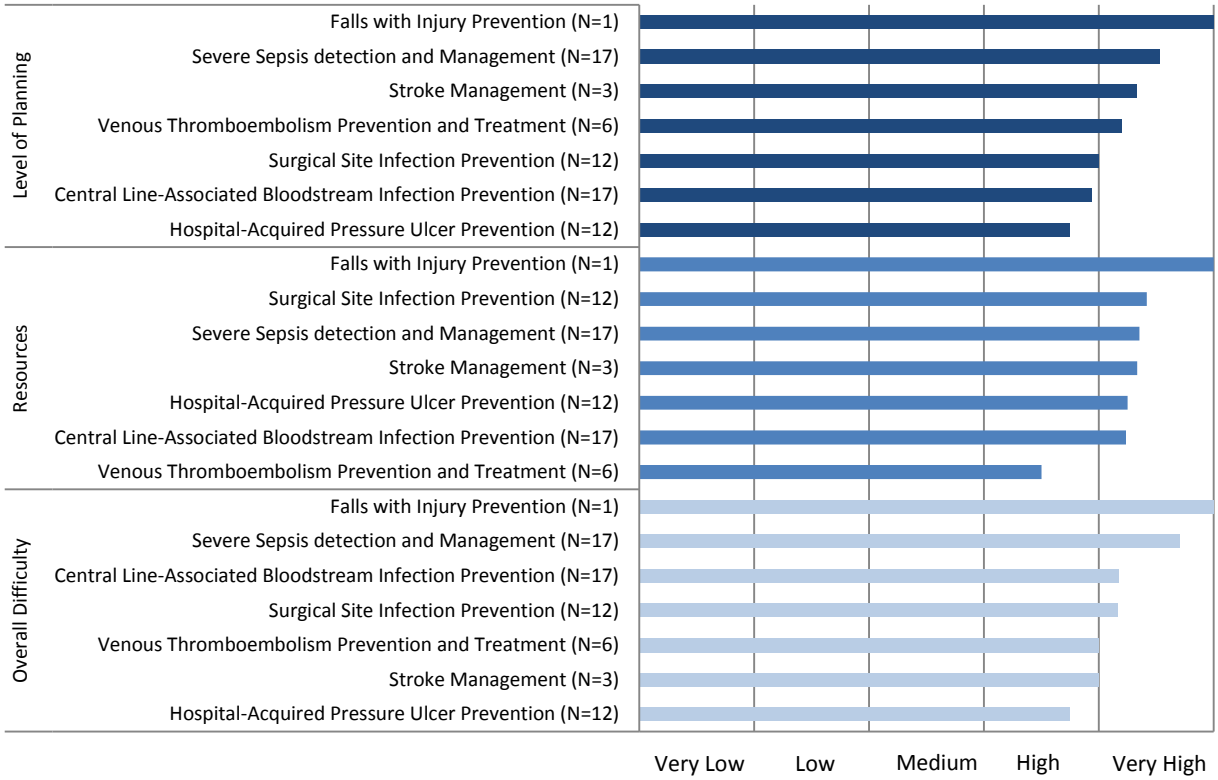
Exhibit 58: Level of Modification of Original Plans, Reorganization of Personnel and Care Processes, and Stakeholder Engagement for Category 4 Projects



Source: UCLA survey of designated public hospitals (DPHs).

Note: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Exhibit 59: Amount of Effort and Overall Level of Difficulty in Implementing Category 4 Projects



Source: UCLA survey of designated public hospitals (DPHs).
Note: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Top Challenges and Solutions to Implementation

DPHs reported top challenges and solutions to successful implementation of Category 4 projects. DPHs identified challenges in choice of measures, meeting the DSRIP milestones, obtaining data to implement the measurement strategy, and sustaining the projects. Challenges in choice of measures and in achieving the DSRIP milestones included low volume or incidence, engaging physicians and nursing staff and identifying specific procedures to target. DPHs resolved these challenges through hypervigilance to avoid missing cases, educating and training staff, and identifying high volume procedures.

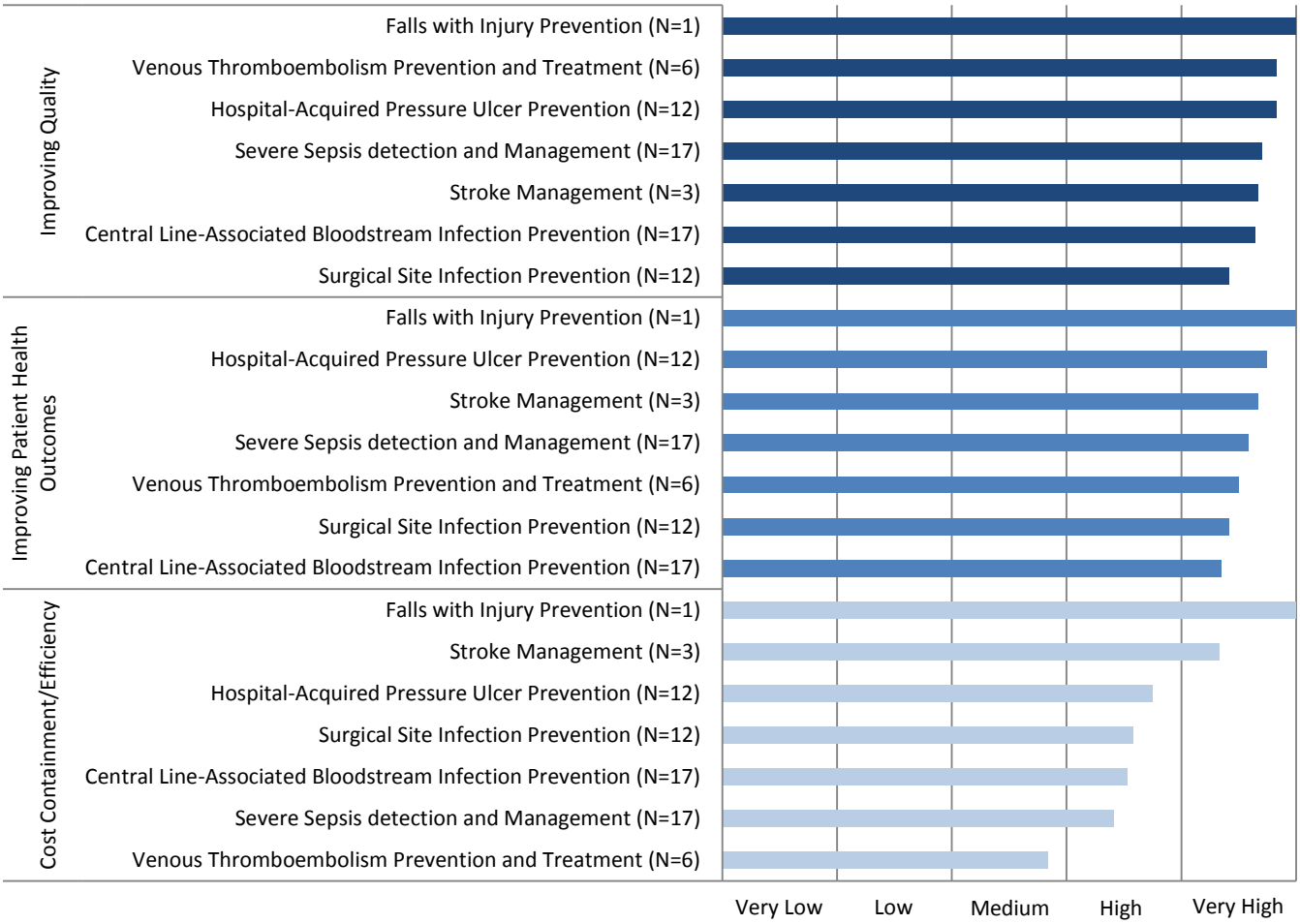
Challenges in obtaining data for the denominators and numerators and in sustaining the projects included a lack of consistent documentation, data criteria that was extremely complex (e.g. identifying when a patient screened positive for sepsis was identified as a major problem), lack of resources for data collection, changing data reporting requirements, high levels of resources and time required for manual data abstraction, and keeping all caregivers apprised of

performance. DPHs found a variety of ways to overcome these challenges, including identifying physician and nurse champions, conducting daily and monthly audits, training providers on ruling out diagnoses though training and monitoring, hiring additional staff, developing forms to capture data and using electronic data collection whenever possible, and sending feedback to staff on surveillance data.

Perceived Impact on Triple Aim

DPHs reported the perceived impact of Category 4 on the Triple Aim of improving quality of care, improving patient outcomes, and increasing cost containment and efficiency. Each response was assessed on a one to five scale from "very low" impact to "very high" impact. The average rating for each project is presented in Exhibit 60. Average ratings for all projects were very high for the impact on quality and patient outcomes. There was greater variation in the answers regarding impacts on cost containment and efficiency, with the impact of some projects such as falls and stroke projects assessed as very high, while VTE was assessed on average as having only a medium impact, and other projects assessed as high. For projects with many DPHs participating, a substantial number assessed the impact on costs and efficiency at the low or very low end of the scale. When asked about this in interviews, those DPHs indicated that they did not have the data to demonstrate cost impact or that it was too early to assess the impact on costs and efficiency.

Exhibit 60: Perceived Impact of Category 4 Projects on Triple Aim of Improving Quality, Patient Health Outcomes, and Increasing Cost containment/Efficiency

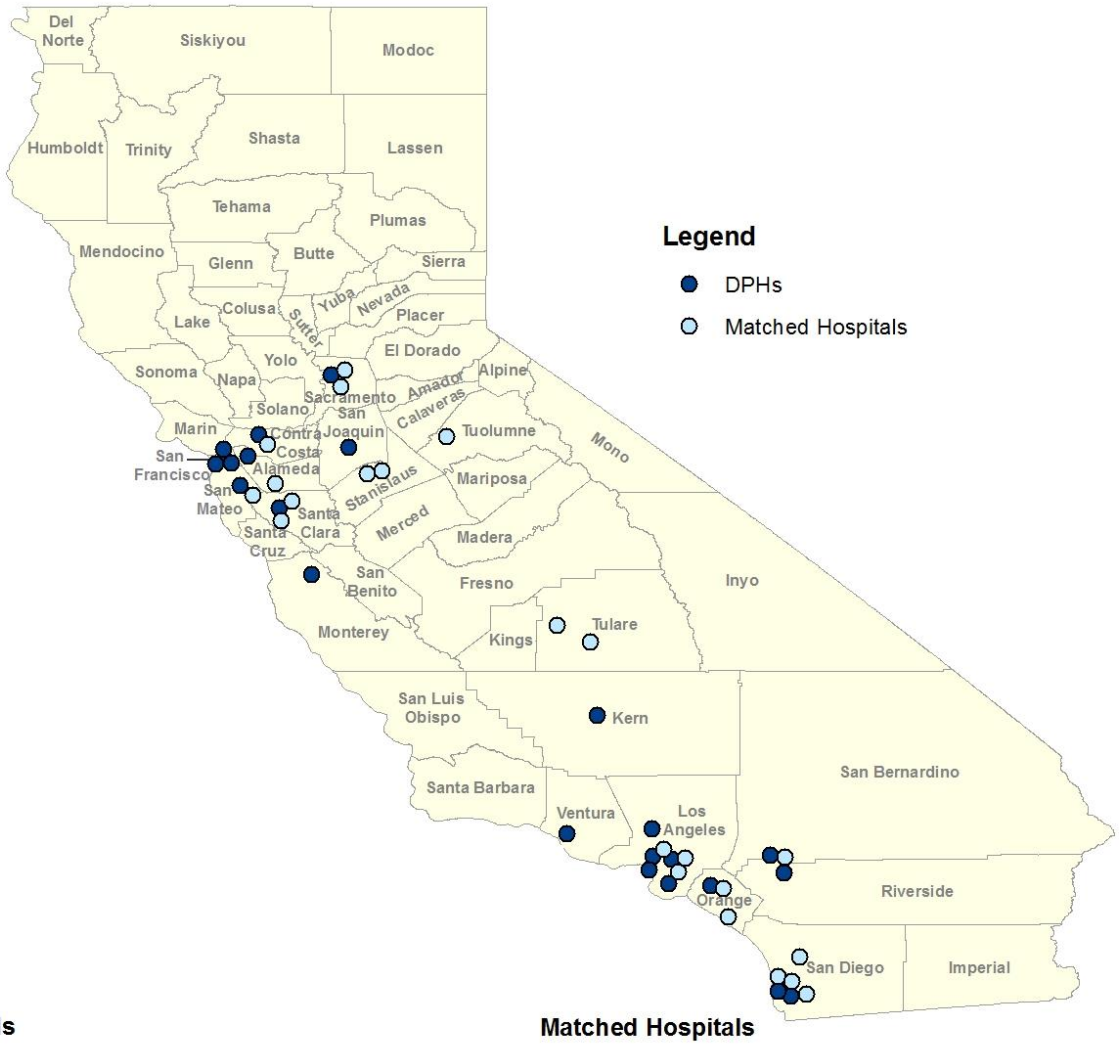


Source: UCLA survey of designated public hospitals (DPHs).
Note: The Ns for each category represent the total number of projects implemented in the category across all DPHs.

Pre-DSRIP Comparison of Category 4 Outcomes with Other California Hospitals

DPHs progress in improving inpatient care is compared with hospitals in California that are "matched" on a number of characteristics. In this interim report, UCLA used OSHPD data to construct trends in Category 4 outcomes for DPHs, matched hospitals, and the "other" remaining selected California hospitals. The data, sample selection, measure construction, risk adjustment, and statistical analysis methods are provided in Appendix 1 (Category 3). DPHs and matched hospitals are presented in Exhibit 61. In the findings presented below, DPHs are further divided into "DPH participating" and "DPH non-participating" depending on whether the DPH implemented an optional Category 4 project.

Exhibit 61: Map of DPHs and Matched Hospitals



DPHs

Alameda County Medical Center - Highland Campus
Arrowhead Regional Medical Center
Contra Costa Regional Medical Center
Kern Medical Center
LA County + USC Medical Center
LA County/Harbor-UCLA Medical Center
Los Angeles County Olive View-UCLA Medical Center
Natividad Medical Center
Riverside County Regional Medical Center
Ronald Reagan UCLA Medical Center
San Francisco General Hospital
San Joaquin General Hospital
San Mateo Medical Center
Santa Clara Valley Medical Center
Santa Monica - UCLA Medical Center And Orthopaedic Hospital
UCSD-La Jolla, John M And Sally B. Thornton Hospital
UCSF Medical Center
UCSF Medical Center At Mount Zion
University Of California Davis Medical Center
University Of California Irvine Medical Center
University Of California-San Diego Medical Center
Ventura County Medical Center

Matched Hospitals

Cedars Sinai Medical Center
Doctors Medical Center
El Camino Hospital Los Gatos
Grossmont Hospital
John Muir Medical Center-Walnut Creek Campus
Kaiser Foundation Hospital - Fremont
Kaiser Foundation Hospital - Sacramento/Roseville-Morse
Kaiser Foundation Hospital - South Sacramento
Loma Linda University Medical Center
Memorial Hospital Medical Center - Modesto
Mission Hospital Laguna Beach
Palomar Medical Center
Regional Medical Of San Jose
Scripps Green Hospital
Scripps Memorial Hospital - La Jolla
Sierra View District Hospital
Sonora Regional Medical Center - Greenley
St. Francis Medical Center
Stanford Hospital
Tulare Regional Medical Center
Western Medical Center - Santa Ana
White Memorial Medical Center

*Hospitals are listed in alphabetical order

The means and variance for each matching variable was examined for the matched sample and DSRIP hospitals included in the analysis (Exhibit 62) and judged to be comparable.

Exhibit 62: Averaged Scores of Matching Criteria

	DPHs	Matched	Other
Case Mix	1.31	1.28	1.30
	(0.28)	(0.33)	(0.45)
Ratio of Intensive Care Unit to General Acute Care beds	0.10	0.11	0.08
	(0.05)	(0.06)	(0.05)
Proportion Pediatric Beds	0.03	0.06	0.02
	(0.04)	(0.04)	(0.04)
Pediatric Beds	11.82	20.14	4.74
	(17.59)	(20.82)	(9.00)
Non-pediatric Beds	300.00	303.64	171.86
	(198.06)	(156.32)	(123.42)
Outpatient Volume to Inpatient Visits	15.03	29.01	14.26
	(13.71)	(17.00)	(25.93)

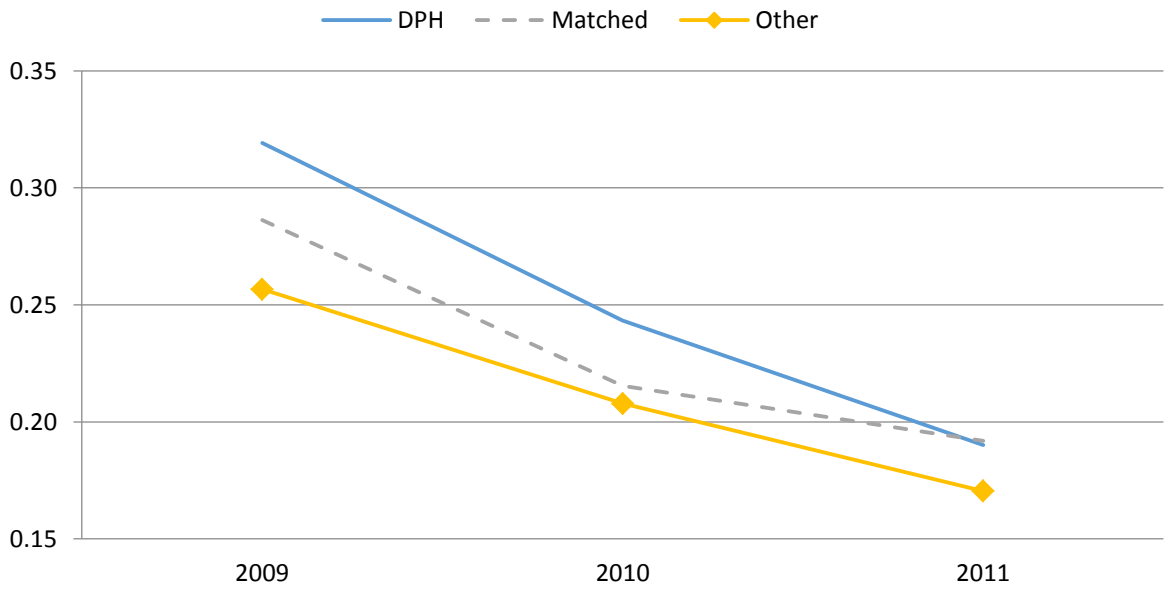
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: Standard Deviations in Parentheses.

Pre-DSRIP Trends in Category 4 Project Outcomes

Exhibit 63 through Exhibit 70 include the preliminary trends for the Category 4 project outcomes prior to the implementation of DSRIP. In general, DPHs have different initial rates for each outcome in the baseline period. The preliminary trends for DPHs are higher than the matched or other hospitals for five of the eight measures, and lower than the matched controls or other controls for three measures. Five of the measures display a slight downward trend, with the trend for both DSRIP hospitals and controls sometimes parallel, sometimes converging and sometimes diverging. For three measures during the baseline period the patterns of change are different for the DSRIP participating and non-DSRIP control hospitals.

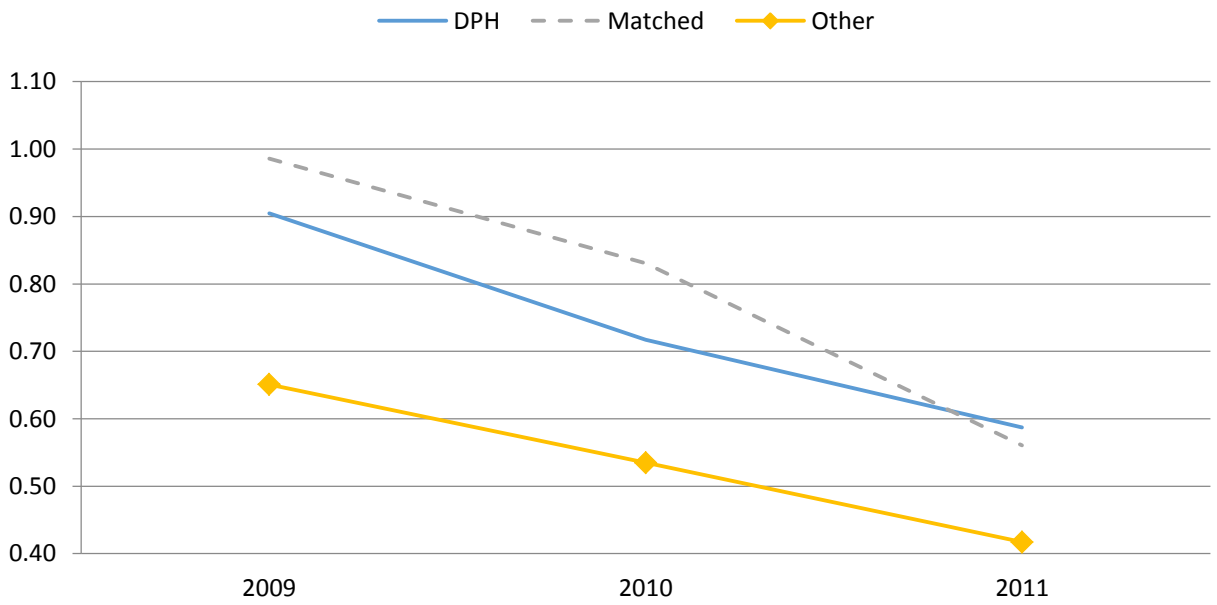
The preliminary analysis demonstrates the feasibility of conducting this analysis using OSHPD data and the value of including both the matched sample and other hospitals. Further analysis with post-project data and more effective risk adjustment will provide better insights into the relative performance of DPHs, matched, and other hospitals in improving care over pre- and post-demonstration years.

Exhibit 63: Proportion of Severe Sepsis Events Leading to Mortality by Calendar Year and Comparison Group



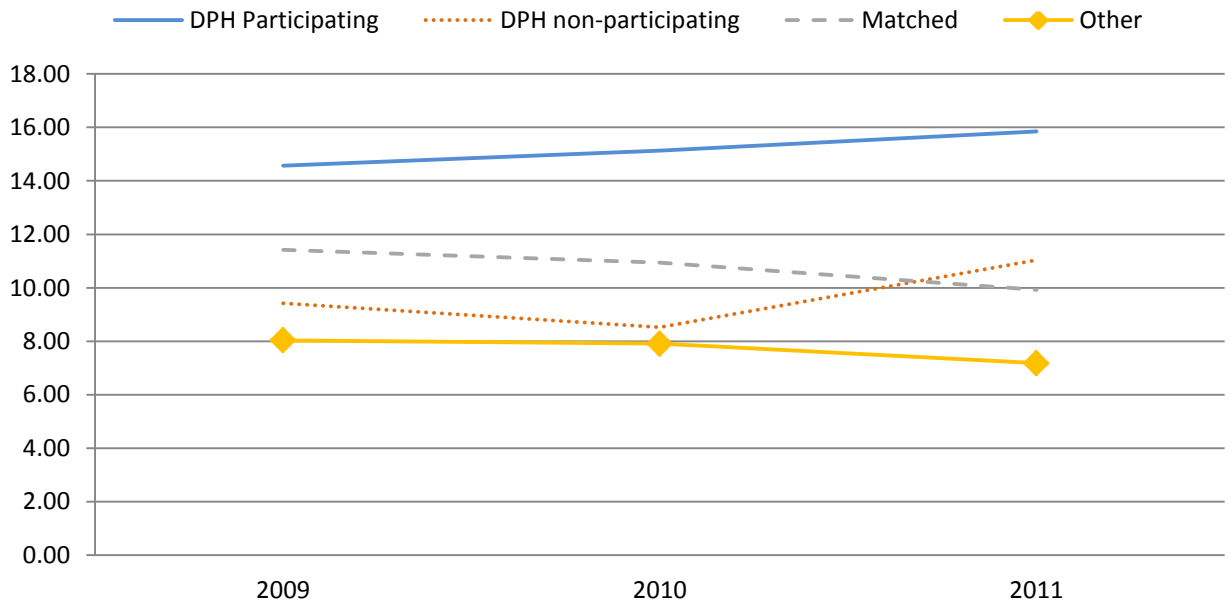
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.

Exhibit 64: Bloodstream Infections per 1,000 Days on a Central Vein Catheter by Calendar Year and Comparison Group



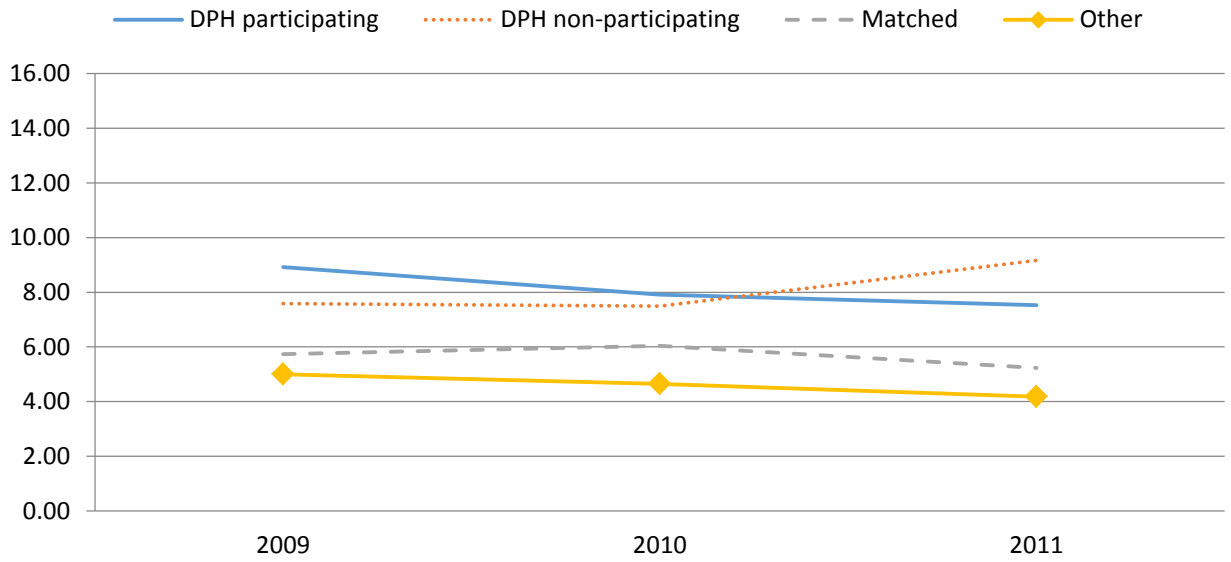
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.

Exhibit 65: Surgical Site Infections per 1,000 Encounters with a 30-Day Monitoring Period by Calendar Year and Comparison Group



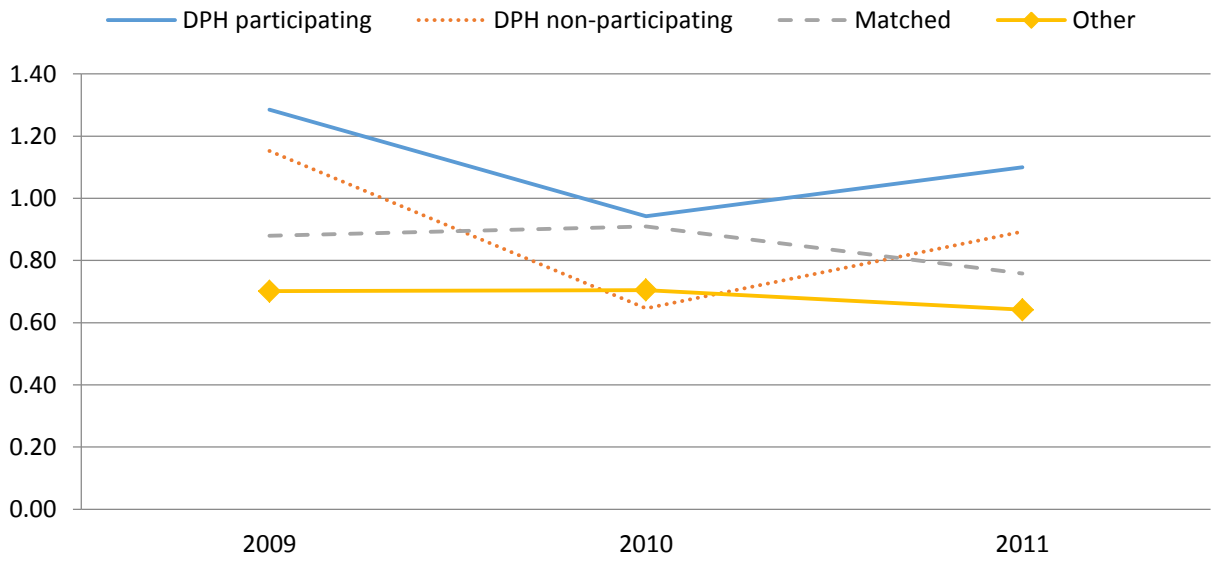
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: DPH participating is based on the number of DPHs who selected surgical site infection prevention (n=12) and DPH non-participating is based on the remaining number of DPHs (n=5).

Exhibit 66: Surgical Site Infections per 1,000 Encounters with a 90-Day Monitoring Period by Calendar Year and Comparison Group



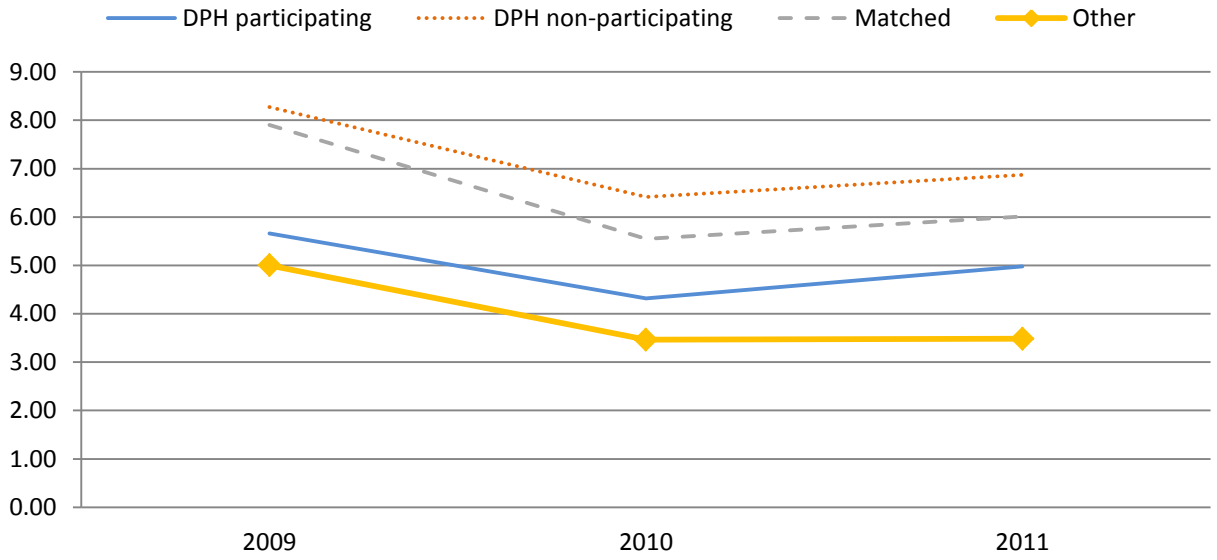
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: DPH participating is based on the number of DPHs who selected surgical site infection prevention (n=12) and DPH non-participating is based on the remaining number of DPHs (n=5).

Exhibit 67: Hospital-Acquired Pressure Ulcer Infection Rates per 1,000 Encounters by Calendar Year and Comparison Group



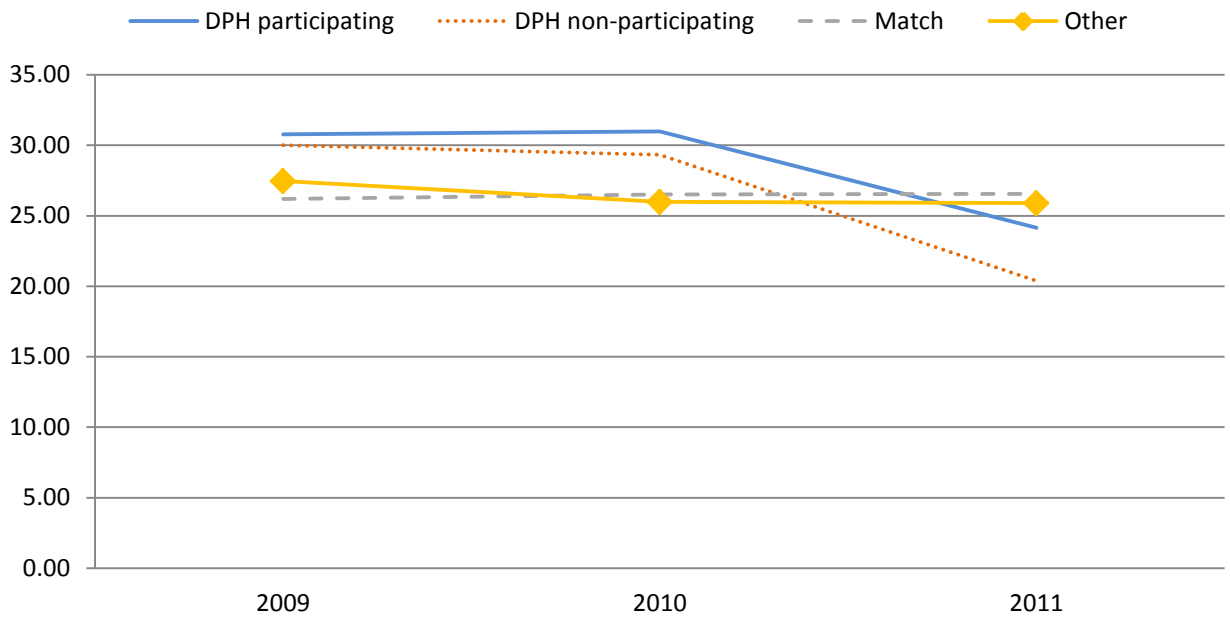
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: DPH participating is based on the number of DPHs who selected hospital-acquired pressure ulcer prevention (n=12) and DPH non-participating is based on the remaining number of DPHs (n=5).

Exhibit 68: Venous Thromboembolisms per 1,000 Encounters by Calendar Year and Comparison Group



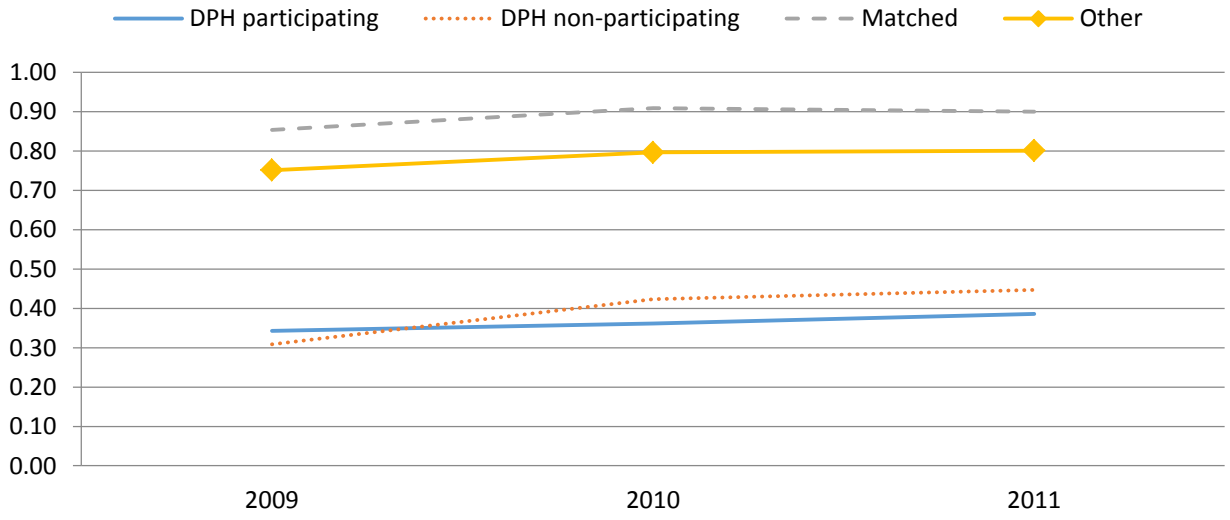
Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: DPH participating is based on the number of DPHs who selected venous thromboembolism prevention and treatment (n=6) and DPH non-participating is based on the remaining number of DPHs (n=11).

Exhibit 69: Stroke Mortality Rates by Calendar Year and Comparison Group



Source: UCLA analysis of Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data.
Note: DPH participating is based on the number of DPHs who selected stroke management (n=3) and DPH non-participating is based on the remaining number of DPHs (n=14).

Exhibit 70: Hospital-Related Falls per 1,000 Patient Days by Calendar Year and Comparison Group



Source: UCLA analysis of Office of Statewide Health Planning and Development Patient (OSHPD) Discharge Data.
Note: DPH participating is based on the number of DPHs who selected falls with injury prevention (n=1) and DPH non-participating is based on the remaining number of DPHs (n=16).

Future Analyses

Additional analyses of the Category 4 projects and measures in DY 9 and DY 10 will be provided in the final report. This includes further analyses of OSHPD data as indicated in above sections. A review of existing data on potential of Category 4 projects to increase cost containment/efficiencies will be included. The final report will include complete key informant interview data to provide context and depth to implementation decisions of DPHs and challenges they faced. Data from DY 6 -DY 10 DPH reports will be analyzed to explore specific challenges or other implementation issues provided in those reports.

Summary

DPHs were all asked to implement projects for sepsis and CLABSI and to undertake two other projects from a set of five. The most commonly selected were SSI (70%) and HAPU (70%). As with efforts reported in other categories, DPHs had begun or planned work in most of these project areas prior to DSRIP (a key exception being sepsis), and program participation served to enhance and expand existing work in many cases. All of the DPHs that selected HAPU and falls with injury prevention had ongoing projects and 92% of DPHs that selected SSI had an existing SSI project ongoing prior to DSRIP.

High in the factors considered in choosing projects were consistency with organizational goals (97%), synergy with existing projects (97%), and slightly less frequently presence of organizational champions (71%).

Overall, rates of adherence were high at baseline and increased for all measures in DY 8 over baseline. In DY 8 most of the measures had compliance rates over 90%, and the three measures with the lowest baseline compliance (between 45% and 80%) increased by 10-20 percentage points, with the largest gain for the measure with lowest compliance.

DPHs dedicated high levels of planning and resources, in some cases undertaking considerable levels of reorganization of care processes and personnel. Despite considerable efforts in these areas prior to DSRIP, all projects received "high" or "very high" overall difficulty ratings. Preliminary analysis of the interview data suggests that this was associated with the challenges of measurement and data abstraction for the measurement process, engaging staff and finding champions, and integrating the new processes into existing care systems. Almost all DPHs adopted existing models for Category 4 projects but over 70% projects required at least moderate levels of adaptation and it was necessary to design a new intervention model in 10% of projects.

From the DPHs' perspective, Category 4 projects realized their greatest impact on improving quality of care and health outcomes, compared with increasing cost containment and efficiency, although results varied by project and DPHs cautioned that it was too early to estimate long-term impacts. DPHs prepared for sustaining Category 4 achievements by incorporating project results into quality improvement initiatives and reporting outcomes to providers and administrators.

The success achieved did not come easily. DPHs cited many challenges in implementing Category 4 projects, most notably staffing difficulties and the lack of standardized definitions and tracking processes. The issues were similar to those identified in the other categories.

Data for analysis of outcomes is only available for the baseline period at this time. The preliminary analysis presented here and plans for its refinement for the final report indicate that post-project analysis of the experience of DPHs participating in DSRIP and control hospitals is feasible and likely to be productive.

Category 5: HIV Transition Projects

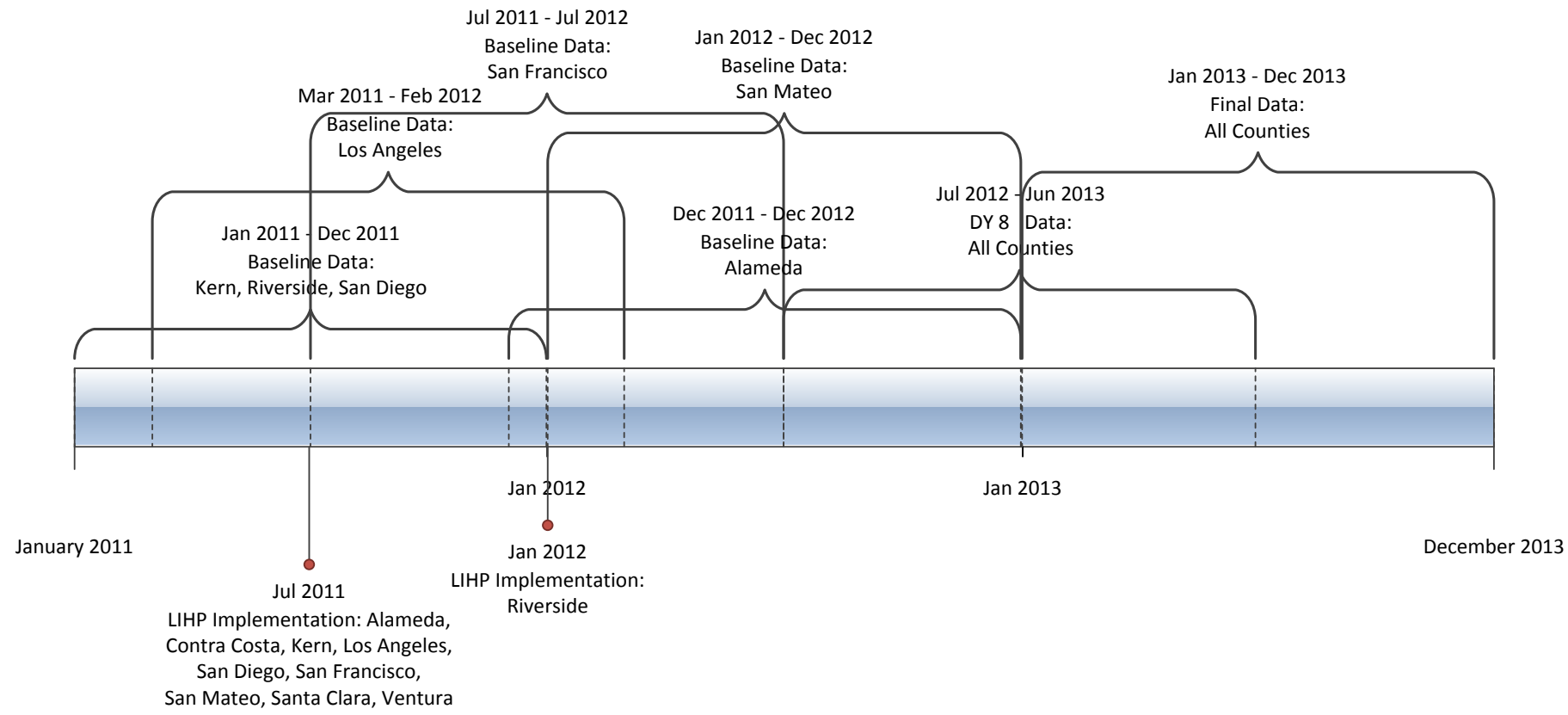
Category 5A projects were designed to improve the delivery of services to people living with HIV/AIDS (PLWHA) as they transitioned from Ryan White services to the Low Income Health Program (LIHP). Ryan White delivers HIV services within the context of a medical home and includes access to many supportive services (e.g. substance abuse treatment, mental health treatment, assistance with housing). As part of California's waiver, counties had the option of implementing LIHP as part of the early expansion of Medicaid. During the summer of 2011, the federal Health Resources and Services Administration (HRSA), provided guidance that Ryan White was the "payer of last resort" and that Ryan White cannot pay for services for persons diagnosed with HIV/AIDS who are eligible for and enrolled into LIHP. The local LIHPs screened Ryan White clients for eligibility and enrolled them into LIHP. These Ryan White clients could still access Ryan White wrap around services that were not available through LIHP. After receiving the Ryan White payer of last resort ruling, DHCS worked collaboratively with California Association of Public Hospitals (CAPH) and Department of Public Health, Office of AIDS to establish DSRIP Category 5.

The DSRIP program was designed to restore the continuity that may have been lost as PLWHA transitioned from Ryan White to LIHP-supported services. DPHs implementing DSRIP Category 5A projects were required to select three of seven approved projects designed to achieve the overall DSRIP goals of better care, better health, and lower cost. The presentation of Category 5 findings differs from Categories 1-4 due to fundamental differences between these categories and the subsequent evaluation design. Additional detail on methodology and references for Category 5 are available in Appendix 3 (Category 5).

Exhibit 71 shows when Category 5 projects were implemented and reported data. All ten sites reported data for the DY 8 period July 2012 to June 30, 2013 at the time of this interim report. However, the year covered for the baseline data varied.

The sources of information for Category 5A and 5B projects are from the DSRIP proposals, the two DY 8 semi-annual reports and the DY 8 annual report. UCLA also conducted literature reviews to document the expected impact of Category 5A interventions on Category 5B outcomes.

Exhibit 71: Category 5 Implementation Timeline



Source: UCLA analysis of designated public hospital reports.

Note: Exact dates for baseline measurements are unavailable for Contra Costa, Santa Clara, and Ventura.

Projects Implemented

The implemented Category 5 projects in the participating DPHs are displayed in Exhibit 72 and Exhibit 73. Of the Category 5A projects, four were most commonly selected by six hospitals: the empanelment of patients into an HIV-specific medical home, creation of disease management registries, development of a retention program, and the establishment of provisions for wraparound services for HIV patients transitioning from Ryan White to LIHP. In addition, DPHs had to choose four of the 22 Category 5B projects that targeted specific preventive care outcomes. The most commonly selected measures were hepatitis C and syphilis screening.

Exhibit 72: Projects Selected, by Designated Public Hospital, Category 5a

Designated Public Hospital	Empanel Patients into Medical Homes with HIV Expertise	Implement and Utilize Disease Management Registry Functionality	Build Clinical Decision Support Tools	Develop Retention Programs for Patients Diagnosed with HIV	Enhance Data Sharing between DPHs and County Departments of Public Health	Launch Electronic Consultation System between HIV Primary Care Providers and Specialty Care Providers	Ensure Access to Ryan White Wraparound Services for New LIHP Enrollees	Total
Alameda Health System	✓	✓		✓				3
Contra Costa Health Services			✓		✓		✓	3
Kern Medical Center		✓	✓	✓				3
Los Angeles County Department of Health Services	✓	✓				✓		3
Riverside County Regional Medical Center	✓	✓					✓	3
San Francisco General Hospital		✓		✓	✓		✓	4
San Mateo Medical Center	✓						✓	2
Santa Clara Valley Medical Center	✓			✓			✓	3
University of California, San Diego Health System	✓			✓			✓	3
Ventura County Medical Center		✓		✓	✓			3
Total	**6**	**6**	**2**	**6**	**3**	**1**	**6**	**30**

Source: UCLA analysis of designated public hospital reports.

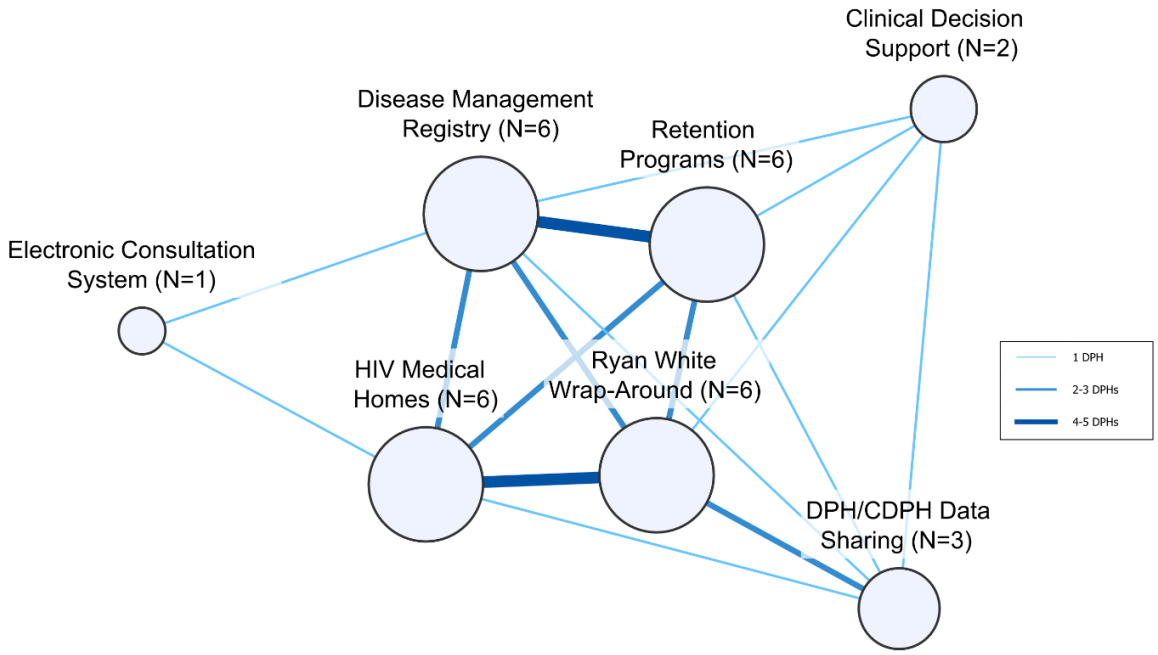
Exhibit 73: Projects Selected, by Designated Public Hospital, Category 5b

Designated Public Hospital	Group 2: Cervical Cancer Screening	Group 2: Hepatitis B Screening	Group 2: Hepatitis B Vaccination	Group 2: Hepatitis C Screening	Group 2: Syphilis Screening	Group 2: TB Screening	Group 3: Chlamydia Screening	Group 3: Gonorrhea Screening	Group 3: Influenza Vaccination	Group 3: Mental Health Screening	Group 3: Pneumococcal Vaccination	Group 3 Tobacco Counseling	Total
Alameda Health System	✓					✓			✓				3
Contra Costa Health Services			✓		✓						✓		3
Kern Medical Center				✓	✓					✓			3
Los Angeles County Department of Health Services		✓	✓									✓	3
Riverside County Regional Medical Center			✓	✓							✓		3
San Francisco General Hospital		✓		✓							✓		3
San Mateo Medical Center					✓		✓	✓					3
Santa Clara Valley Medical Center				✓			✓	✓					3
University of California, San Diego Health System						✓	✓	✓					3
Ventura County Medical Center	✓				✓				✓				3
Total	**2**	**2**	**3**	**4**	**4**	**2**	**3**	**3**	**2**	**1**	**3**	**1**	**30**

Source: UCLA analysis of designated public hospital reports.

Exhibit 74 shows which Category 5A projects were frequently selected and which projects were most frequently selected together. DPHs that implemented medical homes (six DPHs) also tended to select enhanced Ryan White wraparound services, while DPHs implementing disease management registries often also selected development of formal retention programs. Three DPHs that selected medical homes also selected disease management registry projects.

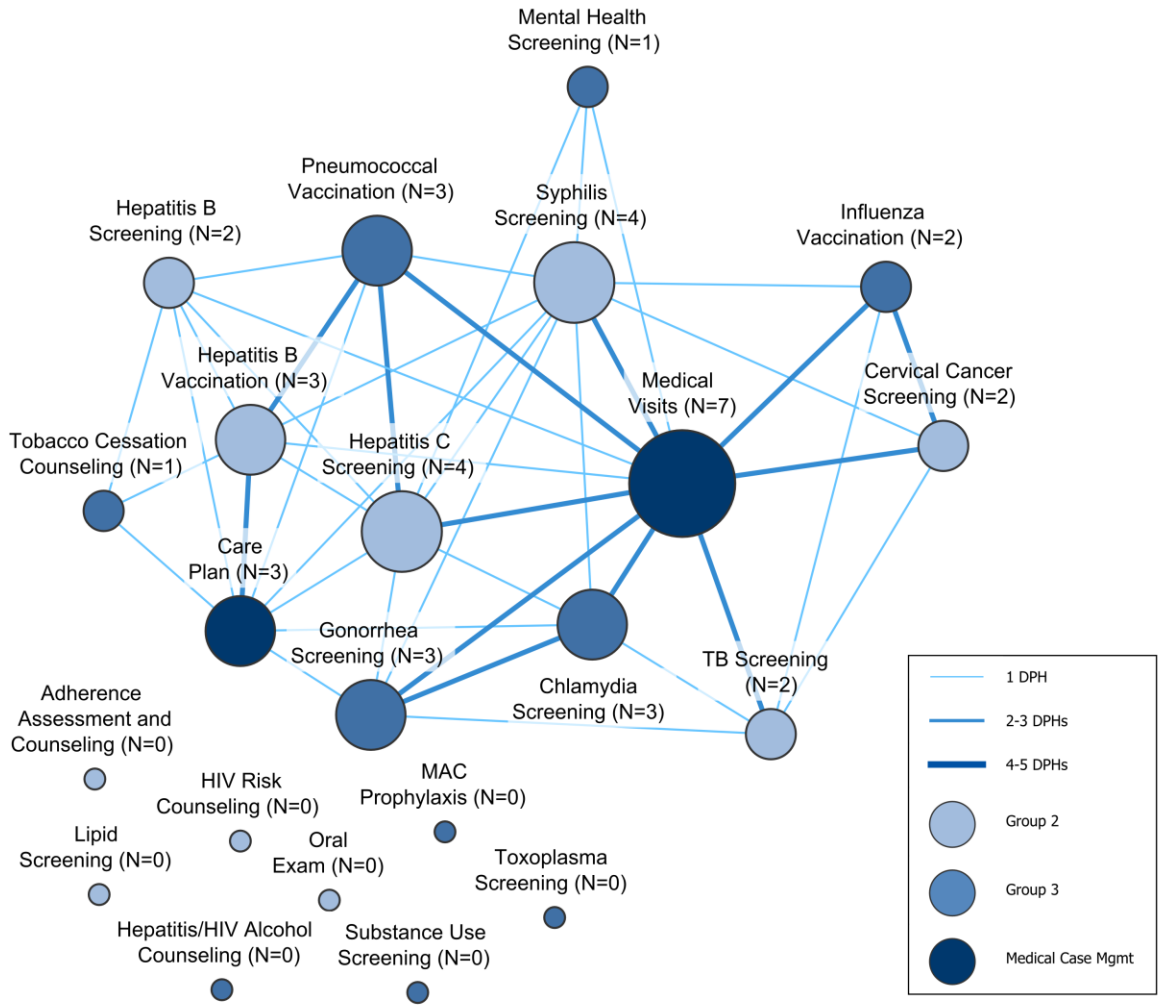
Exhibit 74: Relationship among 5A Projects



Source: UCLA analysis of designated public hospital reports.
Note: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

Exhibit 75 shows which Category 5B optional projects were frequently selected together. Seven DPHs selected medical case management of medical visits. These DPHs most frequently also selected screening of sexually transmitted infections (syphilis, hepatitis C, gonorrhea, and chlamydia) as well as pneumococcal vaccination. Several Category 5B projects were not selected by any DPHs.

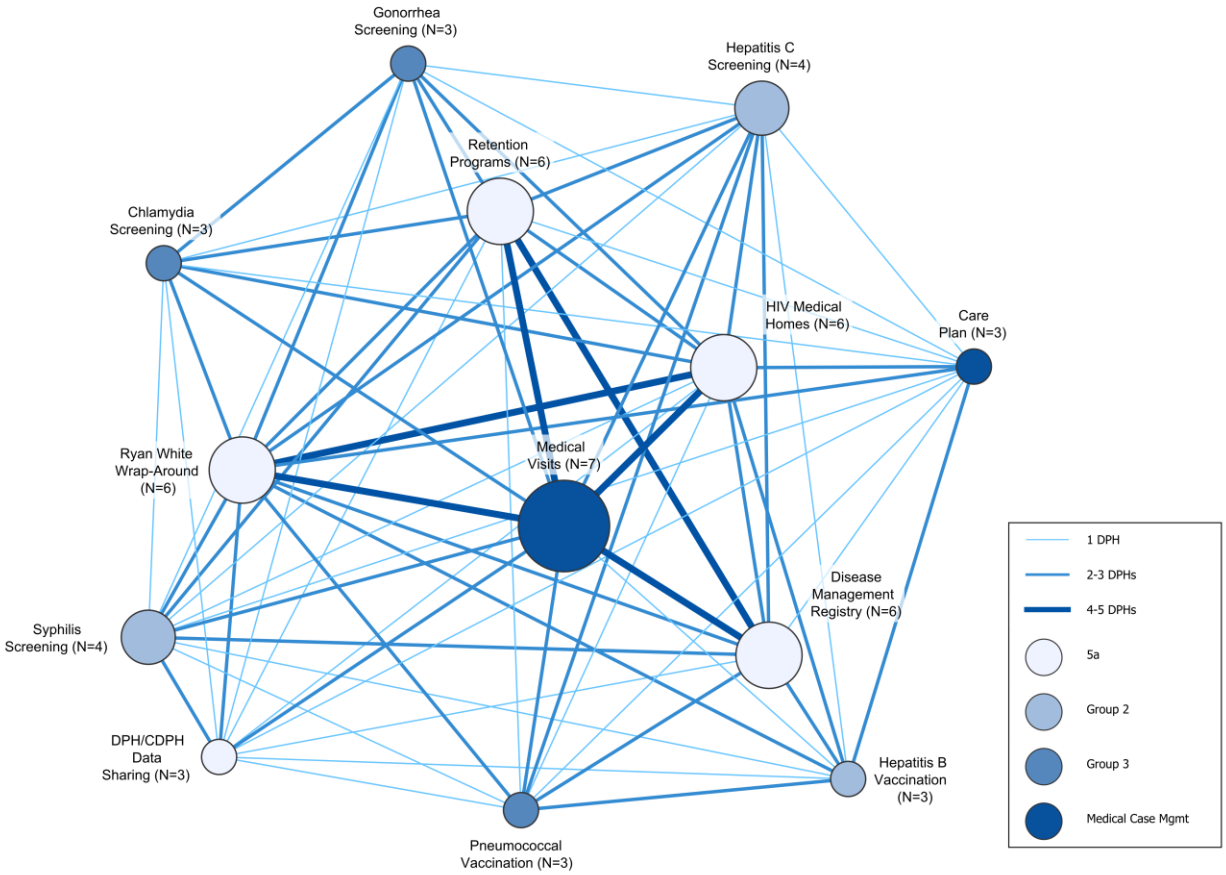
Exhibit 75: Relationship among Category 5B, Group 2 and 3 and Medical Case Management Optional Projects



Source: UCLA analysis of designated public hospital reports.
Note: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

Exhibit 76 highlights the projects that were most frequently chosen by DPHs in Categories 5A and optional 5B projects. DPHs that selected Category 5B medical case management of medical visits also selected the four most common Category 5A projects. Other patterns of selecting the remaining Category 5B Group 2 and 3 projects were not as clear.

Exhibit 76: Relationship among Selected Category 5A and 5B Optional Projects



Source: UCLA analysis of designated public hospital reports.
Note: The Ns represent the number of DPHs that implemented a specific project and larger circles correspond to more DPHs. The lines between circles represent projects that are concurrently selected by the same DPHs and thicker lines represent how many DPHs implemented the same projects concurrently.

Transition of PLWHA into LIHP

DSRIP Category 5 projects were designed to help create a smoother transition for patients transitioning from Ryan White programs into LIHP. To date, improvements in coordinated care, use of disease registries and electronic health records, and patient empanelment into HIV-specific medical homes have facilitated this transition for at-risk clients.

Rationale for Selecting Category 5 Projects

DPHs within a county operating a LIHP program were eligible to propose Category 5 HIV transition projects. During the planning process, several DPHs conducted an evaluation of patient barriers to care to determine gaps and challenges in delivering care and to inform their choice of projects. DPHs chose specific projects through a series of local stakeholder meetings

prior to the start of Category 5 to determine areas most in need of improvement. DPHs benefited from these meetings by sharing best practices, evaluating 5A project plans, participating in group training, and collaborating using educational resources. Some counties complemented stakeholder input with population surveys that assessed health care needs from a patient perspective on the choice of projects. Additionally, most DPHs selected 5A projects whose goals align with the Federal Implementation Plan of the National HIV/AIDS Strategy. Projects were also selected because they are complementary to DSRIP Category 1-4 projects, which are being implemented concurrently with Category 5.

Across DPHs participating in Category 5, projects were selected to serve important roles including: improving population health through preventative care and better use of resources, moving from a disease-focused to a patient-centered model to enhance patient experience, improving health outcomes through support services, providing more coordinated and pro-active care between clinical and public health sectors, and reducing the cost of care while strengthening infrastructure for improved quality of care and program sustainability.

DPH Implementation

To achieve the goal of supporting PLWHA in a medical home, one DPH hired a full-time pharmacist to educate patients and monitor medication adherence, while another trained all staff on the use of the AIDS Regional Information and Evaluation System (ARIES) database to ensure timely and accurate data entry. One DPH hired new staff to create a multidisciplinary care team to ensure patient retention and compliance.

Through the use of disease management registries, DPHs sought to streamline communication across providers by using EMR prompts to assure more thorough and comprehensive medical visits, create quality evaluation and improvement programs, and prevent duplication or omission of tests during medical visits.

The two DPHs that chose to implement clinical decision support tools report that they first found patients in need of retention in care services by identifying patients with outstanding labs, medications, visits, and immunizations. They then developed methods to help these patients attend medical visits and return appointments, implemented a new EMR to customize patient care and better manage the population, and identified clinical decision support tools to ensure easy transition to wraparound services.

Several DPHs that chose to develop formal patient retention services participated in shared learning to gain input from other programs and providers with expertise to develop best practices. As the transition to LIHP has created challenges for both patient and provider, another reported goal of the project was to hire retention specialists and redefine roles of

clinical staff to more effectively use the EMR system and deliver patient information to providers. A combination of more efficient use of electronic records and monitoring of patients by a retention specialist, led to increased retention in care.

The three DPHs that sought to enhance data sharing between DPHs and County Departments of Public Health reported plans to streamline data sharing through resolving chart inconsistencies across providers and linking DPH-specific EMRs to a shared system with data mapping. Data sharing with Departments of Public Health should alert DPHs to patients who have fallen behind in CD-4 and Viral Load Screening and will aid DPH retention efforts. With enhanced data sharing, DPHs expect to see a reduction in duplication and omission of important screenings, a more synchronized model of care and treatment, and an overall reduction in costs by removing barriers to coordination between DPHs and Departments of Public Health.

LADHS chose to expand its electronic consultation system between HIV primary care medical homes and specialty care providers to include three more specialties: gastroenterology, nephrology, and podiatry. LADHS plans to train providers to use an internal web-based platform to securely share health information and discuss patient care methods.

Easing the transition from Ryan White to LIHP services and ensuring access to Ryan White wraparound services post-transition were major goals of the DSRIP Category 5 programs. Several approaches were implemented across DPHs. The most common is the creation of a Memorandum of Understanding between primary providers and wraparound service providers to improve coordination and delivery of wraparound services. In order to link patients to wraparound services and retain them in care, DPHs plan to use EMRs to monitor service delivery and patient health outcomes. Those DPHs also implementing the empanelment or retention projects have assigned a staff member to monitor referrals and patient follow-through to ensure that there are no barriers in accessing wraparound services.

Patient Experiences during Transition

DPHs have reported increasing numbers of PLWHA who are accessing services through DSRIP sites. However, lacking DY 8 data on numbers of patients served at LADHS and SFGH, the two largest sites at baseline, and at ACMC and VCMC, it is not possible to quantify meaningfully the increase in numbers of patients served.

DSRIP Category 5 sites report that the improvements in 5B health outcomes demonstrate a smoother transition to LIHP, but more information is needed to measure the extent to which the transition process has improved. Upon receipt of questionnaires and completion of follow-up telephone interviews with DPHs, a comprehensive assessment of patient experience will be conducted. Transition of new patients into receiving care is discussed more fully below, where

numbers of visits and receipt of particular services are described. CG-CAHPS data are not available for this analysis. Thus, the final report will rely on DPH reports of patient satisfaction.

Outcomes of Care

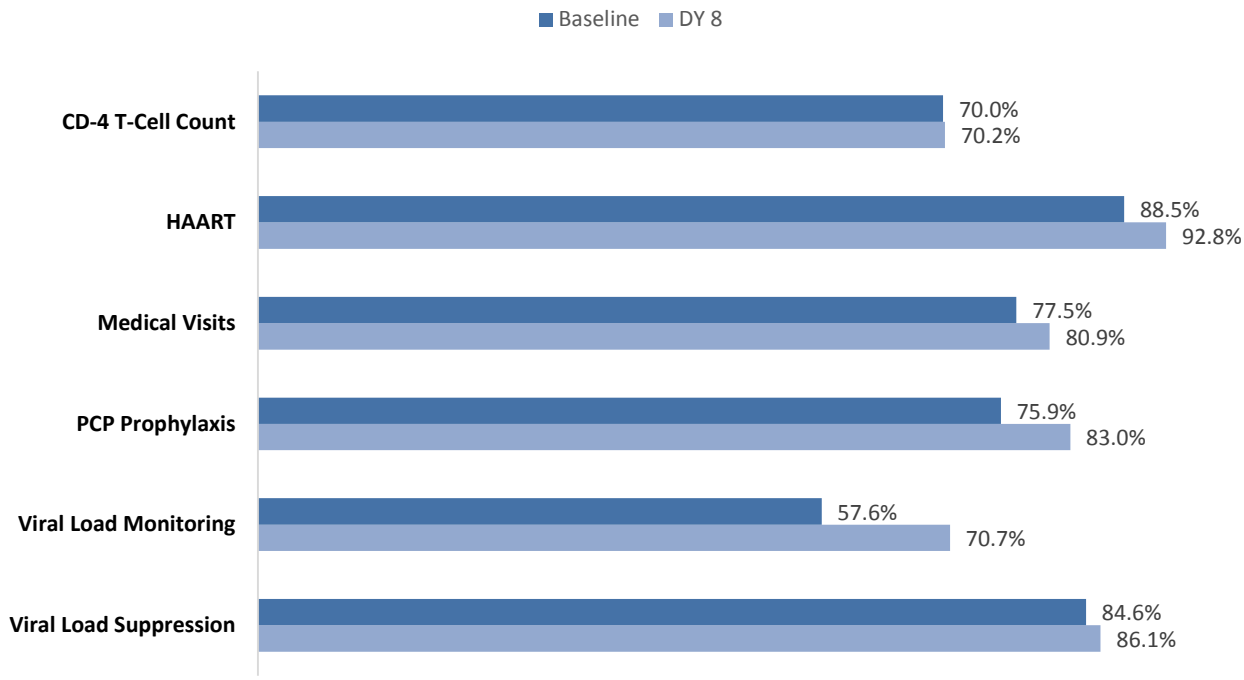
Trends in Category 5b Projects Group 1 Outcomes

This section summarizes trends in improvement in Category 5B, Group 1, outcomes between the baseline and DY 8 periods. All DPHs reported improvement in Category 5B Group 1 health outcome measures, with variation across DPHs.

Taken as a whole, the DPHs reported significant increases in four of the six required Group 1 outcomes, as shown in Exhibit 77. Across all the sites, the proportion of clients living with HIV/AIDS who had at least one medical visit in a year with a provider with prescribing privileges who received the recommended medical visits (two medical visits at least three months apart) increased from 77.5% in the baseline period to 80.9%. As shown in Exhibit 77, this increased contact with medical providers likely paved the way for improved process of care (e.g., viral load monitoring, expanded use of highly active antiretroviral therapy (HAART), and increased use of PCP prophylaxis). There were also important increases in measured health as viral load suppression grew to 86.1% of patients from a baseline value of 84.6%.

Examining outcomes for individual DPHs shows that compliance with HAART, medical visits, and PCP prophylaxis standards increased in all DPHs with the exception of one decrease for each measure (HAART in SMMC, medical visits in RCRMC, and PCP prophylaxis in UC-San Diego). CD-4 T-Cell count, viral load monitoring, and viral load suppression measures improved in half of the DPHs, but decreased in CCRMC, KMC, RCRMC, and VCMC. Two DPHs discussed reasons for a decline in outcome measures. One DPH cited the use of a disease management registry as the reason for lower measurements in DY 8. Having an updated registry changed the denominator of the patient population for that DPH, and the new measure demonstrates a percentage decrease in health outcomes but an actual increase in the number of patients receiving care. Another DPH cited the need for further analysis to determine the cause of decline in outcome measures, but believes the decline in various outcome measures is a temporary response to changes from the initial implementation of 5A projects.

Exhibit 77: 5B Group 1 Health Outcomes



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.
Note: Data is unavailable for LADHS and SFGH. Data from VCMC are available for CD-4 T-Cell Count, but unavailable for all other Group 1 health outcomes.

Anticipated Impact of Category 5A Projects on Category 5b Group 1 Outcomes

The anticipated impact of Category 5A projects on Category 5B outcomes in Group 1 are assessed from the existing literature on effective methods of improving outcomes among PLWHA. The results are presented separately for each Category 5A project.

Empanel patients in medical homes with HIV expertise. The Institute of Medicine report, *Crossing the Quality Chasm: a New Health System for the 21st Century[6]*, promoted the idea of developing medical homes for PLWHA in order to increase their engagement in care, and ultimately, to improve their health outcomes[7]. Saag[7] called the Ryan White program an "unintentional home builder" because early evidence documented that Ryan White-supported sites had more coordinated care than non-Ryan White sites.[8] Beane et al[9] describes the development, definition and implementation of medical homes within the Ryan White Program.

Since the publication of the IOM report in 2009, the published literature had continued to provide supporting evidence for a positive link between medical homes and improved health

outcomes for PLWHA. For example, Gallant et al[10] showed that rates of care and treatment adherence were best supported within a medical home framework. Hoang et al[11] showed that patients in Veterans Health Administration hospitals with integrated clinics were more likely to achieve viral suppression.

Most of the studies cited above focus on adults living with HIV/AIDS. Yehia et al[12], call particularly for future studies of children and adolescents living with HIV to determine whether providing treatment for these youth in a setting with greater conformity to the Patient-Centered Medical Home model improves clinical outcomes and yields cost savings.

Implement a disease management registry. Handford et al[13] authored a Cochrane Collaborative Review that evaluated the literature to that time and concluded that settings with case management had fewer deaths and had higher use of antiretroviral medications. Kushel et al[14] reported that case management promoted improved antiretroviral adherence and led to higher CD4+ cell counts among homeless and marginally housed PLWHA. More recently, Keller et al[15] showed that PLWHA in urban areas who attended clinics providing adherence counselling or case management were more likely to meet quality of care measures. Willis et al[16] found that patients in Washington, D.C. treated in facilities that provided medical case management programs were significantly more likely to be retained in care, but not more likely than PLWHA treated in other sites to be virally suppressed.

Build clinical decision support tools. Virga et al[17] found that a health information support system improved outcomes for PLWHA, in particular use of CD4 T cell counts and viral load suppression. Clinical support tools may be particularly valuable in preventing harmful combinations of antiretroviral drugs. In a study in the New York State AIDS Drug Assistance Program, ARV drug interaction safety alerts reduced by 77% the prescribing of non-recommended combinations of drugs among prescribers who had previously prescribed contraindicated combinations.[18] A randomized trial of a clinical decision-support system in an HIV practice led to improvements in CD4 T-cell counts as compared to a control group.[19] In a later study, Robbins[20] found that combining a clinical decision support system with community intervention reduced acute respiratory tract infections requiring treatment among a group of PLWHA in a rural setting and led to more appropriate prescribing.

Develop retention programs. Comparing six measures of retention in HIV care, Mugavero et al[21] found that in each case, greater retention in care was associated with improved viral load. Sporadic retention in HIV care was associated with a number of adverse outcomes, as compared to optimal retention. PLWHA with optimal retention after diagnosis experienced greater decreases in viral load and increases in CD4 T-cell counts than those with sporadic retention.[22] Mortality rates were also lower among PLWHA with optimal retention in care

than among persons with sporadic retention or loss to care.[22] Gardner et al[23] reported that providing patients with an opportunity to speak with an interventionist improved visit adherence, as compared with a standard of care group. Horstmann et al[24] summarize the evidence that shows that retention in care has positive effects on viral load, CD4 T-cell counts and other health outcomes.

Enhance data sharing between DPH and County Departments of Public Health. The Louisiana Public Health Information Exchange (LaPHIE) provides real-time alerts to providers about PLWHA who have not monitored their CD4 or HIV viral load (VL) in a year or more. Magnus et al[25] analyzed LaPHIE data and showed that the median time out of care was 19.4 months. Among those followed up for at least 6 months, 85% received at least one CD4 T-cell count and/or viral load test after being identified. After two years, both medical use and measures of health status improved[25].

Launch electronic consultation system. Horner et al[26] examined early findings of a system that sought to facilitate consultations between primary care and specialty care clinicians.

Self-Reported Impact of Category 5A Projects on Category 5B Group 1 Outcomes

DHPs participating in DSRIP Category 5 projects have reported a significant impact of 5A projects on 5B health outcome measures. Organizing the 5A projects into two groups facilitates the understanding of each project's effect on health outcome measures.

The first group of projects is designed to enhance interaction between patients and providers to link and retain patients in treatment and monitor their adherence. These projects include empaneling patients into medical homes, developing retention programs, and ensuring access to Ryan White wraparound services for new LIHP enrollees. DPHs report that the use of medical case managers within medical homes and clinical staff in charge of new retention programs have been able to effectively monitor patient follow-up for medical visits. As a result of an increase in medical visits, patients miss fewer appointments, complete required testing more often, and have improved access to wraparound services, all contributing to improvements in Group 1 health outcomes. This reported success is consistent with the literature review, which suggests that retention programs positively affect the number of medical visits when comparing patients enrolled in a retention program with those who are not enrolled in a retention program.

The second group of projects is designed to use data systems and clinical decision support tools to improve the comprehensiveness of services delivered in the medical visit and enhance communication and coordination across providers. These projects include the implementation of a disease management registry, enhancement of data sharing between DPHs and County

Departments of Public Health, building of clinical decision support tools, and launching electronic consultation systems between HIV primary care medical homes and specialty care providers.

One DPH trained staff on the efficient use of electronic medical records and the newly implemented DMR to improve panel management and sharing of patient data among providers. The project has been helpful in reducing duplication of testing at different sites. Two DPHs consider the use of a DMR as the most important tool for sustainability of improved health outcomes because they can monitor patient compliance and retention, and reach out to at-risk patients and those who have fallen out of care. Building clinical decision support tools and launching electronic consultation systems between HIV primary care medical homes and specialty care providers have helped reduce duplication of testing, and helped remind providers to schedule necessary yearly screenings for syphilis, chlamydia, gonorrhea, and tuberculosis (TB). Support tools have also been effective in helping providers and case managers refer patients to wraparound services, which have improved health outcomes.

Increases in preventative care and screening services have also been enhanced by Category 5A projects. The fact that more patients are being brought into and retained in care is key to improving health outcomes because it provides the opportunity for providers to initiate HAART therapy, provide routine CD-4 cell count and viral load monitoring, promote viral suppression and prescribe PCP prophylaxis for patients who require it. Across DPHs, many have chosen high improvement targets that exceed national HIV benchmarks. Improvements in outcome measures during DY 8 demonstrate DPH efforts to continue implementation of 5A projects to improve health outcomes.

Coordination of Care

Trends in Category 5B Groups 2 & 3

The DPHs reported that health outcome measures for Category 5B Group 2 have improved overall. Across the DSRIP program, all five of the measures for which there were available outcome data increased. Exhibit 78 shows that there were improvements in the proportion of women with a medical visit who received cervical cancer screening, from 42% to 70% in the two sites that targeted this outcome (ACMC and VCMC). The 70.4% rate matches the 70.8% mean reported in the National HIVQUAL data for cervical cancer screening. Screening rates for hepatitis C jumped from 36% to 66% and syphilis screening increased from an average of 63% of patients to 77% of patients. TB screening increased slightly from 89% of patients to 92% of patients. Hepatitis B screening was targeted only by LADHS and SFGH, sites for which there

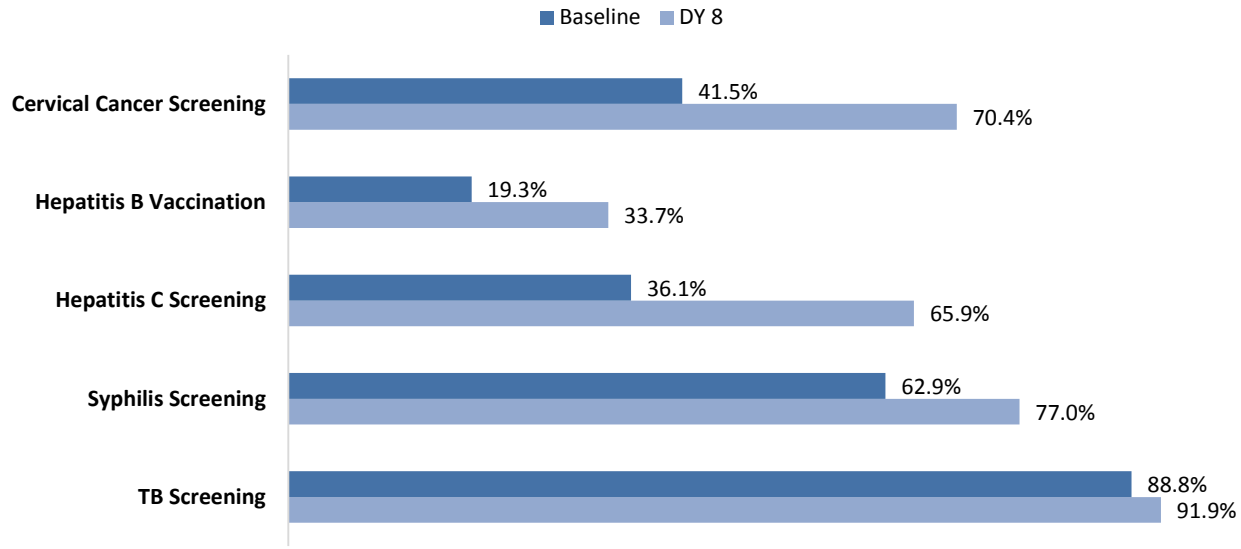
were not comparable baseline and 6 month report data. Although all five measures showed improvement, those sites that had low baseline levels showed the greatest improvement (e.g., KMC increased screening rates for syphilis from 30% of patients at baseline to of 49% of patients in DY 8), while DPHs with high initial screening rates tended to maintain their high levels.

All the Group 3 measures also showed substantial average improvements, as illustrated in Exhibit 79, suggesting better care coordination. In the three DPHs that targeted chlamydia and gonorrhea, screening rates rose from 58% to 73% of patients. KMC started with only 3% of patients screened for mental health problems, and increased that rate to 18%.

DPHs also improved vaccination rates, although there was variation across sites. CCRMC began with a high rate of vaccination for pneumonia, which was further improved, and RCRMC increased its vaccination rate from 29% of patients to 82% of patients, for an average increase in immunization rates from 47% to 82%. The proportion of patients who received a flu vaccine rose from 49% to 82% in ACMC, but fell marginally from 58% to 54% in VCMC. Overall, hepatitis B vaccination rose from 19% of patients to 34%.

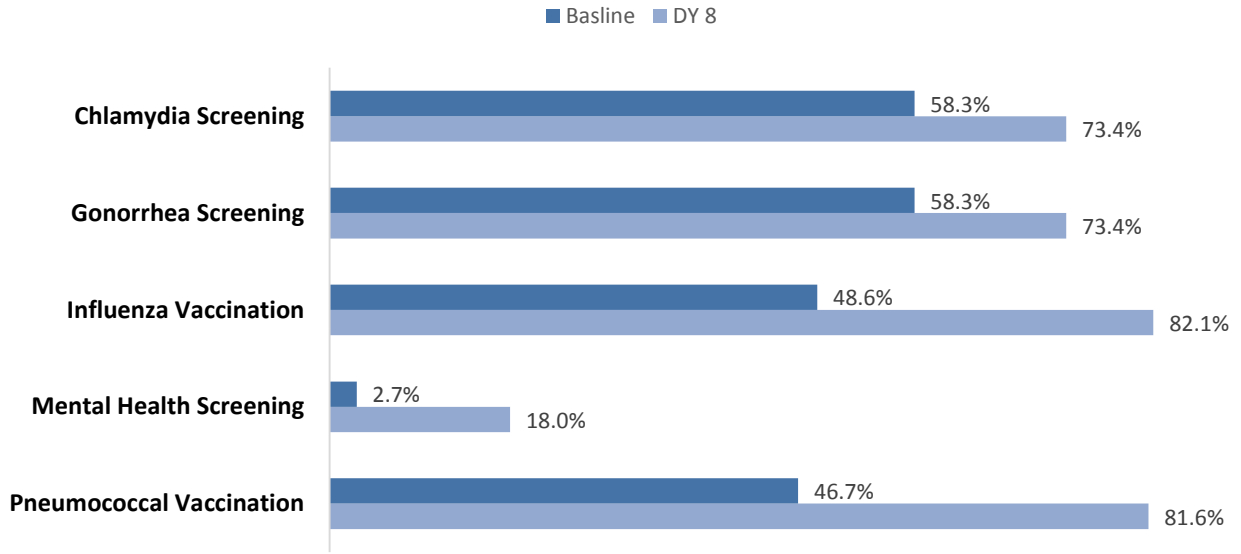
It is important to note that for many measures, only two to three DPHs have selected that measure, making it difficult to know whether improvement would occur across all DPHs for this measurement. Upon receipt of the DY 9 reports, a more comprehensive analysis of these health outcomes will be conducted.

Exhibit 78: 5B Group 2 Health Outcomes



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.
Note: Data are unavailable for LADHS, SFGH, and VCMC. Hepatitis B Screening has been omitted from this chart as only LADHS and SFGH selected this outcome, and data are unavailable.

Exhibit 79: 5B Group 3 Outcomes



Source: UCLA analysis of designated public hospital annual reports submitted to the Department of Health Care Services.
Note: Data are unavailable for LADHS, SFGH, and VCMC. LADHS is the only DPH that selected Tobacco Cessation Counseling, and as data were pulled from electronic records for baseline and a sample pool for DY 8 data, results cannot be reported at this time.

Anticipated Impact of Category 5A Projects on Category 5b Groups 2-3 Outcomes

The anticipated impact of Category 5A projects on Category 5B outcomes in Groups 2-3 are assessed from the existing literature on effective methods of improving outcomes among PLWHA. The results are presented separately for each of Category 5A project.

Empanel patients in medical homes with HIV expertise. Ryan White sites, which typically function as medical homes for PLWHA, provided better PCP prophylaxis and greater use of TB tests.[27] In a study that compared university clinics to county hospital clinics, Ramsey et al[28] found that the organization of the clinical services was more important than patient characteristics in predicting whether patients received primary care preventive services. Keller et[15] al showed that clinics that engaged in case management or were Ryan White Program funded, were more likely to provide a greater percentage of the elements in a summed quality of care measure that included retention in care, CD4 T-cell counts and viral load testing, screening of hepatitis and sexually transmitted infections, mental health and substance abuse screenings.

Implement a disease management registry. Parry et al[29] developed an electronic patient database that tracked patients across a metropolitan community of 150,000 inhabitants. Following the introduction of this registry, medication adherence rose from 82% to 100%, immunization rates rose from a mean of 72% to a mean of 87%, perinatal HIV transmission rates fell from 31% to 4% and emergency department use decreased. An algorithm that queried hospital databases nightly generated patient-specific electronic alerts about missed appointments and virologic failure and toxicity. Alerts were posted on the electronic medical records and providers' EMR home pages. The patients assigned to interactive alerts had improved CD4 T-cell counts and were more likely to have optimal follow-up medical appointments than a control group[19]. The two groups did not differ significantly in toxicity or confirmed virologic failure[19].

Build clinical decision support tools. Rudd et al[30], developed an integrating clinical decision support tool that increased both HIV and chlamydia screening. Nader et al[31] implemented a clinical decision support tool designed to elicit symptoms among PLWHA at the VA. There was a trend among the small number of patients receiving the decision support tool to report that their providers were very aware of their symptoms, but there was no significant difference in numbers of symptoms charted. In addition to improving CD4 T-cell counts and viral load suppression, Virga's[17] web-based health information support system increased syphilis screening from 66.5% of cases to 93.8% and also improved the prescription of PCP for patients with CD4 T-cell counts under 200.

Self-Reported Impact of Category 5A Projects on Category 5B Groups 2-3 Outcomes

Similar to the impact of 5A projects on 5B Group 1 measures, the DPH reports suggest that the two groupings of 5A projects have significantly impacted Group 2 and Group 3 health outcome measures. DPHs report that for Group 2 and 3 health outcomes, the combination of a disease management registry and retention programs have created significant improvements in health outcomes because medical home staff can efficiently and effectively track patients who have missed appointments or who have gone longer than a year without testing. Empanelment and data sharing have improved coordination of care between primary care providers, specialists, and wraparound services, leading to better access to and quality of care for clients.

Patient Retention and Compliance

Anticipated Impact of Category 5A Projects on Retention and Compliance

In a review of the literature on the HIV care cascade, Gardner et al[23] conclude that there is clear evidence that individuals incompletely engaged in care "account for the largest proportion of HIV-infected individuals with detectable viremia." Therefore, they conclude, it is important to improve engagement and retention in care. A number of recent studies have demonstrated the challenges in retaining patients in care over time. Rowan et al[32] examined retention in care using mandated laboratory reporting databases for CD4 lymphocyte counts and HIV-1 RNA levels for PLWHA seen at two large HIV care centers in the Denver metropolitan area from 2005 to 2009. By 18 months after HIV diagnosis, 84% of the cohort had linked to care, 73% were retained in care, 49% were prescribed antiretroviral therapy, and 36% were virally suppressed. By five years after HIV diagnosis, 55% of the cohort were retained in care, 37% were virally suppressed, 15% had moved out of state, and 3% were deceased. The sections below summarize the ability of a variety of interventions available in Category 5A to increase retention in care.

Empanel patients in medical homes with HIV expertise. Soto et al[33] review the literature and show a positive relationship between integrated HIV care and engagement and retention in care. Improved case management and a close relationship with a medical provider such as that provided in a medical home have been found to be key to engagement in HIV care in a variety of settings.[34-36] Waldorp-Valverde[37] found that PLWHA who had more positive relationships with their providers, such as those found in medical homes, were more likely to remain engaged in care.

Implement a disease management registry. A brief case management intervention increased the percentage of recently diagnosed HIV-infected persons who were linked to care within six months of initial diagnosis from 60% to 78%, compared to passive referral.[38] Willis et al[16] found that patients in Washington, D.C. treated in facilities that provided medical case

management programs were significantly more likely to be retained in care, but not more likely than PLWHA treated in other sites to be virally suppressed.

Build clinical decision support tools. Virga et al[17] found that a health information support system improved outcomes for PLWHA, in particular CD4 T cell counts and viral load suppression. Zuniga[39] has developed a guideline-consistent clinical management algorithm to promote entry into and retention in care.

Develop retention programs. Horstmann et al[24] review the literature on the effectiveness of patient navigators and case management in promoting retention of HIV-infected patients in care. In addition, they summarize the evidence that documents the positive effects on health outcomes of being retained in care.

Enhance data sharing between DPH and County Departments of Public Health. Increasingly, public health data systems that track CD4 and viral load laboratory tests are being used to examine visit frequency and retention in care as Torian et al[40] have done in New York City and Rowan[32] has done in Denver. Data shared by public health agencies and providers can also be used to reengage PLWHA who have fallen out of care. Herwehe et al[41] informed providers about their patients who have fallen out of care, based on lack of recent records in laboratory surveillance files. Seventy-six percent of the identified patients were aware of their HIV status, but had not had a medical visit for over 12 months (median = 20 months). Eighty-two percent of these patients did receive at least one CD4 count during the next 18 months, and 62% had at least one visit with an HIV specialist. The Louisiana Public Health Information Exchange (LaPHIE) provides real-time alerts to providers about PLWHA who have not monitored their CD4 or HIV viral load (VL) in a year or more. This program led to increased engagement, re-engagement and retention of out-of-care PLWHA who had been out of care for a median of 19.4 months. Of those followed up for at least 6 months, 85% received at least one CD4 and/or VL after being identified. After two years, both medical use and measures of health status improved.[25]

Self-Reported Trends in Impact of Category 5A Projects on Retention and Compliance

DPHs have reported the success of all 5A projects in improving patient retention and compliance. Based on qualitative data provided in DPH annual reports, the three projects that stand out as having the largest impact on patient retention and compliance include the empanelment of patients into medical homes with HIV expertise, implementation of a disease management registry, and development of retention programs. These projects were the most successful because DPHs have been able to improve compliance and retention by sending out appointment reminders to patients, reaching out to and linking lost-to-care and at-risk patients

into a medical home, following-up on appointments, issuing referrals for wraparound services, and creating a sense of community and trust between patient and provider.

Challenges and Lessons Learned

DHPs stressed the successful implementation of 5A projects in helping to reach performance improvement targets in their reports. However, DPHs encountered obstacles for both 5A projects and 5B measures that have made it difficult for them to achieve their targets. Challenges related to timing, staff training, physician compliance, retaining patients in care, and sustainability after DSRIP funding has ended were consistent across DPHS.

Category 5A Project Challenges

Empanel Patients into Medical Homes with HIV Expertise. Across the six DPHs who selected this program, challenges encountered in empanelling patients into medical homes include inconsistencies in continuity of care, establishing new staffing models and treatment protocols, and accurately and consistently utilizing new data systems. Two DPHs discussed difficulty in re-identifying and linking patients previously lost to care. Additionally, DPHs report difficulty in establishing strong relationships between patients and providers in a short time setting, and DPHs report the need for patient trust for retention and adherence. Consistent with challenges reported across 5A projects is the identification and facilitation of linkage to wraparound services for LIHP enrollees who have been newly empanelled in a medical home.

Implement a Disease Management Registry module suitable for managing patients diagnosed with HIV. The two main challenges reported across the six DPHs who implemented this project are the training of staff and timely updating of the disease management registry. Two DPHs did not previously use an HIV-specific disease management registry and have had to identify and launch a new system in addition to training staff for technical competency. One DPH reports difficulty in finding a panel manager to oversee use of the registry, and there have been reports of staff confusion over use of new electronic systems. Another DPH chose to merge existing data systems and encountered problems with chart inconsistencies and inaccurate reporting between systems. Fortunately, many of these challenges are specific to the initial implementation of the system, and DPHs are confident that technical difficulties will be resolved in DY 9.

Build clinical decision support tools to allow for more effective management of patients diagnosed with HIV. Two DPHs implemented this project and to date have reported relatively few challenges. CCRMC discussed the need to standardize appropriate "alerts" for long-term

success of the project as there has been some confusion over the newly implemented strategies. Overall, the main challenge of this project has been the cost of training staff on the new protocol, which CCRMC has met through the expansion of ancillary staff roles to assist primary care providers.

Develop Retention Programs for patients diagnosed with HIV who inconsistently access care. Based on qualitative data from DPH reports, the retention program has been the most successful in the overall improvement of care coordination, care quality, and health outcomes for the six DPHs who selected this project. The main challenge reported is the sustainability of the program after DSRIP funding has ended. From a clinical standpoint, providers encountered initial problems in locating patients who had fallen out of care and developing protocols for patient follow-up and appointment reminders. Again, as protocols have been established to identify and retain patients into care, DPHs are identifying structural methods to sustain this project beyond DSRIP. The majority of the remaining challenges stem from patient barriers to care and are discussed in the 5B challenges section.

Enhance Data Sharing between DPHs and County Departments of Public Health. DPHs that implemented enhanced data sharing encountered fewer challenges than some of the larger projects. VCMC discussed obstacles in accurately sharing data due to patients accessing care in unpredictable patterns and frequency. Inconsistency in medical visits has made it difficult for providers to coordinate care, and VCMC reports problems with duplication and omission of services due to inaccurate or lack of patient information.

Launch Electronic Consultation System between HIV Primary Care Medical Homes and Specialty Care Providers. LADHS is the only DPH that selected this project. Prior to DSRIP Category 5, LADHS had already implemented an electronic consultation system for selected specialists, and chose to expand the system to include a wider selection of specialists. LADHS serves a very large population and in expanding the electronic consultation system found a series of workflow issues. These include a lack of efficient and effective processes for triage and referral tracking, long wait times for specialty care, and failure to conduct appropriate testing prior to specialty visits. LADHS has reported a thorough evaluation of these workflow issues and plans to address all of them in DY 9.

Ensure access to Ryan White wraparound services for new LIHP enrollees. Six DPHs selected this project to minimize the disruption of moving patients from Ryan White to LIHP. The biggest challenge reported for this project is the coordination of care between primary care providers, specialists, and wraparound service providers. Most of the DPHs who selected this project also implemented projects related to data systems and information sharing across providers, and have encountered problems with accurately and efficiently utilizing patient data to link patients

to other services. Additionally, DPHs report challenges in monitoring patient compliance with treatment received from wraparound service providers, making it difficult for providers to coordinate care.

Category 5B Measurement Challenges

Regarding 5B health outcomes, DPHs have reported difficulty in measuring real improvements during DY 8. However, all DPHs implementing Category 5 projects hope to demonstrate significant improvement in all 5B measures by either meeting or exceeding the targets set for DY 9. The most frequently reported challenge for improving 5B health outcomes is the series of obstacles encountered in removing patient barriers to care. These include issues of transportation to medical visits, homelessness, psychological problems and social factors that prevent or deter patients from seeking care, co-infections, and patient adherence to treatment plans.

From the provider perspective, a commonly reported challenge is the inconsistency of patient information being updated in the EMR system. When providers do not update problem and medication lists, patients are at an increased risk of missing a follow-up appointment or failing to complete required screenings. Concurrent with this problem is the issue of manual data entry in many DMRs, which makes it difficult to access patient data in a timely manner. This challenge further complicates patient retention because it is difficult to monitor patients so that they can be reminded of upcoming appointments. Additionally, slow data entry complicates coordination of care between primary care providers and specialists.

A few DPHs reported challenges due to problems of capacity and funding. One DPH discussed problems with long wait times and inconvenient location of labs that discourage patient follow-through. Another DPH has encountered patient loads that exceed assignment caps during the LIHP enrollment period, and is attempting to find a solution to retain patients in care while mitigating provider overload. As with difficulties in consistently updating patient information in the EMR system, large counties require more staff and funding for uptake and maintenance of the entire HIV population. Moreover, in large counties, patients are sometimes diagnosed outside the primary care provider setting or receive screenings and vaccinations at locations whose EMR system is not linked to the DPH.

How Challenges Were Met

To date, DPHs have reported success in addressing the initial obstacles met in the implementation of 5A projects. Through a series of stakeholder meetings, DPH-specific needs assessments, and evaluation of problems in the patient population, DPHs identified areas for improvement. At the time of the October 2013 annual reports, DPHs reported success in achieving all project milestones. These milestones have included training current staff and

hiring additional staff to create multidisciplinary care teams for successful implementation of empanelment and retention programs, identifying and launching electronic data sharing methods, and consistently evaluating and improving 5A projects through shared learning. Upon receipt of DY 9 annual reports, DPH questionnaires and follow-up information from telephone interviews, a more complete analysis of DPH methods to overcome obstacles will be conducted.

Lessons Learned

During the planning and implementation of 5A projects, DPHs discussed many helpful lessons learned that will improve health care for PLWHA during and after DSRIP Category 5. Increased communication and coordination across providers is one of the most important factors in improving care. Many DPHs refer to the "silos" of care prior to implementation of Category 5 projects that created poor care coordination and data accuracy. When providers can quickly and accurately share patient information, DPHs report that both compliance and retention improve among the patient population. Six DPHs chose to implement the medical home empanelment and retention program projects, and all reported that the use of active follow-up, formal protocol-setting, and continuity through standardization of care has increased medical visits and improved overall patient health. One DPH implemented a project through which primary care providers ran a "learn and lead" program to educate clinical staff and demonstrate best practices for quality care. The use of oversight and accountability has also helped this DPH achieve success by creating a team-based staffing model.

Lessons learned in the improvement of 5B health outcomes relate to data sharing across providers and coordination of care. Accurate and updated patient information in the EMR and DMR helps DPHs track and reach clinical goals by improving provider communication and patient retention. Up-to-date data systems help clinicians follow-up with patients and increase the number of screenings and data monitoring activities necessary to provide consistent, high-quality care. For example, one DPH reports that through consistent, timely updates of ARIES, it has been able to identify patient viral loads earlier and track medication adherence to improve this health outcome. Shared learning through stakeholder meetings has also helped DPHs solve technical problems associated with DMRs, which has helped maintain successful use of data systems.

Future Analyses

The findings in this report were limited by unavailability of DY 9 reports and LIHP data. The final evaluation report will include analyses using these data sources. To the degree possible, the final report will also include:

- Analyses of Category 5B outcomes by the end of the implementation period to determine trends.
- Assessment of Category 5B health outcomes against DY 9 targets set by individual DPHs.
- Analyses of LIHP data to determine differences in Category 5B health outcomes between participating and non-participating DPHs as well as non-DSRIP hospitals.
- Analyses of survey and interview data to assess DPH evaluations of the impact of Category 5A interventions on 5B outcomes in terms of cost, quality of care, and patient health outcomes; DPH plans for continuing Category 5 projects; implementation challenges; and the patient experience in the transition from Ryan White to LIHP.

Summary

Category 5 interventions were designed to improve the delivery of services to PLWHA and facilitate the transition from Ryan White to LIHP. The analyses of available data in this interim report indicate that the DPHs were successful in implementing Category 5 projects.

Many of these interventions were intended to enhance interaction between patients and providers and to link and retain patients in treatment and monitor their adherence. DPHs reported selecting Category 5A projects that aligned with the Federal Implementation Plan of the National HIV/AIDS Strategy. Projects were also selected because they were complementary to DSRIP Category 1-4 projects. DPHs reported significant increases in four of the six required Category 5B Group 1 outcomes. In their semiannual reports, DPHs reported that empanelment of patients into medical homes with HIV expertise, implementation of a Disease Management Registry, and development of Retention Programs were the three interventions with the greatest impact on retention.

The DPHs also reported significant increases in preventive care. All five available Category 5B outcome measures showed significant increases. All the Group 3 measures also showed substantial average improvement.

DPHs faced many challenges, including short timelines, the need for staff training, physician compliance and timeliness of inputting patient information in the EMR system. The most frequently reported challenge was removing patient barriers to retention in care. DPHs also had concerns about sustainability of 5A programs after DSRIP funding has ended. Despite the challenges, the DPHs reported widespread success in implementing the interventions and improving patient outcomes.

Overall Impact of DSRIP and DPH Recommendations for Future

DSRIP Impact on DPHs

DPHs reported on the overall impact of DSRIP Categories 1 to 4 on their organizations during key informant interviews. Examples of this impact are summarized below.

Systematic and major change, investment in the future of DPHs

DPHs reported that DSRIP provided an opportunity to expand and accelerate existing projects, invest in additional projects, and innovate. DSRIP projects were used to initiate more deliberate and comprehensive changes in care delivery and culture, incorporate new methodologies such as LEAN, and focus on specific outcomes and benchmarks. DSRIP improved the focus of DPHs on population health, primary and patient-centered care, and integrated care delivery, which prepared DPHs to thrive in the post-reform era. DSRIP helped create common goals and performance across each organization. The specific and non-negotiable nature of DSRIP measures helped DPHs to stay on target and perform consistently with an impetus to complete projects despite difficulties. Many DSRIP projects were well integrated into the day-to-day activities of DPHs rather than being viewed as temporary projects that were imposed from above, helping to fundamentally transform care.

Transformation of operations and information technology

DSRIP data collection requirements were a major catalyst for implementation of electronic health records and improved data collection and reporting capabilities. DPHs reported creating new infrastructure such as EMRs, analytic teams, measurement strategies, and better management systems. DSRIP projects led to the breaking down of silos between different departments, improved collaboration, and a more multi-disciplinary approach to quality improvement. One DPH reported implementing a Category 4 DSRIP project in a population group not targeted by DSRIP, an indication that the program's influence exceeded its initial scope.

Resources and financial incentives

DPHs reported that the funding provided by DSRIP helped provide a sound business case for implementing the projects and changing care delivery. The newly available resources improved provider buy-in, aligned goals and increased focus on specific targets, filled gaps left by the loss

of other revenues that supported such activities, and allowed DPHs to negotiate with boards of directors for more resources.

Collaboration between DPHs and innovations

DSRIP provided the impetus for collaboration between DPHs, including the sharing of forms, methodology, and innovations. Some DPHs found the ability to sound off on ideas and share lessons learned in real time particularly useful.

Examples of innovations included creating a learning collaborative in the organization, having a single person in the organization who is accountable for the success of DSRIP overall, and using healthcare navigators to reduce the burden of activities on higher level staff.

DPH Recommendations for DSRIP II

DPHs were asked to provide their recommendations for renewal of DSRIP under the next Medicaid Section 1115 Waiver. These recommendations are summarized below.

Alignment with other initiatives and organizational goals

DPHs emphasized the importance of aligning DSRIP measures with other publicly reported goals or CMS initiatives such as meaningful use of EHRs. Also, projects should aim to build systems for delivery of high quality care. DPHs highlighted differences between organizational missions of county-based DPHs and academic DPHs and asked that goals align with the type of organization.

Preparing DPHs for the future

DPHs highlighted the potential of DSRIP to prepare DPHs for the challenges brought about by the ACA. One DPH suggested that there should be more focus on dealing with costs and questioned the assumption that models such as the patient-centered medical home would lead to cost control due to lack of sufficient evidence. Other DPHs proposed adopting risk-based arrangements and involving the payers in these arrangements, moving towards more ACO-type projects. DPHs also desired more innovative projects to promote telephone and electronic access.

Narrower focus and fewer projects

DPHs suggested a reduction in the number of different projects and milestones. The difficulties presented with many projects included identifying champions for so many overlapping projects, inability to focus on multiple projects simultaneously, lack of sustainability of plans and focus, and high demand for personnel and resources to implement projects and report results. Two

DPHs said Category 3 should have fewer measures and that they should be organized as strongly correlated plans linked to a greater goal.

Clear metrics with clear instructions and direction

DPHs commented on the difficulties posed by lack of clarity in the definition of measures as well as changes in measurement over time. DPHs suggested developing clear and detailed measures, including instructions on how measures should be calculated and reported. For example, concepts such as the patient-centered medical home should be more specifically described and measured. Consistency in reporting requirements across years is not currently possible and would be beneficial to allow for comparisons. DPHs also reported that frequent changes in definitions have a detrimental impact on the progress of the staff members who are focused on a given goal. They suggested that measurement remains consistent across DPHs allows for comparisons system-wide. It is important to decide on numerators and denominators at the beginning and agree on standards before projects start.

DPHs requested more time to provide input into the development and planning of the next DSRIP than was provided in the first round. They expressed a need for more support and explanation of milestones from DHCS, and better framework in preparation of the annual and semi-annual reports. DPHs also suggested fostering more information sharing through available webinars on measurement strategies and in-person meetings to build stronger connections among DPHs and move towards local collaboratives to promote community-centered care.

Reevaluate the relevance of measures

DPHs made additional comments on the selection of measures and methodology in DSRIP. These comments included reexamining the use of baseline milestones created in earlier years, which may be outdated and no longer relevant, and examining the science behind some projects to provide supporting evidence that a specific project will lead to desired outcomes.

Flexibility versus standardization

DPHs highlighted the importance of maintaining flexibility to insure that DSRIP projects and measures can be tailored to fit each DPH's organizational goals, strategic direction, culture, and regional context. Flexibility would allow DPHs to focus on areas that are the most important to their patients or focus on projects that can be achieved within their resource or other limitations.

At the same time, DPHs recommended more standardization, particularly in Categories 3 and 4, to have specific and consistent measurement protocols and procedures that would allow for comparisons across DPHs and improve the ability of DPHs to exchange ideas and lessons

learned to achieve the best possible outcomes. DPHs highlighted the importance of maintaining focus on the same measures in DSRIP regardless of changes in leadership at CMS.

Assessing performance level

DPHs commented on the difficulties of improving on milestones when organizations started DSRIP at a high performance level or significantly improved outcomes in the first year. DPHs suggested that the baseline performance improvement levels be considered in developing milestones and that there should be flexibility in selecting projects that accounts for significant room for growth.

Better measurement of time and effort required to complete projects

DPHs proposed better assessment of the level of effort required to complete DSRIP projects. DPHs reported that the level of effort required to complete DSRIP projects was high and was not fully captured in milestones and in current reports.

Timely feedback and direct communication lines

DPHs suggested improving the direct communication lines with CMS to make sure information does not get lost or interpreted differently than intended. DPHs also suggested more timely feedback and updates from CMS.

Appendix 1 (Category 3)

Measure Definitions

Metric	Definition
Patient/Care Giver (CG) Experience	Each CG CAHPS theme includes a standard set of questions. The following CG CAHPS' themes will be reported on: a. Getting Timely Appointments, Care, and Information b. How Well Doctors Communicate With Patients c. Helpful, Courteous, and Respectful Office Staff d. Patients' Rating of the Doctor e. Shared Decision making
Diabetes, short-term complications	**Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Uncontrolled Diabetes	**Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Congestive Heart Failure	**Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for CHF within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 years and older who have visited the DPH system primary care clinic(s) two or more times in the past

	12 months
Chronic Obstructive Pulmonary Disease	**Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for COPD within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 years and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Mammography Screening for Breast Cancer	**Numerator:** All female patients age 50 – 74 years who had a mammogram to screen for breast cancer within 24 months who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Influenza Immunization	**Numerator:** All patients age 50 and older who received an influenza immunization during the flu season (September through February) who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Child Weight Screening	**Numerator:** All patients age 2 – 18 years with a calculated BMI documented in the medical record within the demonstration year reporting period. **Denominator:** Number of patients age 2 – 18 years who have visited the DPH system primary care clinic(s) within the current demonstration year.
Pediatrics Body Mass Index (BMI)	**Numerator:** All patients age 2 – 18 years with a BMI above the 85th percentile within the demonstration year reporting period **Denominator:** Number of patients age 2 – 18 years who have visited the

	DPH system primary care clinic(s) two or more times in the current demonstration year with a BMI recorded.
Tobacco Cessation	**Numerator:** Number of patients 18 years and older who screened positive for tobacco use and who received or were referred to cessation counseling within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients 18 years and older who screened positive for tobacco use who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl)	**Numerator:** All patients age 18 – 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Diabetes Mellitus: Hemoglobin A1c Control (<8%)	**Numerator:** All patients age 18 – 75 years with diabetes whose most recent hemoglobin A1c level is in control (<8%) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
30-Day Congestive Heart Failure Readmission Rate	**Numerator:** All patients age 18 years and older who experience a readmission with a ICD-9-CM principal diagnosis for CHF or related conditions (within 30 days of discharge for an index l admission with ICD-9-CM principal diagnosis code for CHF) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 years and older with CHF who

	have visited the DPH system primary care clinic(s) two or more times in the past 12 months and had an admission
Hypertension (HTN): Blood Pressure Control (<140/90 mmHg)	**Numerator:** Number of patients age 18 – 75 years with a diagnosis of hypertension with the most recent blood pressure level (in clinic or with ambulatory blood pressure monitoring) in control (less than 140/90 mmHg) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 18 – 75 years with a diagnosis of hypertension who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Pediatrics Asthma Care	**Numerator:** Number of patients age 5 – 18 with persistent asthma who were prescribed at least one controller medication for asthma therapy within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients age 5 – 18 with persistent asthma who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
Optimal Diabetes Care Composite (Minnesota Community Measurement as adopted by the National Quality Forum)	**Numerator:** Number of patients ages 18 – 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months **Denominator:** Number of patients ages 18 – 75 with a diagnosis of diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

Appendix 2 (Category 4)

Selection of Comparison Hospitals

Data

OSHPD public use patient discharge data for 2009-2011 was used for this analysis. The data has a separate record for each discharge. Each discharge includes the hospital at which the patient was treated; basic demographic characteristics of the patient such as age, sex, or race/ethnicity; where the patient came from; primary and secondary diagnoses and whether each diagnosis was present upon admission; procedure codes and when each procedure was performed relative to admission; length of stay; and the severity of the case. The diagnosis and procedure codes are both based on ICD-9-CM codes. For the final report, we will expand this data set to include 2012 and 2013, the post-project period, and will use the non-public data that will allow implementation of more precise risk adjustment (discussed further below).

Sample

The analysis sample includes all short-term general hospitals that provided OSHPD discharge data. The sample is divided into three categories: DPHs further divided into hospitals participating (for those projects adopted by some hospitals) and not participating, a sample of 22 hospitals closely matched to the DSRIP hospitals on the basis of size, case mix, and other variables (matched), and the balance of short term general hospitals in the state (other hospitals).

Two DPH facilities and other hospitals were excluded from the analysis. Two DPH rehabilitation hospitals (Alameda – Fairmont and Los Amigos) were excluded. Ventura – Santa Paula was excluded because they indicated that they did not participate in Category 4. Children's hospitals were excluded, as were hospitals that closed or that had their license suspended were excluded at any point in the period under study.

Matching was done on the basis of trauma, emergency services, case mix, non-pediatric bed size, relative size of ICU units, and the outpatient volume relative to inpatient care in the following way. The EMSA trauma levels were grouped into I and II vs. III and IV although no DPHs fall into the latter category. "Comprehensive" and "basic" emergency department levels were combined.

The remaining pool of hospitals was compared to each DPH by exact matching on the following:

- License category (all DSRIP hospitals are general acute care)
- Principal service type (all DSRIP hospitals are general medical/surgical)
- EMSA trauma center designation (Level I/Level II vs. Level III/Level IV vs. None)
- Licensed emergency department level at the end of the year (Comprehensive/Basic vs. Standby/None)

The next step was to calculate Gower's distance between each DSRIP hospital and its pool of potential comparison hospitals based on:

- Case mix
- Ratio of ICU to General Acute Care beds
- Number of non-pediatric beds
- OP volume to inpatient visits (total outpatient visits is the sum of ER, clinical, and referred outpatient visits, not the OSHPD definition that includes home health visits)

In the case of UCSD – La Jolla and UCSF – Mt. Zion, several variables were missing and the distance was calculated based on available variables.

After defining the eligible pool of possible comparison hospitals for each DPH, the pool was sorted by the Gower's distance and took closest match (if one even existed) for each DPH, cycling through the DPHs in a random order. The selected comparison hospital was then removed from all of the pools so it could not be matched again to any other DPHs. Because the DPHs have most of the academic medical centers in the state, the group of matched hospitals was augmented with any non-DSRIP academic medical center not included in the initial matching process. The map of DPHs and matched hospitals is presented in Exhibit 61.

Category 4 Measures

Measure Construction

The measures being calculated by DPHs are constructed from medical record data that includes clinical information to define the measure or the sample and cannot for the most part be replicated from discharge data sets. UCLA conducted a literature search for measures similar to DSRIP and constructed new measures when others were not found. AHRQ patient safety indicator measure set (measures for: CLABSI, PSI 7; pressure ulcers, PSI 3; venous thromboembolism, PSI 12) was used when possible. Two different measures were constructed for Surgical Site Infections (SSI) and one measure was constructed for other conditions. Definitions for each measure are presented in Exhibit 80 .

Exhibit 80: List of Outcome Measures Constructed from OSHPD Data

1. Severe Sepsis Detection and Management
Denominator: All patients with a severe sepsis diagnosis defined by ICD-9 diagnosis codes: 995.92 or 785.52 that did not have that particular diagnosis upon admission. Any patients with a do not resuscitate status (DNR= "Y"), elect for palliative care within the first 24 hours of admission (ICD-9 diagnoses codes: V49.86, V66.7), or any patient who refuses care (ICD-9 diagnosis code: V62.6) are excluded.
Numerator: Any patient in the denominator that dies during their hospital stay.

2. Central Line-Associated Bloodstream Infection (CLABSI) Prevention: AHRQ PSI # 07.

3. Surgical Site Infection (SSI) Prevention: Two measures, one using a 30 day and one a 90 day surveillance period.
Denominator: The National Healthcare Safety Network (NHSN) surgical procedures list in *Surgical Site Infection (SSI) Event* (2014).
Numerator: Patients with postoperative infection (ICD-9 diagnosis code: 998.59) not present on admission.

4. Hospital-Acquired Pressure Ulcer (HAPU) Prevention: AHRQ PSI # 03.

5. Stroke Management
Denominator: Patients with acute stroke diagnosis (ICD-9 diagnosis codes: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 436) not present on admission.
Numerator: Number of deaths, of patients with acute stroke diagnosis.

6. Venous Thromboembolism (VTE) Prevention and Treatment: AHRQ PSI # 12.

7. Falls with Injury Prevention
Denominator: The sum of days that all patients have stayed in a hospital based on the length of stay variable.
Numerator: All patients that have sustained an injury due to a fall during their stay at a hospital (ICD-9 codes: E88.00, E88.01, E88.09, E88.10, E88.11, E88.2, E88.31, E88.32, E88.39-E88.46, E88.49-E88.54, E88.59, E88.60, E88.80, E88.81, E88.88, E88.89, E91.6, E91.77, E91.78, E92.93).

The data available for analysis from the OSHPD are substantially more limited than that used by DPHs. The measures available do not capture the rate of compliance towards new or recommended hospital procedures for approaching the problem of preventable hospital-acquired infections and conditions. For instance, the Sepsis Resuscitation Bundle requires four policies to be administered: measurement of serum lactate, blood cultures obtained prior to antibiotic administration, improving time to broad-spectrum antibiotics to be within 3 hours for ED admissions and within 1 hour for non-Emergency Department ICU admissions, and if the patient has hypotension and/or the patient has a lactate reading of >4 mmo1/L (36mg/dl) then the patient is given 20 ml/kg of crystalloid (or equivalent) and is given vasopressors. This type of information and other process information is not available in OSHPD. Therefore, the analyses included here should allow for these caveats.

Risk adjustment

Because of the limitations of the public use data set, variables used in standard risk adjustment models such as gender and detailed age categories are not available. UCLA has requested confidential OSHPD data that will allow for a full risk adjustment model to be used for the AHRQ PSIs and the other measures.

Analysis Methods

The measures were compared by type of organization (DPH, matched, other hospitals) and by year. Regression models included a difference-in-difference or interrupted time series analysis, using logistic regression to regress the odds of an adverse event on DPH or matched hospitals, a year trend, and hospital status interacted with year. Further interaction for the post-project period and the individual level risk adjustment variables will be conducted in the final report.

Appendix 3 (Category 5)

Data

The DY 8 reports filed by the DSRIP sites detail each site's overall progress in implementing Category 5A interventions and also contain information on Category 5B outcomes for a 12 month period. Exhibit 1 provides a timeline showing the periods covered. However, the reports available for this interim evaluation did not contain data for the final six months of 2013. Thus, any conclusions about the effect of Category 5A interventions on Category 5B outcomes must be considered preliminary.

Two factors that affect the 5B health outcome measures should be noted. First, SFGH's measures cannot be compared with the other DPHs because only baseline data and an established target are available. VCMC is also lacking outcome data for the second semi-annual report. Examining overall effects required us to pool data over counties based on the numbers of patients treated in each period, and thus creates a weighted average effect. Although LADHS based baseline measures on the total population of patients with HIV served, they calculated outcome data only for a sample of patients. Thus, LADHS could not be included in the weighted averages.

All DPHs were required to report on the Group 1 outcomes targeted in Category 5B, but they were allowed to choose which Group 2 and Group 3 outcomes to target. The following optional health outcome measures were not selected by any DPHs: Adherence Assessment and Counseling, HIV Risk Counseling, Lipid Screening, Oral Exam (Group 2), Hepatitis HIV/Alcohol Counseling, MAC Prophylaxis, Substance Use Screening, Toxoplasma Screening (Group 3), and therefore could not be evaluated. Further, we could not evaluate health outcomes selected only by LADHS, SFGH, and VCMC because they did not supply outcome data in the 2nd semi-annual report.

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Healthy Families Program Transition to Medi-Cal

Final Comprehensive Report

All Phases

January 1, 2013 – November 1, 2013

February 4, 2014

Submitted to the Legislature by the
California Department of Health Care Services
In Fulfillment of the Requirements of
Assembly Bill 1494 (Chapter 28, Statues of 2012), as amended by AB 1468 (Chapter 438, Statutes of 2012), Welfare and Institutions Code Section 14005.27(e) (10)

BACKGROUND

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of Healthy Families Program (HFP) subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. California Health and Human Services Agency, in collaboration with the Department of Health Care Services (DHCS), which administers the Medi-Cal program, the Managed Risk Medical Insurance Board (MRMIB), which administered HFP, and the Department of Managed Health Care (DMHC), which oversees the licensing of HFP and most Medi-Cal managed care health plans, have worked closely with the Legislature and stakeholder partners to transition children from HFP to Medi-Cal.

Children in HFP have transitioned into Medi-Cal's new Optional Targeted Low Income Children's Program (OTLICP) covering children with incomes up to and including 250 percent of the Federal Poverty Level (FPL). The Centers for Medicare and Medicaid Services (CMS) granted federal approval for DHCS to begin Phase 1A of the transition on January 1, 2013, via the Bridge to Reform 1115 Demonstration Waiver. Federal approvals for subsequent phases were granted upon compliance with the Special Terms and Conditions (STC) as detailed in the waiver amendments.

Pursuant to Welfare and Institutions (W&I) Code §14005.27(n)(4), DHCS has submitted enrollment information on the transitioned population and more in the monthly monitoring reports from February 15, 2013, through December 18, 2013. In addition, pursuant to W&I Code §14005.27(e)(10), the enrollment numbers are summarized in this final comprehensive report. The information in this report illustrates the following:

- Population of transitioned children and their integration into OTLICP, other Medi-Cal programs, or disenrollment from Medi-Cal;
- Children's ability to maintain services through the same/different providers and health plans (health, dental, mental health, and substance use disorder); and,
- Feedback from families via call centers, appeals, grievances, and surveys.

KEY SUMMARY FINDINGS

Based on the collective information contained in the monitoring reports and network adequacy assessments, covering all four phases of the transition, DHCS has been successful in transitioning 751,293 children from the HFP program to Medi-Cal. This transition has also resulted in the addition of 286,679[1] children gaining access to services under Medi-Cal's new OTLICP. These children receive comprehensive health, dental, mental health and substance use disorder services under Medi-Cal and a majority of these children have been able to maintain access to the same primary care providers that they had while enrolled in HFP. It should be noted that there were issues brought to the attention of DHCS regarding children diagnosed

[1] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* *http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

with autism and the access to applied behavioral analysis (ABA) services. Specifically, based on survey information provided by the health plans, approximately 500 children of the total transitioned population (.07 percent) were impacted. While ABA services are not discrete services available under Medi-Cal, other services used in the treatment of children with autism such as physical, speech or physical therapy are available based on the medical needs of the child and meeting medical necessity requirements for the identified services.

DHCS worked collaboratively with partners from the various state agencies engaged in the transition, legislative staff, consumer and child advocates, county partners, CMS, representatives from health plans, dental plans, mental health plans and substance use treatment providers, associations affiliated with the various provider groups, including physician groups and interested stakeholders during the planning and implementation phases of the transition. Key components lending to the success of the transition include the ongoing engagement of all interested stakeholders through regular communication using multiple strategies for this engagement such as webinars, in-person meetings, and listening sessions, development of regular reports, and comprehensive assessments of health and dental delivery systems completed prior to each transition to ensure network adequacy and when areas of concern were identified, providing time for the health plans to correct/address the areas of concern.

POPULATIONS

During the transition, DHCS tracked various populations of children in the monthly monitoring reports. The populations are identified in the following categories:

- Transition children that meet the description of each transition phase;
- Children who are going through the annual renewal process;
- Children who are newly enrolled into OTLICP; and,
- Children who are disenrolled for various reasons.

Transition Children

PHASES

The transition of the HFP children to the Medi-Cal program was premised on four major phases occurring throughout calendar year 2013. The phases were structured around the particular Medi-Cal managed care arrangements between the plans and the State, specifically the extent to which the contracting arrangement was direct or via subcontracted relationships. Prior to each phase, DHCS and DMHC assessed the network adequacy of each participating plan, by county. In some instances, the departments expressed concern with the networks and targeted delays were made until concerns were addressed.

Children that transitioned in Phase 1 were in a HFP plan that was also a Medi-Cal managed care health plan. The children generally stayed with the same health plan and provider; and DHCS reimbursed the plans instead of MRMIB for services provided to these children. The Phase 1 transition consisted of the following four sub-phases:

- *Phase 1A* on January 1, 2013, transitioned children in the following counties: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego (except for Health Net managed care health plan).
- *Phase 1B* on March 1, 2013, transitioned children in Medi-Cal managed care health plans, except for Health Net, in the following counties: Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Tulare, Sacramento, Napa, Solano, Sonoma, Yolo, Monterey, Santa Cruz, Santa Barbara, and San Luis Obispo.
- *Phase 1C (April)* on April 1, 2013, transitioned children in the Health Net managed care health plan in the following counties: Kern, Tulare, Sacramento, San Joaquin, and Stanislaus.
- *Phase 1C (May)* on May 1, 2013, transitioned children in the Health Net managed care health plan in the following counties: Los Angeles and San Diego.

On April 1, 2013, Phase 2 transitioned children in all Medi-Cal managed care counties who were enrolled in a HFP health plan that is a subcontractor of a Medi-Cal managed care health plan. To the extent possible, these children were transitioned into the Medi-Cal managed care health plan that subcontracted with the children's current plan.

On August 1, 2013, Phase 3 transitioned children in all Medi-Cal managed care counties who were enrolled in a HFP plan that was not a Medi-Cal managed care plan and did not contract or subcontract with a Medi-Cal managed care plan. Some beneficiaries had to choose a new primary care provider (PCP) after the transition to Medi-Cal because the PCP that they were seeing in the HFP did not contract with the Medi-Cal managed care plan into which they transitioned. Per Medi-Cal contract requirements, beneficiaries have 30 days from the date of enrollment to choose a PCP. If a PCP is not chosen within 30 days, the Plan will assign the beneficiary to a PCP. During the 30 days while the beneficiary is deciding on which PCP to choose, they are able to see any PCP in the Plan's network.

Finally, Phase 4 transitioned children who were residing in a county that was not previously a Medi-Cal managed care county. In July 2013, DHCS announced the geographic expansion of Medi-Cal managed care in the 28 primarily rural fee-for-service (FFS) counties as a component of the budget which also had implications for the HFP transition to Medi-Cal. As a result of this geographic expansion, the Phase 4 transition effort was split into two phases as described below. Some beneficiaries had to choose a new PCP after the transition to Medi-Cal because the PCP that they were seeing in the HFP did not contract with the Medi-Cal managed care plan into which they transitioned. Similar to Phase 3, beneficiaries also had 30 days to choose a PCP. Phase 4 consisted of two sub-phases:

- Phase 4A on September 1, 2013, transitioned children in the following eight (8) County Organized Health System (COHS) counties: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

- Phase 4B on November 1, 2013, transitioned children in the following 20 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito Sierra, Sutter, Tehama, Tuolumne and Yuba.

AID CODES

For children who transitioned, DHCS used the last known HFP eligibility information provided by MRMIB to enable Medi-Cal eligibility for transitioned children. The following are the aid codes used to identify children transitioning from HFP into Medi-Cal:

- Aid Code 5C provides no-cost, full-scope, Medi-Cal coverage with no premium payment to children with a family income at or below 150 percent of FPL during the transition period until their next annual eligibility redetermination (AER).
- Aid Code 5D provides full-scope Medi-Cal coverage with a premium payment to children with family income above 150 percent and up to and including 250 percent of the FPL during the transition period until their next AER. The applicable monthly premiums are $13 per child with a maximum family contribution of $39 per month for a family with three or more children.

IDENTIFICATION OF TRANSITION POPULATIONS

DHCS established a process to identify populations of children to transition at each phase. DHCS obtained a data file of HFP subscribers from MRMIB months in advance for purposes of mailing notifications per statutory requirements. From the data file, the populations of children who met the criteria for each transition phase were identified. Each phase of children was mailed the applicable 90 day or 60 day, and 30 day/reminder notices. In between the mailings, DHCS received status updates on these children from MRMIB identifying any children that had become ineligible for HFP or did not meet the criteria for the transition phase. For example, for Phase 1A, DHCS used the data file received from MRMIB in October of 2012. From that data file, DHCS identified the applicable group of Phase 1A children and mailed them a 60 day notice on November 1, 2012.

During the months of November and December, some children were identified ineligible for HFP or ineligible for Phase 1A transition per updates from MRMIB; therefore, these children were not sent the subsequent 30 day notice and did not transition on January 1, 2013. Children who became eligible for HFP or the Phase 1A transition phase after the November 1, 2012, mailing of the 60 day notice were not added to the Phase 1A group since they did not receive the first notice. These children were considered the Phase 1A “tail” and were added to subsequent Phase 1B or Phase 1C transition groups to ensure they received the required notifications prior to their transition to Medi-Cal.

DHCS identified an initial total of 846,016[2] children eligible for the transition in December of 2012. Of the 846,016 identified for transition, 94,723[3] were found ineligible for transition throughout the year as they had left HFP prior to their scheduled transitioned date for various reasons including income ineligibility, aging out of the program, non-payment of premiums, and requests for disenrollment. Children who left HFP and reapplied for health coverage and children newly applying for health care coverage after January 1, 2013, who would have formerly been HFP eligible, would have been enrolled in the OTLICP.

Pursuant to AB 82 (Committee on Budget, Chapter 23, Statutes of 2013), infants enrolled into HFP as a result of being born to a mother who was on the AIM program with an income above 250 percent and up to 300 percent of the FPL, were transitioned to DHCS, effective November 1, 2013. The total number of AIM–Linked infants that transitioned to DHCS on November 1, 2013, was 531 and these infants will be integrated into the new DHCS AIM-Linked Infant and Children's Program. In prior phases beginning August 1, 2013, DHCS transitioned approximately 11, 318 children with FPL's at 250 percent and below into the OTLICP. As of February 1, 2014, DHCS has fully implemented the transition of the AIM-linked Infant and Children's Program under DHCS including processes to register and enroll these children into the applicable programs under DHCS, similar to what occurred when the program was operated by MRMIB.

The "Transitioned Populations" table below shows the remaining children who successfully transitioned in each phase:

Transitioned Populations						
Phase 1A January	**Phase 1B March**	**Phase 1C/2 April**	**Phase 1C May**	**Phase 3 August**	**Phase 4A September**	**Phase 4B November**
178,623	106,443	270,308	59,077	104,915	6,840	25,087
						Total 751,293[4]

Annual Eligibility Review (AER)

In accordance with statutory requirements (W&I Code Section 14005.27(c)) pertaining to the HFP transition to Medi-Cal, a Medi-Cal redetermination must be made for all transitioned children within one year of their HFP AER date. A Medi-Cal determination can be initiated based on one or more of the following reasons:

[2] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*
[3] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*
[4] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report December 18, 2013, http://www.dhcs.ca.gov/services/Documents/DHCS%20HFP%20Transition%20to%20Medi-Cal%20Monitoring%20Report%20December%202013.pdf*

- Date of the child's HFP AER;
- Change in circumstance that warrants a Medi-Cal review of eligibility; or,
- Family's Medi-Cal Redetermination (Redetermination Verification (RV)) occurs sooner than the child's HFP AER month for existing Medi-Cal cases.

Prior to the transition commencing, for HFP AERs due in January, February, and March of 2013, the administrative vendor, MAXIMUS, sent these families a HFP renewal package in October, November, and December of 2012, respectively. Depending on the timing of when the renewal information was returned, the children retained their HFP eligibility or were placed in the appropriate transition aid codes. The child's next eligibility redetermination will be in the corresponding month of 2014 for Medi-Cal redetermination under the OTLICP, unless there is a change in circumstance prior to then.

For HFP AERs due after April of 2013, renewal packages were sent using a modified pre-populated form specific to the Medi-Cal program similar to the format used for the HFP AERs. The timeframe for mailing these Medi-Cal renewal packages is consistent with the current Medi-Cal processes for sending out renewal requests. Once the renewal packages are returned, the Medi-Cal eligibility determination process is completed, in accordance with current program annual renewal policies and procedures, including the use of provisions under Senate Bill (SB) 87. Below are counts of the total number of children undergoing annual renewal in each month and numbers of children that meet certain categories upon getting their AERs processed in that month.

All Phases /AER Due Month	*Total # of children undergoing annual renewal*[5]	*Total # of children eligible for OTLICP*	*Total # of children eligible for other Medi-Cal programs not OTLICP*	*Total # of children remaining on 5C/5D*	*Total # of children disenrolled*	*Total # of children subject to SB 87*
Jan	10,040	1,717	1,212	3,148	1,495	913
Feb	17,804	3,172	1,996	6,706	3,734	1,751
Mar	32,682	5,009	2,929	12,908	8,403	3,570
Apr	46,573	11,515	3,507	N/A	28	19,669
May	51,405	10,641	3,292	N/A	54	21,519
Jun	48,855	6,616	2,512	N/A	44	21,432
Jul	22,700	7,443	3,246	N/A	574	25,726
Aug	22,740	8,466	3,517	N/A	767	27,712
Sept	22,747	8,626	4,090	N/A	913	33,320

[5] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

All Phases /AER Due Month	Total # of children undergoing annual renewal[5]	Total # of children eligible for OTLICP	Total # of children eligible for other Medi-Cal programs not OTLICP	Total # of children remaining on 5C/5D	Total # of children disenrolled	Total # of children subject to SB 87
Oct	22,748	10,935	4,749	N/A	1,228	47,489
Nov	22,753	12,318	6,056	N/A	851	48,559
Dec	22,762	13,105	7,262	N/A	1,523	42,838
TOTAL	**343,809**	**99,563**	**44,368**	**22,762**	**19,614**	**294,498**

With regards to the percentage of children that were placed in 5C/5D aid codes in January, February, and March 2013, the administrative vendor completed the processing of AERs for the transitioned children in these months. For the children who maintained their eligibility based on their last HFP AER, their eligibility in the 5C/5D aid code was extended for another year. As the Counties began processing all AERs for transitioned children, beginning April 1, 2013, and once determined eligible for OTLICP, children were taken out of the 5C/5D aid code and placed in an OTLICP aid code, H1, H2, H3, H4, or H5 (see New Enrollment section for aid code descriptions).

During the first phases of the transition, the number of children in each phase of transition was significantly higher than in the latter phases. As a result, the number of children disenrolled in February and March are higher as the populations transitioned were higher and represented the larger counties within California. In addition, the percentage of children undergoing an assessment for all Medi-Cal programs when they no longer qualified under the OTLICP program was higher in April, May, and June due to pending cases awaiting counties' review.

New Enrollment

Upon implementation of the transition on January 1, 2013, HFP stopped enrolling new children, with the exception of those born to mothers in the Access for Infants and Mothers (AIM) program, and Medi-Cal began enrolling children in the new OTLICP, which covers children with incomes up to and including 250 percent FPL who would have previously enrolled in HFP. The below "OTLICP Aid Code Definitions" table provides references to age, FPL, and premium requirements for each OTLICP aid code:

OTLICP Aid Code Definitions			
OTLICP Aid Code	**Age of Child *(up to the month of the 1st, 6th, or 19th birthday)***	**FPL**	**Premium Requirement**
H1	0 - 1	Above 200% - Up to and including 250%	None
H2	1 - 6	Above 133% - Up to and including 150%	None
H3	1 - 6	Above 150% - Up to and including 250%	$13 per child, max $39 per family
H4	6 - 19	Above 100% - Up to and including 150%	None
H5	6 – 19	Above 150% - Up to and including 250%	$13 per child, max $39 per family

New Medi-Cal applications could have been submitted to the county welfare administrative offices or the administrative vendor also known as the Single Point of Entry (SPE) for processing. Applications submitted to SPE may qualify for "Accelerated Enrollment" (AE). SPE conducts an initial screening of all applications for presumed Medi-Cal eligibility then forwards them to the county welfare administrative offices for final eligibility determinations. Based on the screenings of the submitted applications at the SPE, AE is granted. AE provides temporary no-cost, full-scope Medi-Cal eligibility which allows children to receive medically necessary services pending their final eligibility determination by the county eligibility worker. During the time that the child has AE, they receive their Medi-Cal services on a fee-for-service basis and once a final eligibility determination has been made, the child is then mandatorily enrolled into the applicable health plan based on their county of residence. AE is available for all children ages zero to the month of their 19th birthday with some restrictions.

The new Medi-Cal applicants approved for OTLICP, which are generally consistent month-to-month, are broken down below in the "OTLICP Enrollment and Percentages" table. These children did not have existing eligibility in the month prior to placement into the OTLICP aid codes. This number is inclusive of applications received from SPE, but did not receive AE, and those initiated directly at the county.

OTLICP Enrollments and Percentage Distribution						
Month	***Total Children in OTLICP[6]***	***H1***	**H2**	**H3**	**H4**	**H5**
Jan	12,737	1%	9%	12%	58%	20%

[6] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

Feb	21,660	1%	9%	11%	59%	20%
Mar	11,941	1%	10%	17%	53%	20%
Apr	83,719	1%	9%	15%	54%	21%
May	23,535	1%	11%	16%	55%	17%
Jun	19,207	1%	12%	17%	54%	17%
Jul	17,378	1%	13%	17%	54%	16%
Aug	19,854	2%	12%	17%	52%	17%
Sept	19,680	2%	12%	18%	52%	17%
Oct	20,464	2%	11%	17%	52%	17%
Nov	18,424	2%	12%	18%	51%	17%
Dec	18,080	2%	11%	17%	50%	20%
TOTAL	**286,679**					

In April 2013, there was a substantial increase in children (83,719) enrolled in the applicable OTLICP aid code compared to other months. This is due to the completion of technology upgrades that has enabled enrollments into these new aid codes. The technology upgrades impacted larger counties with high populations of eligible children for OTLICP.

Disenrollment

In Medi-Cal, the process for disenrollment depends upon what prompts the disenrollment. Voluntary disenrollments are the simplest and upon receipt of a written request from the authorized person over the case, the beneficiary's Medi-Cal eligibility is discontinued effective the first day of the following month. For other disenrollments, such as Medi-Cal redeterminations resulting in denial for income levels above program limits and individual's age above program limits, beneficiaries must be assessed for other Medi-Cal programs in accordance to SB 87, W&I Code, § 14005.37. If the beneficiary does not qualify for other Medi-Cal programs, then they can be disenrolled the first day of the following month after proper notification is given to the beneficiary. Finally, beneficiaries can be disenrolled when there is a change in their circumstance that occurs prior to the annual redetermination date. For children in the applicable OTLICP, if the reported change adversely impacts their Medi-Cal coverage, the child can receive Continuous Eligibility for Children (CEC) and will maintain their Medi-Cal eligibility until their next redetermination date. CEC does not apply for purposes of non-payment of premiums after a certain time period has lapsed subsequent to required noticing of such a pending action. If CEC is not applicable, then the beneficiary is disenrolled the first of the following month after proper notification is given.

Below is a monthly breakdown of disenrollments for transitioned children in the 5C/5D aid codes. Because of the many Medi-Cal programs that exist and are reported by aid codes, the numbers noted below are not additive since the children may move from one program to

another. There were no disenrollments in January 2013, as newly transitioned children were in the process of being evaluated for other Medi-Cal programs per SB 87 and any discontinuance would have occurred in February 2013 or later.

Disenrollment Reasons Out of Transition Aid Codes (5C/5D Other than at Annual Renewal)[7]						
Month	***Total Disenrollment by Month***	***Eligibility Under an Existing Medi-Cal Aid Code***	***Eligible for OTLICP***	***Non-Payment of Premiums***	***Per Beneficiary Request***	***Other reasons (loss of legal residence, relocation, etc.)***
Feb	124	124	N/A	N/A	N/A	N/A
Mar	14,964	14,955	N/A	N/A	9	N/A
Apr	11,192	5,821	N/A	N/A	N/A	4
May	37,697	8,292	18,015	N/A	13	11
Jun	20,837	15,430	6,717	N/A	44	162
Jul	34,347	23,017	10,219	N/A	647	310
Aug	42,640	28,379	13,941	N/A	281	39
Sept	30,415	20,571	9,399	288	137	20
Oct	32,725	23,036	9,421	242	8	18
Nov	39,215	25,693	13,211	300	10	1
Dec	76,597	30,341	45,947	295	1	13

**Note: N/A indicates no data available.*

For purposes of transitioned children's AERs due January 2013 – March 2013, the administrative vendor only extended the applicable AER date and did not have the ability to place beneficiaries into the H1-H5 aid codes or to apply the requirements of the SB 87 rules. Because of this and the application of the SB87 rules by the County eligibility worker to cases requiring this handling, there is no applicable data to report for transitioned children that were eligible for OTLICP in January through April, and January through March in other aid code categories for other Medi-Cal programs where children can be covered such as 1931(b) or the Medically Needy programs.

The figures above demonstrate that many transitioned children were able to continue their Medi-Cal eligibility via other programs when they do not qualify for OTLICP. Also, the disenrollment numbers are comparable to MRMIB's historical monthly HFP disenrollment

[7] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

numbers found at http://www.mrmib.ca.gov/mrmib/HFPReports1.shtml.

In November, DHCS undertook a multi-phase work effort to discontinue children who had not completed and returned AERs between the months of April 2013 to October 2013 which is further described below.

As reported in the July 2013 HFP Transition Monitoring Report, the number of children disenrolled in June 2013 as a result of not returning the AER forms was zero. The children scheduled for disenrollment were not disenrolled in their AER month due to pending system enhancements as described below. The number of pending discontinuance on this basis as of June 2013 was 14,767. With the accumulation of cases that had not returned their AERs as of April 2013 and the need to reconcile this matter, DHCS and the county staff collaborated on a process to address these cases.

For the period of January 2013 through March 2013, a manual process was implemented to disenroll children due to AERs not returned during those months. This manual process raised security concerns because it included emailing client data to counties via a secure email process. The manual process was discontinued beginning with AERs due April 2013 and the automated process designed to disenroll children for non-receipt of AER forms was installed November 13, 2013. Because of the delay with the automated process, there were 70,382 transitioned cases during the time period between April 2013 and October 2013 that should have been discontinued for failure to return the AER. With the installation of the automated process, steps were then taken to appropriately notice these families regarding disenrollment from Medi-Cal for failure to return the AER, with an effective disenrollment date of December 1, 2013. A similar notice was also sent out in December to approximately 16,000 children who failed to return their AER, with an effective disenrollment date of December 31, 2013.

The actual number of children disenrolled effective December 1, 2013, was 68,260 as 2,122 children were reinstated into Medi-Cal upon responding to their notice, prior to the effective date of the disenrollment. As of December 1, 2013, DHCS received approximately 8,000 additional responses to the disenrollment notices. In total, approximately 10,122 of the 70,382 children who received disenrollment notices for the effective date of December 1, 2013, has been reinstated to Medi-Cal coverage and the counties are processing their AERs as appropriate. Because of the concerns raised regarding adequate notice for the children with the December 1, 2013 disenrollment date, DHCS took steps to not effectuate the disenrollments of those children with a December 31, 2013 effective date.

As a result of the concerns received regarding the large number of the December 1, 2013 discontinuances, DHCS took steps to reinstate the affected beneficiaries back into Medi-Cal and provided them with an additional opportunity to return the delinquent AERs. During early January 2014, families that had not already resent the AER, received a letter advising that eligibility for Medi-Cal was reinstated back to December 1, 2013 under the fee-for service delivery system. With the letter, families were also sent a duplicate AER to be completed and returned by February 5, 2014. If the family submits the AER by February 5, 2014 the child will

be reinstated in their health plan pending a final eligibility determination by county. For those that do not return the AER by February 5, 2014, they will be sent a notice for discontinuance, effective February 28, 2014.

Below is a monthly breakdown of disenrollments for children undergoing the annual renewal process.

HFP Transitioned Children Discontinued From Medi-Cal by Transaction Month and Disenrollment Reason[8]						
Month	***AER Not Returned***	***Discontinued By Request***	***Non-Payment of Premiums***	***Failure to Provide Missing AER Information***	***Other reasons***	***TOTAL***
Jan	0	0	0	0	0	0
Feb	0	0	0	0	0	0
Mar	46	14	0	167	0	525
Apr	5,485	141	0	911	910	7,447
May	11,684	63	0	908	1,046	13,701
Jun	337	128	0	946	1,246	2,657
Jul	643	643	0	1,191	10,539	12,759
Aug	407	437	0	1,427	5,085	7,356
Sept	449	298	286	1,473	7,397	9,903
Oct	412	146	262	1,306	8,283	10,409
Nov	68,260*	142	436	1,482	7,854	78,174
Dec	845	239	162	2,716	10,958	14,920

**Note: This number reflects disenrollments with an effective date of December 1, 2013 and is inclusive of AERs not returned for individuals with an AER that was due in the month of November. This number does not include the reinstated cases.*

While the main causes for discontinuance from Medi-Cal for these transitioned children are AER not returned, discontinued by request, child ages out of the coverage programs for children, failure to cooperate, or the child has other health coverage, some children are able to receive Medi-Cal coverage through other programs. The below table represents transitioned children who were discontinued from Medi-Cal and then returned to Medi-Cal within 3 months of discontinuance. The chart reflects the most common Medi-Cal programs in which children are enrolled. The "Other" category is comprised of programs that individually demonstrated statistically immaterial samples,

[8] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

but collectively is a material sample.

Number of Children Transitioned then Discontinued and Reinstated Within 3 months[9]							
	Reinstated Jun 2013	*Reinstated July 2013*	*Reinstated Aug 2013*	*Reinstated Sep 2013*	*Reinstated Oct 2013*	*Reinstated Nov 2013*	*Reinstated Dec 2013*
1931(b)	66	335	443	260	498	402	502
OTLICP	128	1,601	2,646	737	2,525	1,820	2,045
Other Medi-Cal programs	103	2,705	1,419	370	1,331	889	1,164
Total Reinstated	**297**	**4,461**	**4,508**	**1,367**	**4,354**	**3,111**	**3,711**

ACCESS TO CARE

Health Care

Per statutory requirements, HFP subscribers transitioned to Medi-Cal based on the contractual relationship the plan has with DHCS. Additionally, DHCS has an established monitoring and reporting system for its health plans. These monitoring activities are completed regularly to ensure that health plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal requirements. All transitioning HFP and OTLICP children are entitled to the same protections and assurances afforded to enrolled Medi-Cal beneficiaries covered by the plan. In an effort to ensure transitioned children maintain access to medical care, the health plans cumulatively reported the following for Phases 1 through 4:

Transition Months and Phases[10]	**Phase 1A Jan**	**Phase 1B Mar**	**Phase 1C Apr**	**Phase 2 Apr**	**Phase 1C May**	**Phase 3 Aug**	**Phase 4A Sept**	**Phase 4B Nov**
Primary Care Providers (PCP)								
Percentage of transition children assigned to a PCP	100%	93.88%	95.44%	98.14%	99.72%	63.29%	95.60%	93.97%

[9] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014, http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf*

[10] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through December 18, 2013. http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx*

Transition Months and Phases[10]	Phase 1A Jan	Phase 1B Mar	Phase 1C Apr	Phase 2 Apr	Phase 1C May	Phase 3 Aug	Phase 4A Sept	Phase 4B Nov
Percentage stayed with same PCP	98.96%	92.98%	84.69%	94.18%	73%	55.55%	N/A[11]	14.26%
Percentage changed PCP	1.04%	6.07%	14.81%	20.67%	27%	42.15%	N/A	74.29%
Health Plans								
Percentage stayed with same health plan	99.86%	100%	99.24%	99.48%	99.73%	95.82%	98.76%	95.23%
Percentage changed health plans	0.13%	0%	0.07%	0.05%	0.04%	0.12%	0.15%	0.14%
Percentage changed to FFS*	0.01%	0%	0.69%	0.47%	0.23%	4.06%	1.10%	4.63%

**Children assigned to fee-for-service (FFS) Medi-Cal because their zip code is excluded from Medi-Cal managed care delivery systems.*

In Phases 1 and 2, a minimal number of children had to change PCPs because beneficiaries were being assigned to the same Plan and in turn were able to stay with their same PCP. Nearly all of the transitioned children had an assigned PCP. For children who are not assigned to their same PCP, they were provided 30 calendar days from the time of enrollment to choose a PCP or the plan will choose one for them. Considering that the report is inclusive of all members that transitioned in Phases 1 and 2, DHCS does not have any concerns with these results and sees that there has been minimal to no disruption to services.

A small percentage of members were assigned to a new health plan at transition due reasons such as moving out of the county they were living in while in HFP; therefore, the member was assigned to a managed care plan in the county of new residence. Moreover, some members were assigned to FFS because they lived in a zip code that is excluded from the Medi-Cal managed care delivery system.

In Phase 3, over half of the children coming into Medi-Cal were able to keep the same PCP, and a greater number (over 67 percent) had a PCP by linkage or assignment at the time of the

[11] *The HFP plan in the Phase 4A counties operates an Exclusive Provider Organization network and does not assign enrollees to PCPs; therefore, the department was unable to provide PCP information to the health plan so that the health plan could assign the member to the same PCP if that PCP was available.*

transition. These children's families were able to choose a new plan ahead of the transition and had the option of choosing a PCP when they chose a plan.

The number of children that had to change PCPs in Phase 3 was higher than in Phases 1 and 2 because these children were coming from HFP plans that did not contract with Medi-Cal or have a subcontract with a Medi-Cal managed care health plan. For this reason, MRMIB provided the children's PCP information so that DHCS could make it available to the plans, which would allow plans to link children to their PCP whenever possible. Children who were not assigned to their same PCP were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

In Phases 4A and 4B, the vast majority of children were assigned to a PCP at the time of the transition. For Phase 4A, DHCS was not able to track whether these children were assigned to their same PCPs because the HFP plan in these counties, Anthem Blue Cross, operated an Exclusive Provider Organization (EPO) network and did not assign enrollees to PCPs. However, the Medi-Cal managed care health plan, Partnership HealthPlan, was able to contract with the majority of providers who had participated in the EPO network, so there was a high probability that children would be able to continue seeing their same providers.

In Phase 4B, two HFP plans that operated in these counties, Anthem Blue Cross and Kaiser, established a contractual relationship with DHCS to provide Medi-Cal services in these counties. Children who were in either Anthem Blue Cross or Kaiser were able to keep their plans when they transitioned to Medi-Cal. Since the children remained in the same plan, the expectation was that children would be able to continue seeing their same providers. Kaiser was able to keep all of its HFP children and they remained with their same PCPs. The children's families that were not members of Anthem Blue Cross or Kaiser were able to choose a new plan ahead of the transition. Per contractual requirements, these new members were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

Since the start of the transition in January through November 30, 2013, the health plans have reported 182 continuity of care requests for purposes ranging from:

- Unable to remain with same PCP or health network;
- Provider not aware of existing prior authorization;
- Request to change PCP;
- Members not do qualify for specialty mental health; and
- PCPs no longer accepting Medi-Cal due to reimbursement rates.

The health plans have resolved all cases by assisting beneficiaries with selecting new or changing PCPs, bridging information on prior authorizations, and clarifying the extent to which behavioral health services are covered.

In order to track the effectiveness of the transition, DHCS relied on data received directly from plans tracking any increase in call center volume, reported grievances, and continuity of care. This data was submitted daily in the two weeks following a transition date, and then weekly throughout the entire transition. Plans also provided the necessary information for the Monthly Monitoring Reports which included the number of children who were able to keep their requested PCP, had to change their PCP, decided to change plans, and any continuity of care issues that were open at the time of the report. HFP transition data was also added to existing quarterly reports on the plans' provider networks and member grievances, as well as consumer satisfaction. In addition to plan data, DHCS also reviewed the call data from the Medi-Cal Office of the Ombudsman to track any issues reported by families whose children had transitioned from HFP.

Of particular note during the course of the transition, were the issues brought to the attention of the Department specifically regarding children with a diagnosis of autism and their ability to continue to receive ABA services upon their transition to Medi-Cal. Approximately a dozen such cases were brought to the attention of the department regarding families who were informed by their health plan that their ABA services would not continue post transition for those scheduled to transition April 1, 2013, and thereafter. In total, approximately 500 children were affected based on survey information from the health plans.

Medi-Cal does not have a set of services specifically designated as "autism services". Based on the literature, services for autism include, but are not limited to, applied behavioral therapy, psychiatry and psychology services, speech and language therapy, physical therapy, and/or occupational therapy. Services provided to children under Medi-Cal with a diagnosis of autism must meet medical necessity requirements and the acuity level of their given diagnosis dictates the level and amount of services to be provided. Such services may be provided through Medi-Cal, the home and community-based services waiver program and Department of Developmental Services (DDS) or, in some instances, through the county mental health plan if the child is dually diagnosed with a condition eligible for specialty mental health services or in need of psychiatric inpatient services. Through coordination, communication, and continuous monitoring, DHCS has been able to conduct a successful and effective transition that allowed children to receive services with minimal disruption.

Dental Care

In addition to health services, transition children are also eligible for dental services through Medi-Cal at the time of transition. Since Los Angeles and Sacramento counties are the only counties in the state that have dental managed care plans, all other counties will provide dental services through the dental fee-for-service (FFS) system, also known as Denti-Cal. For children who needed to secure a new dental provider, the beneficiary was able to contact Denti-Cal's Beneficiary Customer Service line or locate providers on the Denti-Cal website that were accepting new patients. DHCS has improved the quality of service provided by both sources to ensure beneficiaries can easily access providers and dental services. These changes include:

- Improved referral processes with the Beneficiary Customer Service line and providing for warm transfers (ensuring beneficiaries are connected to a provider and attempting to schedule an appointment before disconnecting from the call);
- Improved ease of adding providers to the online list who are accepting new patients thus offering beneficiaries a wider selection of providers in their area; and,
- Improved Denti-Cal website to include Denti-Cal provider network information allowing individuals to search for providers by state, name of provider, location of residence, specialty, accepting new patients, and other factors through the Insure Kids Now widget.

Similar to Medi-Cal managed care plans, DHCS has a monitoring and reporting process for its Medi-Cal dental providers and dental managed care plans. These monitoring activities are completed regularly to ensure the Medi-Cal dental providers and dental managed care plans are fulfilling their obligation to provide covered Medi-Cal dental services to the transitioned children in accordance with State and federal law. In the first eleven months of transition, the dental providers and plans reported on the following activities:

Dental Statistics												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Appointment Scheduling[12]												
Average number of days between scheduling an appointment and the actual appointment date in Denti-Cal	8.8	6.7	7	7	7	7	6	7	6	6	6	5
Provider Capacity[13]												
Number of newly enrolled FFS providers	30	38	35	19	43	26	49	80	40	36	52	46
Number of newly enrolled dental managed care plan providers[14]	246	250	185	123	142	149	371	199	684	416	404	192
Number disenrolled FFS providers	14	22	30	26	28	30	37	42	15	14	20	24
Number of disenrolled dental managed care plan providers[15]	57	66	43	59	72	63	48	45	113	106	44	139
Percentage of FFS Denti-Cal providers accepting referrals	50%	51%	51%	52%	52%	52%	52%	52%	52%	52%	52%	52%

[12] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx
[13] *There are reporting differences between FFS and dental plans due to characteristics unique to each program.*
[14] *May include duplicate providers across dental plans.*
[15] *May include duplicate providers across dental plans.*

Dental Statistics												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Changes in number of FFS Denti-Cal providers on the referral list	-8	+4	+45	-16	-2	+14	+9	+6	-16	-13	+8	+11
Percentage of FFS referral requests resolved	99.9 %	100 %	100%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Continuity of Dental Care (FFS)												
Total number of warm transfers	45	310	412	303	513	537	580	744	672	671	572	373
Percentage of warm transfers with successful referrals	100 %	100%	100%	100%	100%	100%	100 %	100%	100%	100%	100%	100%
Percentage of successful referrals resulting in scheduled appointment	93%	99%	98%	92%	87%	85.7 %	81%	83%	76%	79%	77%	75%
Prior authorization treatment transfers from HFP (quarterly)	3			22			25			8		
Continuity of Dental Care (Plans)[16]												
Number of continuity of care requests	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of children who stayed with same dental provider (PCD)	N/A	N/A	N/A	N/A	78%	67%	95%	87%	97%	98%	98%	96%
Prior authorization treatment transfers from HFP	N/A	N/A	20	59	174	150	4	8	7	2	0	0
Number of dental exception requests	N/A	N/A	N/A	0	0	0	19	1	1	2	0	1

DHCS has learned that the warm handoff process initiated for the HFP transition to Medi-Cal has resulted in improved outcomes and better experiences for all beneficiaries seeking dental services through the Beneficiary Customer Service line. DHCS has additionally learned the importance of communication with the beneficiary and provider communities, based on continuous engagement with the stakeholder community and follow-up phone calls with beneficiaries utilizing the warm handoff process, and will continue to proactively respond to the needs of the community through process improvement.

[16] *Beneficiaries in dental managed care did not transition until March 1, 2013; hence there were no data results for January and February.*

Mental Health

Children in the Medi-Cal program are eligible to receive the full range of Medi-Cal mental health services, and their specific mental health needs will determine the services they receive and the delivery system they will use to access such services. For the period covered by this report, Medi-Cal managed care plans covered only the mental health services that can be provided by the child's PCP, within the PCP's scope of practice. If the child's needs exceed this level of service, the Medi-Cal managed care plan will either:

1. Refer them to a Medi-Cal fee-for-service provider outside of the managed care plan's provider network; or,
2. Refer them to the county mental health plan (MHP) if the Medi-Cal managed care plan believes that the child meets the medical necessity criteria to obtain Medi-Cal specialty mental health services.

Note that effective January 1, 2014, the Medi-Cal program covers new mental health services through Medi-Cal managed care plans. As a result, beneficiaries enrolled in Medi-Cal managed care plans with mild to moderate impairment of mental, emotional, or behavioral functioning can now access certain mental health services through their Medi-Cal managed care plans that were previously only available through the Medi-Cal fee-for-service delivery system. County MHPs continue to provide Medi-Cal specialty mental health services for beneficiaries that meet medical necessity criteria to receive those services.

Most children previously in HFP that are seriously emotionally disturbed (SED) are already known to and served by the county MHPs; in these cases, the children continue to be served by the county MHP after they transition from HFP to Medi-Cal. The county MHPs will now receive new referrals from Medi-Cal managed care plans or self-referrals from former HFP enrollees for Medi-Cal specialty mental health services. Throughout this transition, DHCS has monitored the following:

Specialty Mental Health Services												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Number of transitioned (5C/5D) and OTLICP children receiving Medi-Cal specialty mental health services[17]	1,552	2,361	3,648	6,716	8,224	8,133	7,274	7,940	7,402	5,229	1,688	256

[17] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014. http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx. Numbers are unduplicated by month; a beneficiary counted in January for a particular category may also be counted in February for a different category.*

Specialty Mental Health Services												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Percentage of each service compared to all services rendered in each month												
Crisis intervention	2.06%	1.56%	1.86%	1.63%	1.83%	1.06%	0.78%	0.97%	1.64%	1.88%	4.15%	0.00%
Crisis stabilization units	1.19%	0.46%	0.73%	0.84%	0.74%	0.44%	0.12%	0.20%	0.33%	0.22%	1.00%	2.27%
Day rehabilitation	2.07%	1.76%	1.39%	0.72%	0.84%	0.51%	0.62%	0.34%	0.61%	0.07%	0.00%	0.00%
Day treatment intensive	2.74%	2.37%	1.78%	1.64%	1.92%	1.61%	1.25%	1.37%	1.18%	1.27%	1.91%	0.00%
Medication support	6.59%	6.65%	5.62%	5.34%	5.07%	5.01%	5.20%	5.39%	5.10%	5.04%	9.68%	9.86%
Mental health services	78.45%	80.80%	81.74%	82.67%	83.55%	84.94%	86.24%	85.24%	84.81%	85.11%	74.82%	80.45%
Psychiatric health facility	0.03%	0.01%	0.03%	0.04%	0.02%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Psychiatric inpatient	0.08%	0.03%	0.06%	0.04%	0.06%	0.04%	0.03%	0.03%	0.02%	0.04%	0.06%	0.00%

Due to the lag in claims submission after the service date, the presented data is under-representative of the actual number of children served and the actual numbers of units of service provided. Nonetheless, the data illustrates that more transitioned and OTLICP children are accessing Medi-Cal specialty mental health services following the transition compared to the number of HFP SED children that accessed these services from the MHPs in the HFP prior to the transition.

Alcohol and Substance Use

Alcohol and substance use disorder (SUD) treatment is a covered Medi-Cal benefit through the Drug Medi-Cal (DMC) program. This program was realigned to counties in July 2011; as a result counties now administer DMC services directly and/or through subcontracted providers. For the period covered by this report, DMC services included individual and group counseling, outpatient treatment and residential services for pregnant/postpartum women. The MRMIB 2010 Behavioral Health report stated that less than one percent of HFP beneficiaries accessed SUD services.

Due to a claims processing period of 30-90 days, the data presented on SUD services accessed by transitioned HFP children is for a point-in-time and not the actual numbers of units and services provided to date. Overall, the data illustrates that HFP children transitioned into Medi-Cal are utilizing SUD services through the DMC program without experiencing barriers to access. To ensure this trend continues, the DMC program remains in close communications with County Alcohol or Drug Program Administrators Association of California (CADPAAC). During weekly calls with CADPAAC members, DMC staff provides information and updates on

state issues as well as solicits information from counties on access or utilization issues regarding DMC treatment services. To date, the transitioned children are not experiencing any break in the continuity of coverage for SUD treatment services.

Phases 1A, 1B, and 1C consisted of managed care plans that contracted either directly or through a subcontractor with the counties' Medi-Cal Managed Care Plans; thus, many of the HFP transitioned children remained under their care of their existing primary care provider At the outset, counties stated they had capacity to provide SUD treatment to the transitioned children during these phases, however, utilization of DMC services for this period was rather low, averaging about 58 unique clients per month. From discussions with health plans the low number of claims submitted could be explained by health plans referring some of the transitioned HFP children into the county MHP. The reason health plans may have taken this approach is that there is a high rate of comorbidity within this population. Counties may have supported this approach because county MHP's reimburse providers at a higher rate than SUD providers. During Phase 2 the number of DMC services delivered to transitioned children increased from an average of 58 to about 200 unique clients per month and continues to average approximately 200 per month.

DHCS has initiated three efforts to strengthen the oversight of the DMC program: targeted site reviews of DMC providers, initiating a statewide re-certification process for all DMC providers, and conducting periodic provider de-activations of sites that have not billed in over 12 months. These three efforts will provide DHCS with a verified list of active provider locations. DHCS is simultaneously working with its county partners to increase the number of DMC providers. Since the transition began in January 2013, DHCS has received 233 DMC certification applications from providers.

To date, no county has reported a waiting list for youth treatment. Below is a breakdown in the number of beneficiaries that received services per claims data:

DMC Services for Transitioned children and OTLICP[18]											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**
Total Beneficiaries	19	51	104	190	234	224	193	225	225	242	80

**November data not yet available due to lag time in claim submissions and adjudications.*

Based on this preliminary data, it appears as though less than one percent of the 751,293 children that transitioned from HFP into Medi-Cal are accessing DMC services, which concurs with the MRMIB 2010 Behavioral Health report.

[18] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

Beginning January 1, 2014, California's DMC services will be expanded to include intensive outpatient treatment and residential SUD services components, pending federal approval. Medi-Cal beneficiaries may access the DMC covered services as deemed medically necessary. DHCS will monitor the impact that the provision of expanded DMC services has on youth service utilization.

BENEFICIARY FEEDBACK

There are various ways for beneficiaries to communicate their questions and concerns with regards to the transition, eligibility determinations, and covered benefits. The information in the notices referred beneficiaries to specific contacts for eligibility processing, health coverage, dental coverage, etc. Below is a summary of the percent of HFP transition related calls compared to total calls received by our administrative vendors such as the Single Point of Entry (SPE), Health Care Options (HCO), and ombudsman offices for Denti-Cal and Mental Health.

HFP Transition Related Calls Received[19]												
Call Centers	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Single Point of Entry*	21,925	14,294	23,334	15,303	8,182	4,935	8,862	10,155	6,409	6,042	3,603	1,214
Health Care Options	3,257	6,079	10,491	20,709	25,709	21,956	25,017	15,583	12,341	13,299	11,671	8,274
Office of Ombudsman ***(Medi-Cal Managed Care Division)***	101	67	183	142	46	18	102	156	36	33	28	9
Denti-Cal (FFS) (not specific to HFP)	15,270	13,769	15,745	18,092	17,622	15,536	17,894	20,385	17,593	18,149	16,083	17,768
Mental Health Ombudsman	103	39	196[20]	137	61	29	85	37	28	18	16	1

The volume of the calls for the Single Point of Entry were significantly higher in the beginning of the transition primarily due to the new process, the transitioning of the program and the volume of children being transitioned to Medi—Cal in the early stages. As the families became more familiar with the transition and fewer cases were transitioned to DHCS, the call volumes significantly reduced. Additional call trends show that during an actual transition month, with

[19] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

[20] *Higher call volume in March due to beneficiaries preparing for large upcoming transition on April 1 (Phase 1C and Phase 2).*

the exception of November where there was an unusual increase, call volumes correlated with the family noticing process.
In addition, beneficiaries are entitled to normal appeals rights and grievances. The amounts are summarized the table below.

Cumulatively, 94 out of a total of 751,293 transitioned children filed appeals as a result of the actual HFP transition. Of the existing 94 appeals; 43 are closed, 31 are scheduled for hearing, 16 are unscheduled for hearing and 4 were dismissed. Although there are pending cases at the Administrative Hearing level, California Department of Social Services (CDSS) Fair Hearing Division, DHCS and the county social services offices collaborate to resolve beneficiary concerns prior to an actual hearing date which can result in a case being withdrawn before a hearing occurs.

Beneficiaries file appeals due to the reasons that are for the discontinuance of eligibility, discontinuance at redetermination, and discontinuance of the Applied Behavioral Analysis services. In CDSS, the normal resolution of these cases, are concluded with the resolution codes that are Withdrawal, Conditional Withdrawal, Verbal Conditional Withdrawal, and Verbal Withdrawal.

Grievances/Appeals for Transitioned Children[21]												
	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Eligibility Appeals	0	1	2	9	8	3	5	10	2	2	9	11
Member Health Plan Grievances (quarterly)	9			22			21			N/A*		
Dental Appeals	0	0	0	0	0	2	1	2	3	6	5	2
Dental Grievances	0	1	3	3	4	4	7	5	4	2	4	6

**Data is reported quarterly by the health plans and per contract terms, results are due to the Department 45 days after the end of the quarter and will be reported in subsequent monthly monitoring reports due to CMS.*

Finally, DHCS is conducting call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey is to provide the department with direct feedback from impacted families on how the HFP transition to Medi-Cal is going and to alert the department to any concerns. Beneficiaries' experiences are evaluated in areas of medical, dental, mental health, and alcohol and drug services. Generally, transitioned beneficiaries scored the following for overall satisfaction:

[21] *Sources: HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

Beneficiary Survey Satisfactory Ratings[22]							
	Phase 1A Jan	**Phase 1B Mar**	**Phase 1C/2 Apr**	**Phase 1C May**	**Phase 3 Aug**	**Phase 4A Sept**	**Phase 4B Nov**
5 - Highest	63.61%	56.81%	57.14%	47.83%	49.22%	31.53%	40.62%
1 - Lowest	2.6%	5.5%	5.2%	7.4%	7.6%	14%	10.6%

With 751,293 transitioned children and 286,679 children enrolled in the OTLICP, the data has demonstrated accomplishments in maintaining the same plans and providers for beneficiaries as well as open lines of communication for beneficiaries to seek assistance and receive resolutions to their concerns. DHCS will continue to work closely with its administrative partners and stakeholders to monitor the transitioned children.

CONCLUSION

The HFP transition to the Medi-Cal program has been successful in effectively moving over 750,000 children, while allowing the majority of them to keep their health and dental plans and providers. DHCS made a concerted effort to work closely with other departments, counties, CMS, advocates, stakeholders, provider associations, and especially the Medi-Cal managed care health plans, dental plans, mental health plans, and the substance use treatment providers. Coordination and communication has been key to ensuring that the transitioning children are provided access to care and effective coordination of services. In addition to coordination and communication, DHCS has relied on its monitoring data to track the transition and ensure that children are remaining in coverage and receiving access to care.

[22] *Sources: HFP Transition to Medi-Cal Beneficiary Surveys.* http://www.dhcs.ca.gov/services/hf/Pages/BeneficiarySurveys.aspx

Interim Evaluation Report on California's Low Income Health Program (LIHP)

Prepared for:

California Department of Health Care Services and the Blue Shield of California Foundation

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Interim Evaluation Report on California's Low Income Health Program

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Interim Evaluation Report on California's Low Income Health Program

Executive Summary

In November 2010, the Centers for Medicare and Medicaid Services (CMS) approved California's "Bridge to Reform" §1115 Medicaid waiver for the Low Income Health Program (LIHP). LIHP is an optional, locally funded, federally reimbursed health care coverage program for low-income individuals that builds upon the success of the state's previous demonstration program, the Health Care Coverage Initiative (HCCI). Ten California counties participated in HCCI from 2007 to 2010, significantly expanding health care coverage in those areas. Under LIHP, these 10 "legacy counties"[1] officially launched local LIHPs on July 1, 2011. Eight other California counties and the County Medical Services Program (CMSP), a consortium of 35 counties, have also implemented local LIHPs. As of March 2013, two more counties had launched their programs.

Standard eligibility requirements for the program are citizenship status, age, income, county residency, and not being pregnant. These criteria were established by the California Department of Health Care Services (DHCS) and CMS. Local LIHPs administer the programs locally and are able to select an income criteria lower than the maximum of 200 percent of the Federal Poverty Level (FPL). Among LIHPs, income eligibility limits range from 25- 200 percent FPL.

LIHP Coverage Expansion

LIHP enrollment has increased steadily since July 2011. By the end of the first program year, more than 680,946 individuals had enrolled in LIHP, surpassing the initial enrollment projection of 512,000 individuals by the program's end in December 31, 2013. Ninety-four percent of

[1] A "legacy county" refers to any of the counties that participated in the previous Health Care Coverage Initiative demonstration waiver program (2007-2010): Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.

current enrollees are projected to be eligible for the Medi-Cal Expansion in 2014, while 6 percent are expected to be eligible for subsidies in California's Health Benefit Exchange, Covered California.[2] Various efforts by each local LIHP contributed to the program enrollment's surpassing the state's initial projection.

The majority of LIHP enrollees to date have been between the ages of 45 and 64 (55 percent). Almost one-third of LIHP enrollees (30 percent) were Latino, 20 percent of LIHP enrollees speak a primary language other than English, and 91 percent of LIHP enrollees had incomes at or below 133 percent FPL. Approximately 34 percent of enrollees had at least one of five common chronic conditions: diabetes, asthma/chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)/cardiovascular disease (CAD), dyslipidemia, and hypertension.

Access to Care

For this report, access to care of LIHP enrollees was measured by utilization of health services. The total volume of outpatient services and emergency room visits increased over the first three quarters of the program, reflecting the continuous growth in enrollment from Quarter 1 to Quarter 3 (July 1, 2011, through March 31, 2012).

To account for differences in the size of the population of LIHP enrollees, the rates of utilization were also measured as service per 1,000 active enrollees per month. These comparisons showed the following:

- The rate of outpatient services ranged from 2,195 in Quarter 1 to 1,745 in Quarter 3.
- The rate of ER visits ranged from 175 in Quarter 1 to 141 in Quarter 3.
- The rate of hospitalizations ranged from 46 in Quarter 1 to 32 in Quarter 3.
- The proportion of active enrollees who used behavioral health services ranged from 2.2 percent in Quarter 1 to 2.0 percent in Quarter 3.
- The proportion of active enrollees who used both behavioral and medical services ranged from 0.9 percent in Quarter 1 to 0.8 percent in Quarter 3.

These rates do not show conclusive trends, as they do not account for differences in patient characteristics and chronic conditions. However, the data do suggest a trend toward more outpatient care and away from high-cost emergency services. In addition, these rates may be influenced by pent-up demand for care among new LIHP enrollees.

[2] UCLA projections based on LIHP enrollment data as of December 31, 2012. For a detailed description of methodology, please see Appendix A: Available Data and Methods.

Quality of Care

All legacy LIHPs had established several structural measures of quality improvement activities. Nine of the ten legacy LIHPs had established evidence-based clinical guidelines for diabetes, and six had electronic diabetes registries. Fewer had established registries for other common chronic conditions. New LIHPs had also begun these processes.

Some LIHPs indicated that they measured the following processes of care:

- Riverside tracked and documented diabetes indicators such as low-density lipoprotein (LDL) and HbA1c test completion rates; annual retinal exam rates.
- San Mateo tracked mammogram and flu shot rates. San Mateo also reported that approximately 70 percent of the enrollees had a second behavioral health follow-up visit within 14 days of initial treatment, and 55 percent of enrollees had a third and fourth follow-up visit within 30 days of a second behavioral health treatment.
- San Diego tracked beta-blocker treatment for those diagnosed with acute myocardial infarction; smoking cessation assistance; and rates of follow-up within seven days following a hospitalization related to mental illness.

Conclusions

By March 2013, 19 LIHPs were operating in California, covering 53 counties. As of December 31, 2012, 680,946 low-income individuals had enrolled in the program since its inception. This enrollment exceeded the projections for the program, most likely due to innovative efforts initiated at the local level. Such efforts included community outreach and partnerships, effective use of IT systems, increased efficiency, cost control measures, staff training, and successful retention and redetermination efforts.

The interim data on utilization of outpatient services, behavioral health services, and emergency room visits indicated an increase in the volume of services provided during the program. However, it is premature to discern the reliability of trends in these utilization patterns due to significant limitations in the availability of data for all participating LIHPs, the rapid growth in enrollment, and changes to newly implemented LIHPs in this time period. Self-reported quality of care data indicated the progress of LIHPs in establishing data systems and benchmarks for tracking quality performance measures and quality improvement efforts.

Overall, available data indicate that the program is succeeding in preparing California for the upcoming transition of a significant portion of the state's population to coverage under Medi-Cal and Covered California. The final LIHP evaluation will provide a comprehensive overview of the successes and challenges of the program during the two and a half years of program operation.

Introduction

Background and Program Description

In November of 2010, California's "Bridge to Reform" §1115 Medicaid waiver was approved by the Centers for Medicare and Medicaid Services (CMS). The waiver expanded Medi-Cal managed care for seniors and persons with disabilities, allowed new pilot projects in the California Children's Services program, approved new quality improvement and patient safety programs for public hospitals through Delivery System Reform Incentive Payments, and created the Low Income Health Program (LIHP) to provide health care to underinsured or uninsured nonelderly adults in California.

LIHP is an expanded, optional, locally funded, federally reimbursed health care coverage program for low-income individuals that is administered at the local level. Local LIHPs receive 50 percent of their overall program spending in federal reimbursement funds through the waiver administered by California's Department of Health Care Services (DHCS). LIHP includes two main program components, distinguished by family income eligibility levels: Medicaid Coverage Expansion (MCE), for those living at or below 133 percent of the Federal Poverty Level (FPL); and the Health Care Coverage Initiative (HCCI), for those with incomes of 133-200 percent FPL. When the Affordable Care Act (ACA) begins on January 1, 2014, the Special Terms and Conditions (STCs) of the waiver will require the transition of LIHP enrollees into available coverage options in California. Currently enrolled MCE beneficiaries will be transitioned from their local LIHPs to Medi-Cal, while HCCI enrollees will be referred to Covered California, the state health benefit exchange.

To be eligible for LIHP, individuals must meet all of the following eligibility criteria:

- U.S. citizen or satisfactory immigration status
- Between the ages of 19 and 64
- County resident
- Family income within the range established by the local LIHP, up to and including 200 percent FPL
- Not be eligible for the Medi-Cal program
- Not be pregnant

Income eligibility criteria are set by local LIHP administrators. Depending on availability of resources, local governments implementing LIHPs may elect to limit enrollment by establishing

thresholds for income below the allowable maximum. However, LIHPs cannot select higher FPL eligibility limits (i.e., above 133-200 percent FPL) without covering lower FPL limits.

LIHP provides access to covered health care services in one of two ways: through the existing safety net health care system within the local LIHP service area, or through an expanded network of providers built upon the existing system for meeting indigent care expectation (Section 17000 of the California Welfare and Institutions Code).

LIHPs are required to include:

- A defined provider network and the assignment of enrollees to a medical home
- A benefit package that includes a comprehensive set of services, including primary and preventive care services, hospital services, pharmacy, and specialty care
- Coordination of care
- Monitoring of quality of care indicators

The goal of LIHP is to shift low-income uninsured or underinsured individuals from more costly episodic care to a more coordinated system of care, thereby improving their access to care, quality of care, and overall health.

LIHP builds upon the previous HCCI demonstration waiver program, which was scheduled to end August 31, 2010 but was extended through October 31, 2010. This HCCI demonstration program was operated by 10 counties and provided an opportunity for expansion of health care coverage for local governmental entities that opted to participate. Beginning on September 1, 2007, the previous HCCI program extended health care coverage to eligible low-income uninsured adults who were otherwise ineligible for Medi-Cal and other public health care programs in 10 selected counties. The participating counties were Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. These counties, known as "legacy counties" under the LIHP demonstration, continued and expanded the original HCCI programs during the transition period (November 1 – June 30, 2011) to meet the new LIHP requirements that began on July 1, 2012.

LIHP enrollees are either transitioned into the program from the previous HCCI demonstration waiver program or are newly enrolled. Those who were transitioned into the program are categorized as "existing" enrollees, whether they are in the MCE or HCCI program component of LIHP. Those who are new to LIHP are categorized as "new" enrollees, regardless of whether they are in the MCE or HCCI program component. Only four of the 10 legacy counties opted to keep income eligibility criteria at up to 200 percent FPL, and they are thus the only local LIHPs that can have new HCCI enrollees.

The University of California, Los Angeles Center for Health Policy Research (UCLA) was selected to conduct an independent evaluation of LIHP. The evaluation monitors the progress of the LIHP demonstration project in four areas:

1. Outreach, enrollment, retention, and transition strategies
2. Coverage expansion
3. Access to and quality of care
4. Care delivery system redesign in anticipation of ACA implementation in 2014

The primary goal of the evaluation is to provide information to various stakeholders on the impacts of LIHP in each of these areas. Rigorous evaluation of LIHP relies on continuous data collection, cleaning, and management by the LIHPs. UCLA offers ongoing training and technical assistance related to variable development, data collection, and data transmission to local LIHP administrators. In addition, UCLA provides quarterly performance dashboards for each LIHP that include summary data on enrollment, demographics of enrollees, and service utilization, enabling individual LIHPs to monitor and compare their progress.

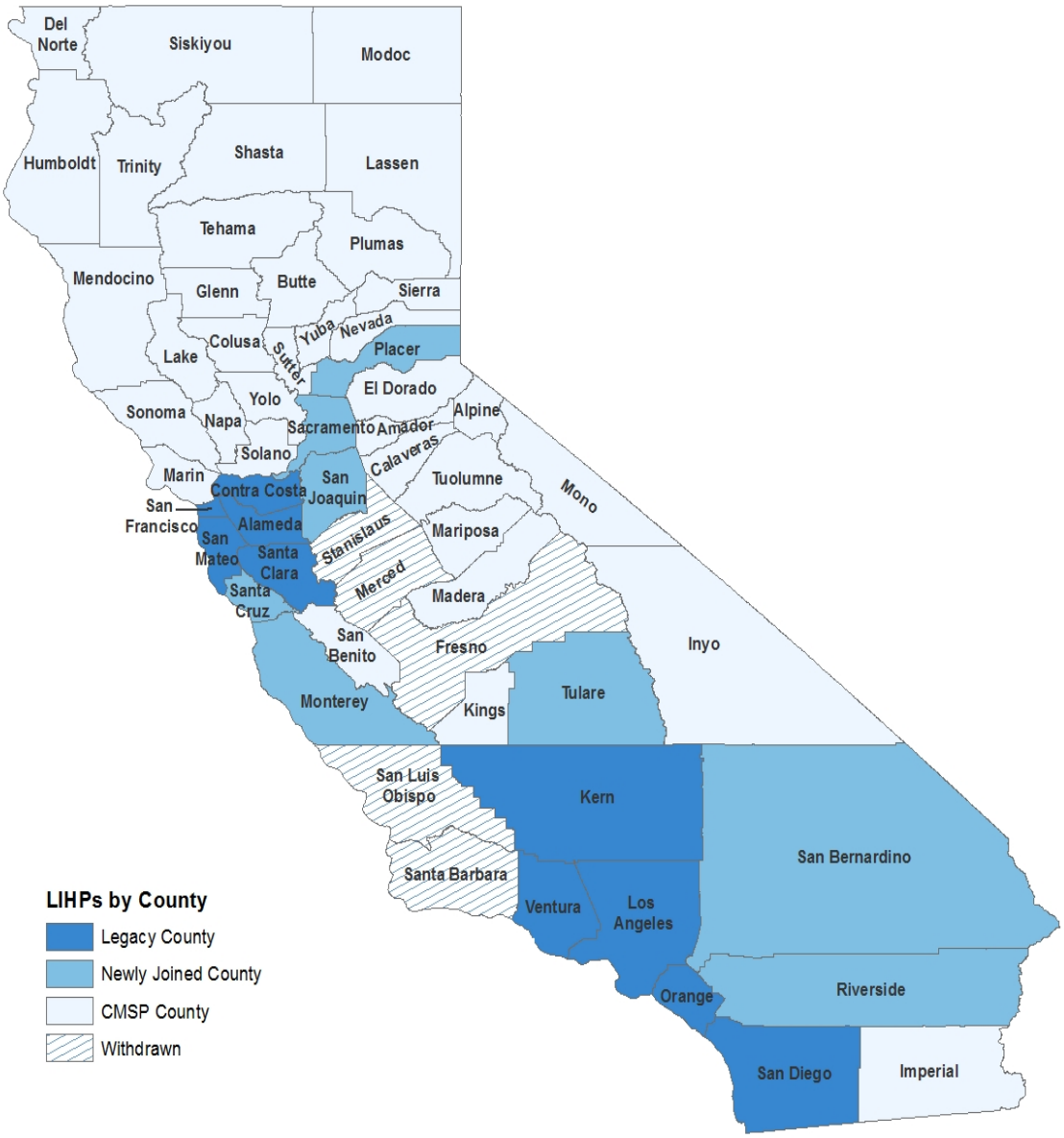
Implementation Process and Program Components

Local LIHPs were implemented from July 2011 until March 2013. The 10 legacy counties comprised the first cohort to implement local LIHPs, in July 2011 (Exhibit 1). In January 2012, Riverside, San Bernardino, and Santa Cruz counties launched local LIHPs. The County Medical Services Program (CMSP), which was a consortium of 34 California counties, also launched at that time.[3] San Joaquin County began operation of its local LIHP in June 2012. CMSP added Yolo County to its LIHP on July 1, 2012, bringing the consortium up to 35 county members. Placer County implemented its local LIHP on August 1, 2012, and Sacramento County implemented on November 1, 2012. Monterey and Tulare, the last two anticipated LIHP counties, began implementation in March 2013. No further LIHP implementation is anticipated, and the LIHP demonstration will end on December 31, 2013.

Local LIHPs have indicated that the variations in LIHP implementation were determined by resources and other considerations, including competing priorities, budget issues, and challenges in contracting with providers, all of which contributed to different implementation dates.

[3]The County Medical Services Program (CMPS) includes 35 rural counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo (joined on July 1, 2012), and Yuba.

Exhibit 1: LIHP Implementation Status by County

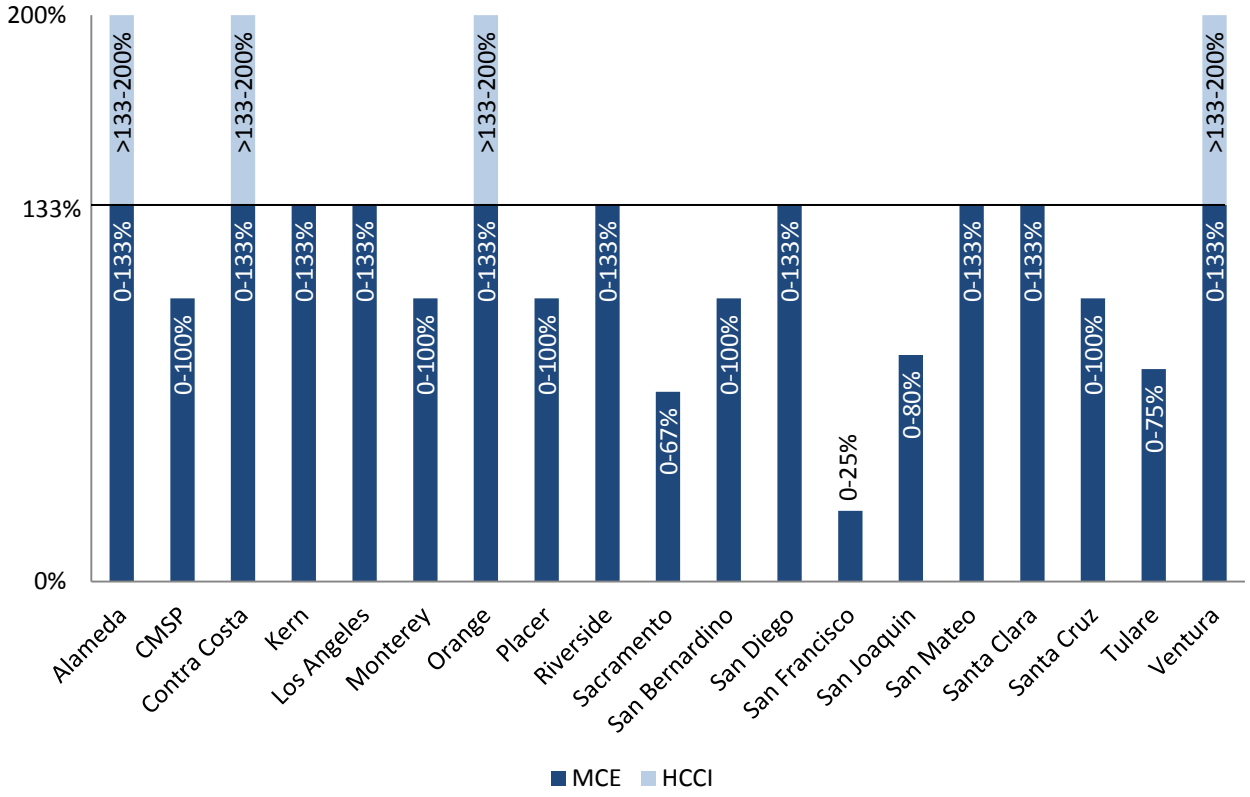


Source: Low Income Health Program contracts with California Department of Health Care Services.

Income Eligibility Criteria

Exhibit 2 demonstrates the various FPL limits by MCE and HCCI program components. Currently, only four LIHPs are enrolling individuals in the HCCI program who have incomes above 133 percent FPL to 200 percent FPL. Four counties have FPL limits below 100 percent and as low as 25 percent (San Francisco). Five LIHPs limit enrollment to 100 percent of FPL, and the remaining six LIHPs chose 133 percent FPL levels. Santa Clara County and Kern County increased their enrollment income eligibility levels to 133 percent FPL early in 2013.

Exhibit 2: Federal Poverty Level Limits by Local Low Income Health Program (LIHP)



Source: Low Income Health Program contracts with the California Department of Health Care Services.

Core Benefits Under LIHP

Under LIHP, all enrollees are entitled to a core benefits package (Exhibit 3). MCE enrollees are entitled to additional core benefits, including mental health and limited medical transportation.

Exhibit 3: Low Income Health Program Core Benefits

MCE and HCCI Core Benefits	Additional Core Benefits for MCE
i. Medical equipment and supplies ii. Emergency care services iii. Acute inpatient hospital services iv. Laboratory services v. Outpatient hospital services vi. Physical therapy vii. Physician services viii. Prescription and limited nonprescription medications ix. Prosthetic and orthotic appliances and devices x. Radiology	i. Minimum mental health services ii. Prior authorized nonemergency medical transportation when medically necessary

Source: Low Income Health Program contracts provided by the California Department of Health Care Services.

Network Structure

The provider networks across all LIHPs vary due to inherent differences in local delivery systems prior to LIHP. Available data as of June 2012 demonstrated that there were close to 5,000 primary care providers in the LIHP network throughout the state (Exhibit 4). CMSP had the highest volume of providers (1,326) across the 35 counties that are within the consortium. The majority of primary care physicians in LIHP networks were in family or general internal medicine. There were 196 hospitals in LIHP provider networks (Exhibit 4), including 95 in the CMSP network.

Exhibit 4: Number of Primary Care Providers and Hospitals in the LIHP Network by Local LIHP

Local LIHP	Number of Primary Care Providers in Network	Number of Hospitals in Network
Alameda	236	2
CMSP (County Medical Services Program)	1,326	95
Contra Costa	137	7
Kern	117	2
Los Angeles	569	7
Orange	716	25
Riverside	47	10
San Bernardino	166	2

Local LIHP	Number of Primary Care Providers in Network	Number of Hospitals in Network
San Diego	1,032	28
San Francisco	132	2
San Joaquin	38	2
San Mateo	144	7
Santa Clara	169	1
Santa Cruz	23	4
Ventura	68	2
Total	**4,920**	**196**

Source: Low Income Health Program Network Provider lists (Deliverable #3) as of June 2012.

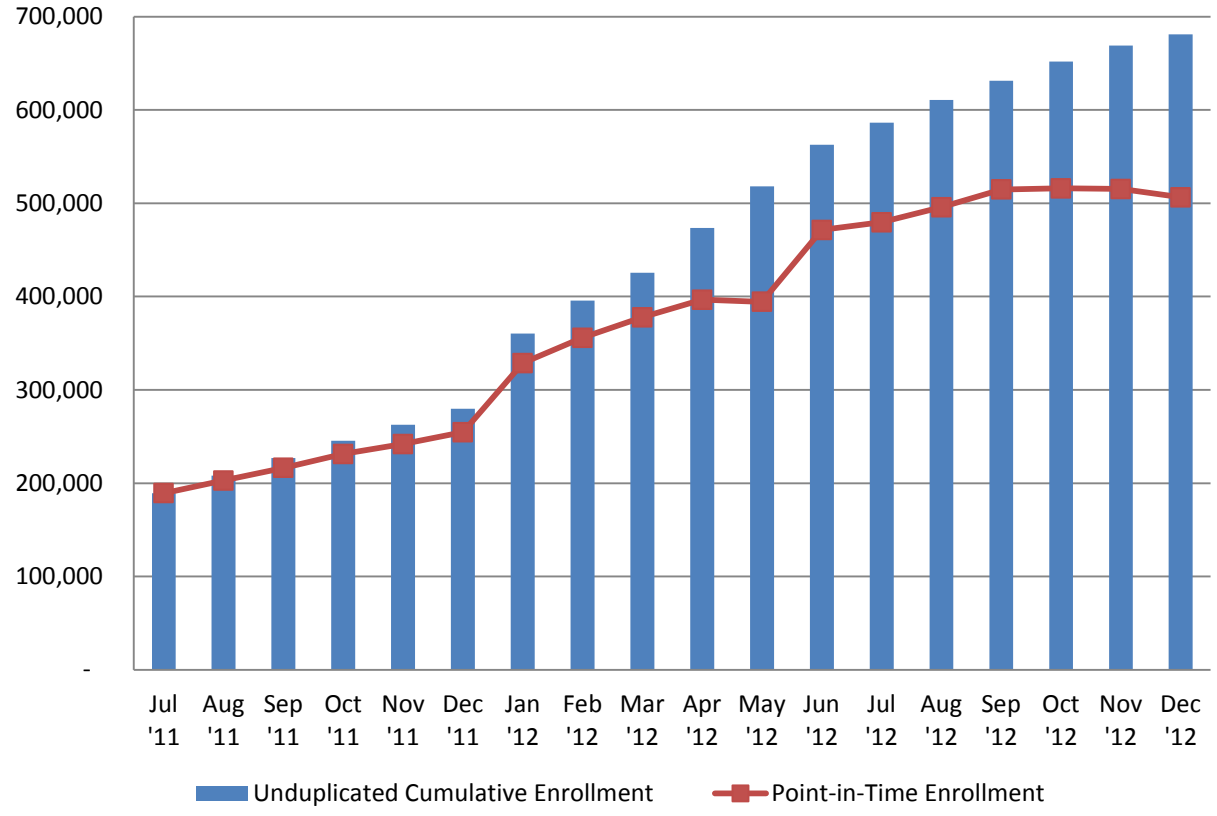
Data and Methods

Individual-level data for the analyses in this report are received on a quarterly basis from local LIHPs. However, due to the staggered implementation process of LIHP, not all data date to the July 2011 official start of the program. Furthermore, because data are still being collected, this report only provides descriptive analyses and does not offer any statistical analyses. For more information on data availability and methods, please see Appendix A: Available Data and Methods.

LIHP Coverage Expansion and Characteristics of Enrollees

LIHP enrollment has increased steadily since the beginning of the program. By the end of the first program year, 680,946 individuals had been enrolled in LIHP, including individuals who were enrolled at any point and those who disenrolled during the program operation period (Exhibit 5). In the first six months of LIHP, enrollment grew by an average of 8 percent each month. This growth reflects an expansion of enrollment in the legacy counties operating during this period. In January 2012, enrollment grew by 21 percent from the previous month, due to the launch of LIHP in three new counties and CMSP. The increase in enrollment continued through December 2012.

Exhibit 5: Monthly Unduplicated Cumulative and Current Enrollment as of December 31, 2012

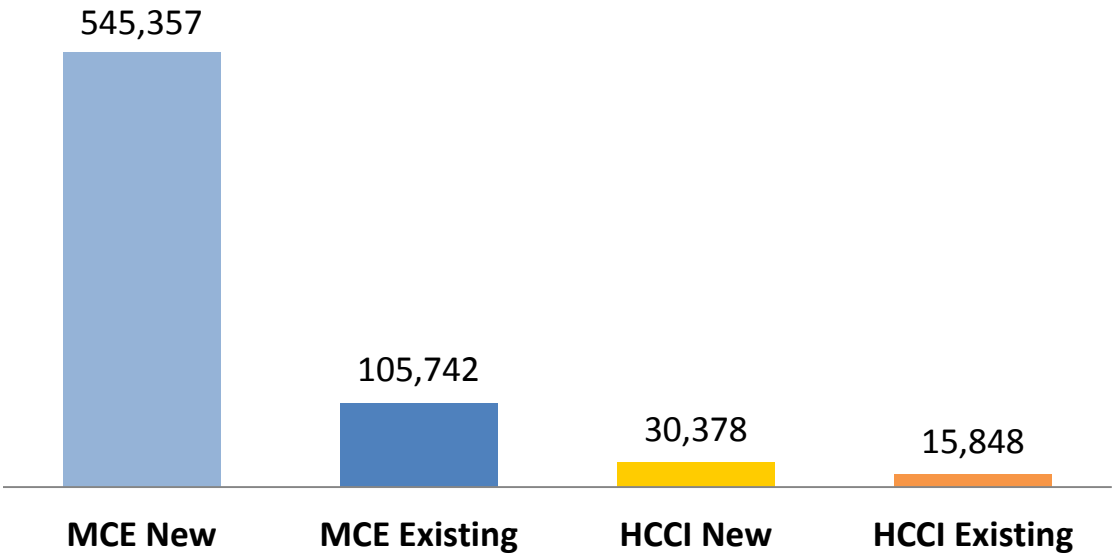


Notes: (1) Ten LIHPs were active from July 2011 through December 2011. Four additional LIHPs, including the County Medical Services Program (CMSP), launched in January 2012. San Joaquin launched in June 2012, Placer in August 2012, and Sacramento in November 2012. (2) Unduplicated cumulative enrollment data by local LIHP can

be found in Appendix B, Exhibit 1. (3) Monthly point-in-time enrollment by local LIHP can be found in Appendix B, Exhibit 2.
Source: UCLA analysis of Low Income Health Program enrollment data.

LIHP enrollees were predominantly MCE new enrollees (545,357; Exhibit 6). The second largest group was MCE existing enrollees, those who were at or below 133 percent FPL and who had enrolled prior to the start of LIHP under the HCCI demonstration waiver. The low number of HCCI enrollees reflects the limited number of local LIHPs that have implemented the HCCI component of the LIHP. Again, these proportions reflect the determination of income eligibility limits by local LIHPs based on their own policy decisions and available resources.

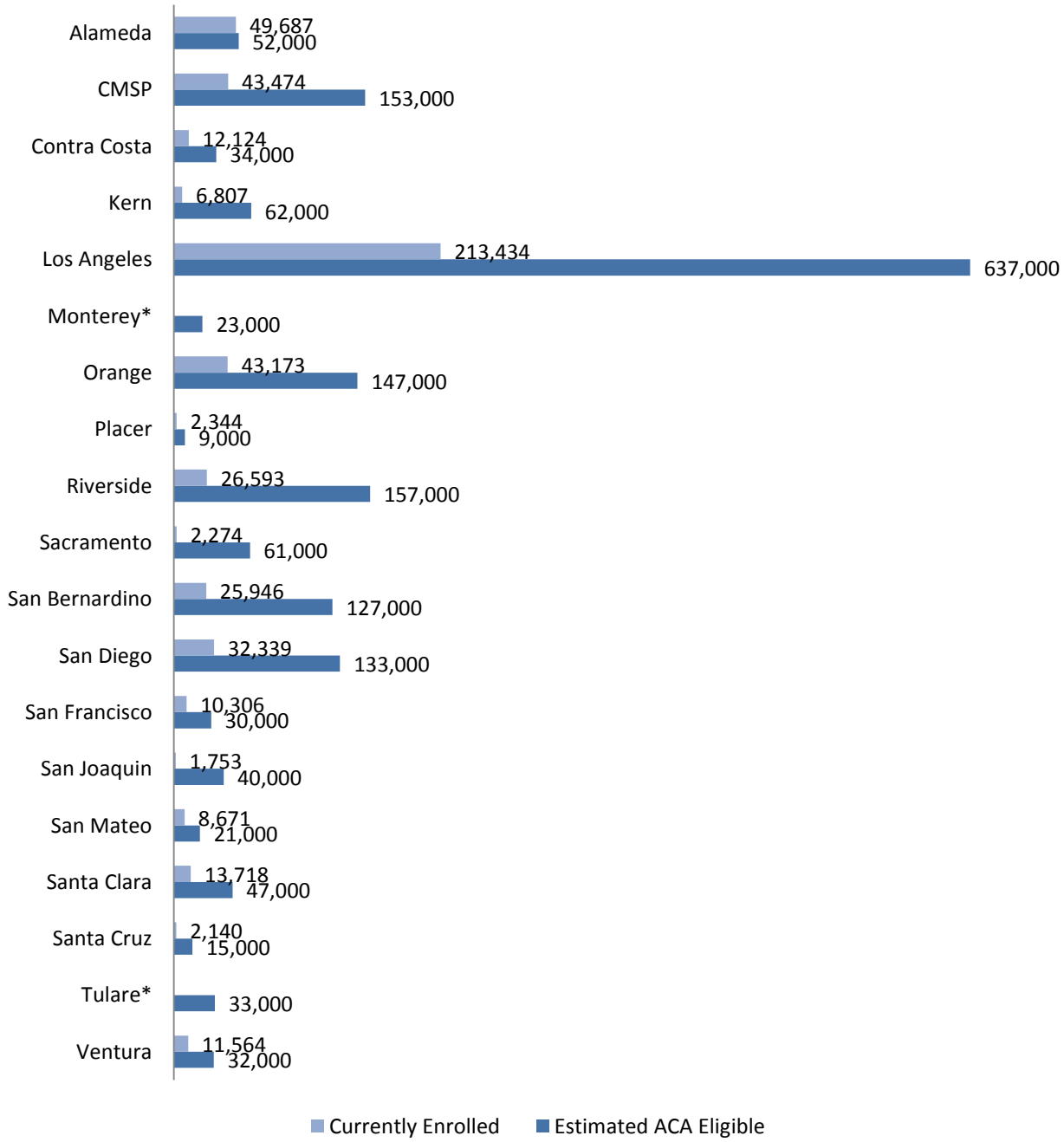
Exhibit 6: Cumulative Total of Unduplicated Enrollees in Each Program Component, as of December 31, 2012



Source: UCLA analysis of Low Income Health Program enrollment data.

The proportions of currently enrolled LIHP enrollees who will be eligible for the Medi-Cal Expansion or for Covered California are 94 percent and 6 percent, respectively (data not shown). Exhibit 7 displays the proportion of the eligible population in each local LIHP if the maximum allowable FPL limit of 200 percent were implemented, as well as the proportion of individuals enrolled in LIHPs as of December 31, 2012. UCLA estimated the total eligible population using small area estimation (SAE) methodology. A detailed description of this methodology can be found in Appendix A: Available Data and Methods. The size of the eligible population does not account for potential uptake by currently insured individuals who may be eligible for Medi-Cal or Covered California after implementation of the ACA. The lower income eligibility thresholds in some LIHPs have translated to lower enrollment and fewer eligible enrollees who would transition seamlessly from LIHP to ACA coverage.

Exhibit 7: LIHP Current Enrollment and Estimated ACA-Eligible Population, per Local LIHP, as of December 31, 2012



Notes: (1) Monterey and Tulare launched local LIHPs in March 2013, and therefore no enrollment data are available. (2) Detailed information on UCLA's SAE methodology can be found in the Small Area Estimation section of Appendix A: Available Data and Methods.
Sources: UCLA Small Area Estimation (SAE) and analysis of Low Income Health Program enrollment data.

Successful Outreach, Enrollment, and Retention Strategies

Outreach and enrollment efforts within each local LIHP contributed to the program enrollment's surpassing the state's initial projection. Moreover, LIHPs successfully retained enrollees to maintain the overall volume of enrollment in LIHP. Outreach and enrollment efforts have included the following:

- Partnering of LIHPs with service providers, county-based organizations, and advocacy groups to reach out to the eligible population.
- Using information technology (IT) systems (e.g., webinars, video conferencing, online training) to train workers in the program's eligibility requirements and covered benefits, which proved to be a low-cost and innovative way to train a large, dispersed workforce.
- Setting up kiosks at service provider venues to screen for eligibility, creating an electronic application for LIHP, placing outreach and eligibility workers in high-volume settings, and using available IT systems to verify documentation for eligibility determinations.
- Using automated phone calls, mailing of notifications, and prepopulated applications to redetermine and renew enrollees, along with Web-based renewal options.

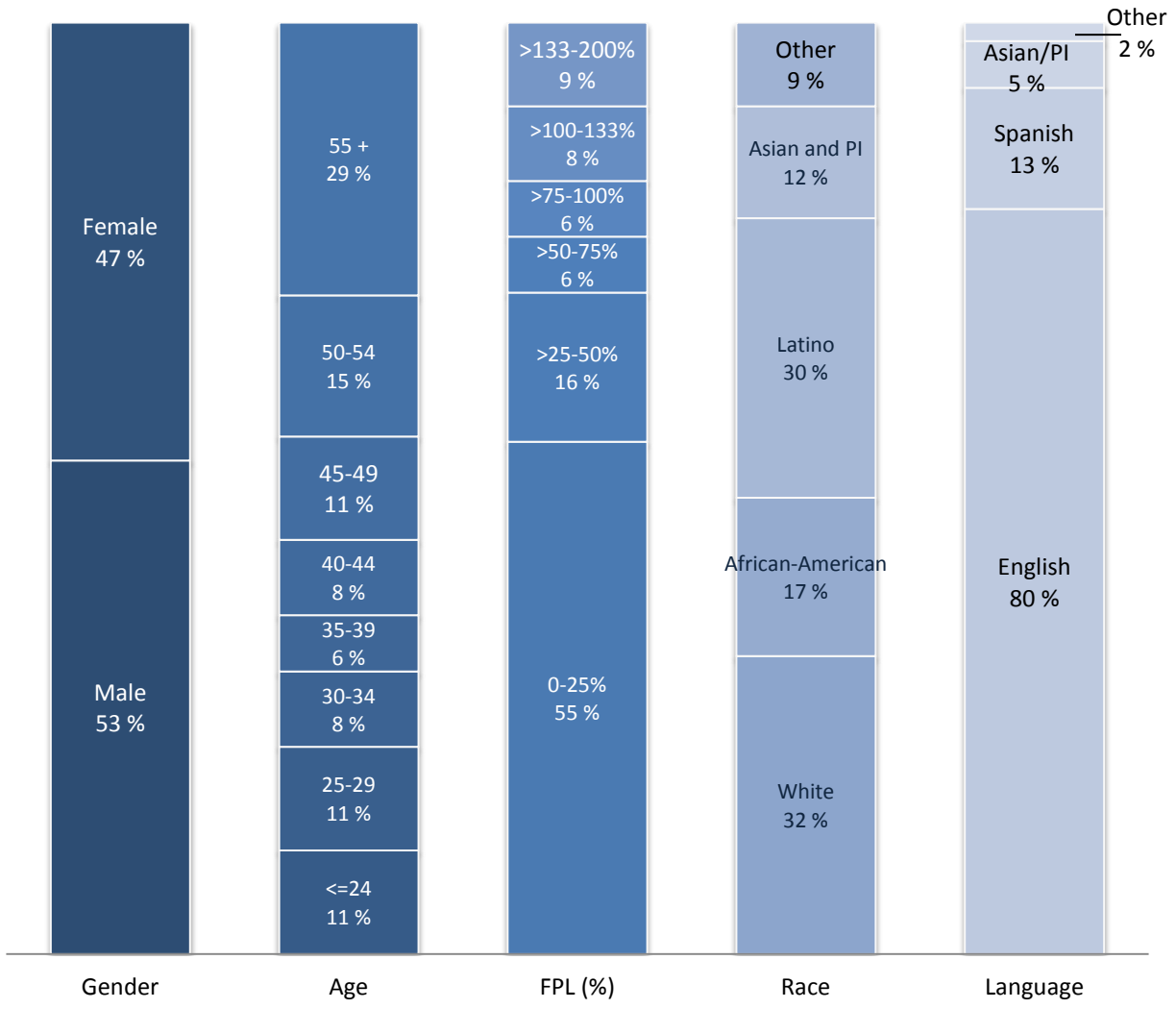
The outreach and enrollment efforts of LIHPs are documented in the UCLA publication *Successful Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP)*.[4]

Sociodemographic Characteristics

The sociodemographic characteristics demonstrate that LIHP enrollees tended to be older, varied in race/ethnicity, primarily English-speaking, and with family incomes at or below 133 percent FPL. Fifty-five percent of LIHP enrollees were between the ages of 45 and 64 (Exhibit 8). According to the available data, almost one-third of LIHP enrollees (30 percent) were Latino, 20 percent of LIHP enrollees spoke a primary language other than English, and 91 percent of LIHP enrollees had an income at or below 133 percent FPL. Approximately half were female. Sociodemographic characteristics by local LIHP are displayed in Appendix B, Exhibit 4 through Appendix B, Exhibit 11.

[4]Meng YY, Cabezas L, Roby DH, Pourat N, and Kominski GF. Successful Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP). Los Angeles, CA: UCLA Center for Health Policy Research, September 2012. Available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/lihppolicynotesep2012.pdf

Exhibit 8: Sociodemographic Characteristics of LIHP Enrollees as of December 31, 2012



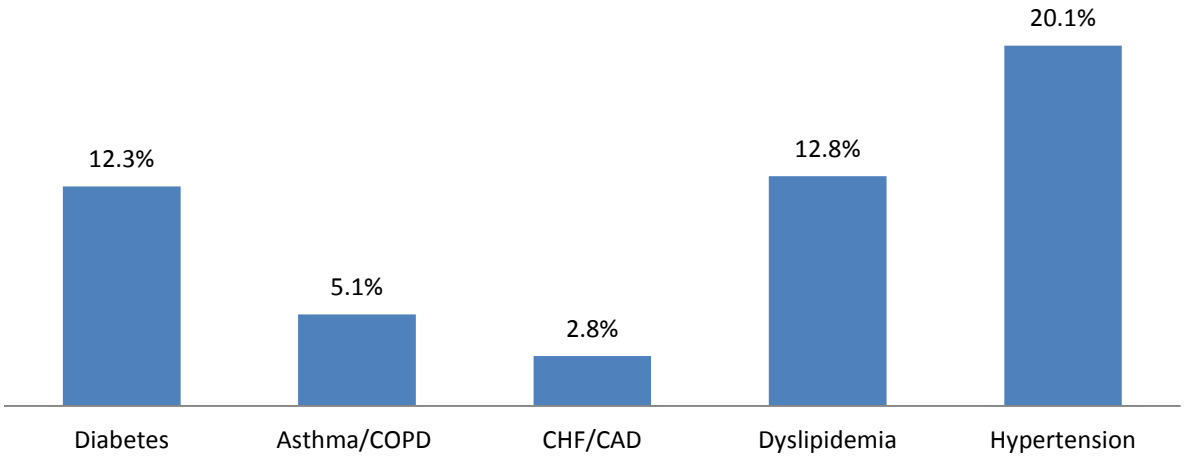
Notes: (1) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (2) For "Race," Asian includes Native Hawaiian, "PI" is for Pacific Islander, and "Other" includes American Indian or Alaska Native.
Source: UCLA analysis of Low Income Health Program enrollment data.

Chronic Conditions

More than one-third of LIHP enrollees had some type of chronic illness. Approximately 34 percent of LIHP enrollees had at least one of five considered chronic conditions – diabetes, asthma/chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF)/cardiovascular disease (CAD), dyslipidemia, and hypertension (Exhibit 9). Twenty percent of enrollees had one of these conditions, 12.7 percent had two to three, and 1.1 percent had

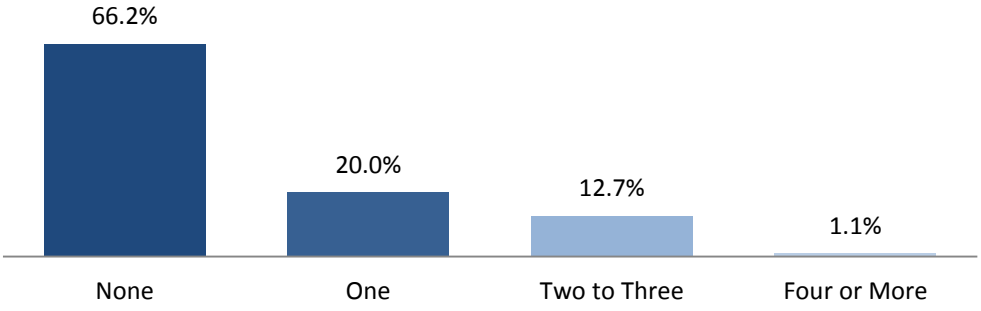
four or more (Exhibit 10). The prevalence of each condition by each LIHP is displayed in Appendix B, Exhibit 14 and Appendix B, Exhibit 15.

Exhibit 9: Chronic Disease Prevalence Among LIHP Enrollees, by Condition, as of December 31, 2012.



Note: According to UCLA Diagnosis Methodology, data are among five chronic conditions investigated.
Source: UCLA analysis of Low Income Health Program claims data.

Exhibit 10: Chronic Disease Prevalence Among LIHP Enrollees, by Number of Conditions, as of December 31, 2012



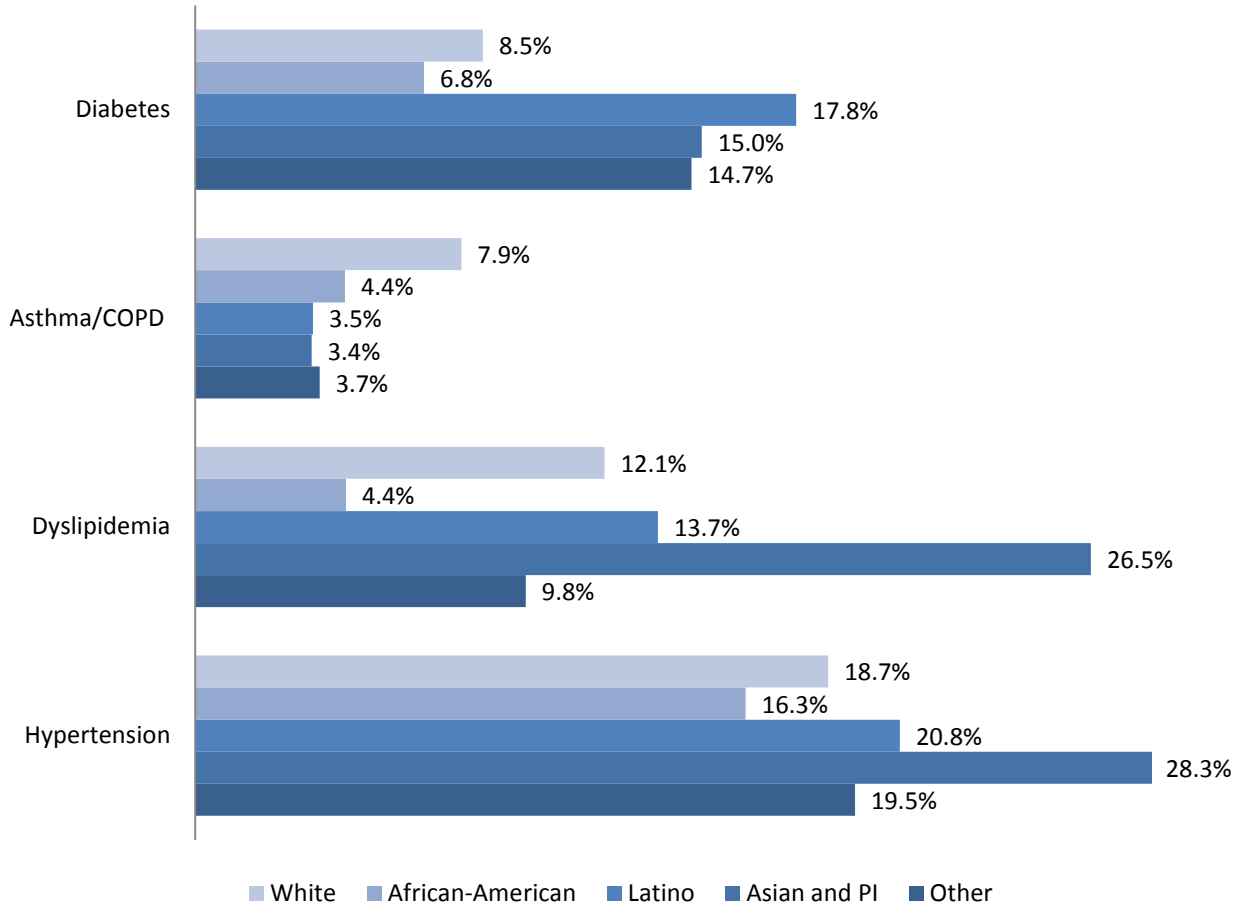
Note: According to UCLA Diagnosis Methodology, data are among five chronic conditions investigated.
Source: UCLA analysis of Low Income Health Program claims data.

Analysis of Characteristics of LIHP Enrollees

This section documents the variation in the prevalence of these chronic conditions by race/ethnicity. Approximately 12 percent of all LIHP enrollees had diabetes. The prevalence of diabetes was 17.8 percent among Latinos, and 8.5 percent and 6.8 percent among Whites and African-Americans, respectively (Exhibit 11). Asthma/COPD prevalence was 5.1 percent among all LIHP enrollees. The prevalence was 3.5 percent among Latinos, 3.4 percent among Asian-Americans/Pacific Islanders, and 7.9 percent among Whites.

Approximately 12.8 percent of LIHP enrollees had a diagnosis of dyslipidemia. Approximately 4.4 percent of African-Americans and 26.5 percent of Asian-Americans/Pacific Islanders had a diagnosis of dyslipidemia. Hypertension prevalence among LIHP enrollees overall was 20.1 percent. More than one-quarter (28.3 percent) of Asian-Americans/Pacific Islanders had hypertension, compared to 20.8 percent of Latinos and 18.7 percent of Whites. Data on these characteristics by local LIHP can be found in Appendix B, Exhibit 16 through Appendix B, Exhibit 25.

Exhibit 11: Chronic Disease Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012



Notes: (1) Asian includes Native Hawaiian. (2) "PI" is for Pacific Islander. (3) Other includes American Indian or Alaska Native.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Access to Care

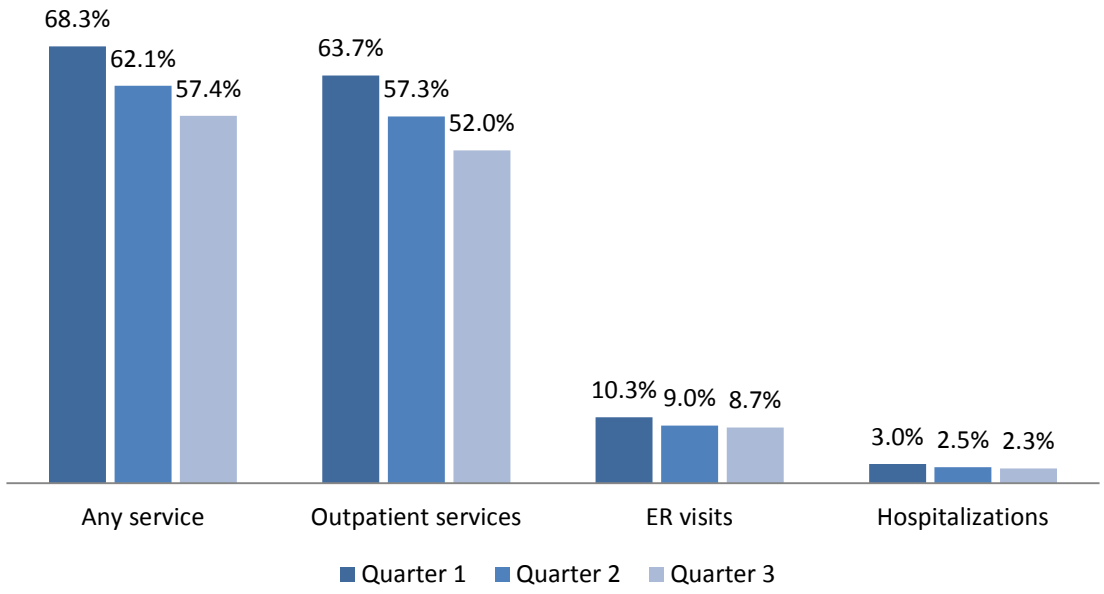
Access to care under LIHP was assessed by utilization of services during the program by active enrollees, defined as enrollees with at least one claim for any service (see Appendix A: Available Data and Methods). Utilization is reported for the program overall, and utilization for each LIHP is reported in Appendix B, Exhibit 26 through Appendix B, Exhibit 30. Services examined include outpatient services, behavioral health services, emergency room visits, and hospitalizations. Rates reported throughout this section are subject to change due to the lag in receipt of claims data.

The utilization data presented in this section include the first three quarters of LIHP. The majority of the data are therefore from the 10 legacy counties that had active programs since the beginning of the LIHP demonstration in July 2011. Later data for legacy counties and data for LIHPs that began operations more recently are not included because of limited data availability and lags in claims data.

Proportion of Enrollees Who Were "Active Users"

The proportion of active enrollees for the first three quarters of 2011 is displayed in Exhibit 12. The data indicate a range in service use from 68.3 percent of enrollees in Quarter 1 to 57.4 percent of enrollees in Quarter 3. Variations in the proportion may be the result of a changing population as outreach and enrollment strategies improve and expand. The enrolled population may also be relatively healthier as pent-up demand decreases among newly insured enrollees.

Exhibit 12: Proportion of Enrollees Who Were Active Users, by Service Type, LIHP, as of March 31, 2012

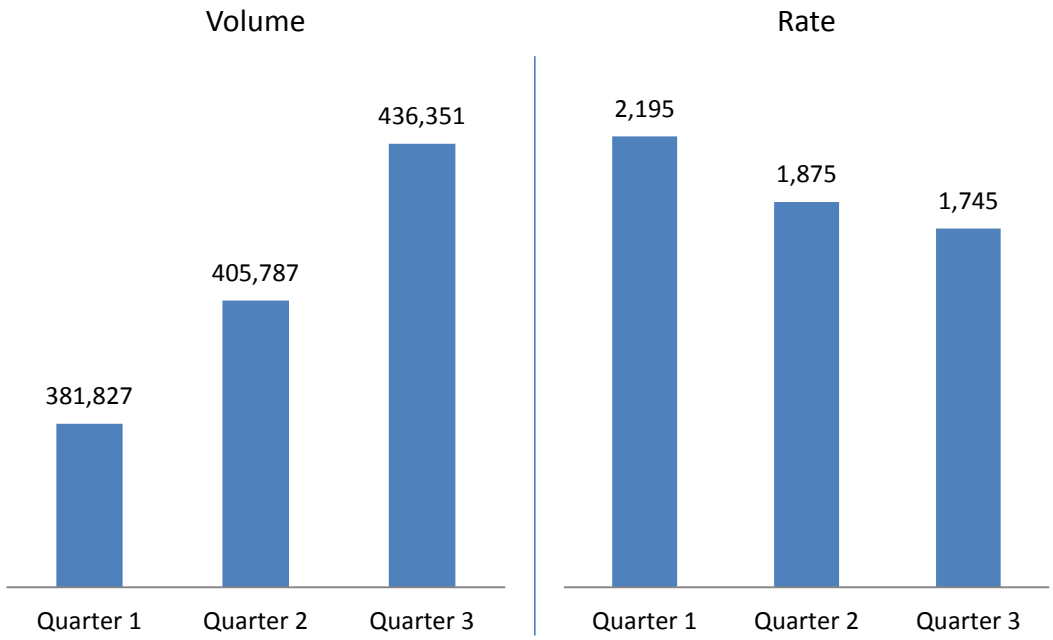


Note: Utilization data are for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Data on active users of behavioral health are reported separately in Appendix B, Exhibit 26 through Appendix B, Exhibit 28.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Outpatient Services

The total volume of outpatient services provided over the first three quarters of LIHP is displayed in Exhibit 13. A steady growth in the number of outpatient services in this time frame is consistent with the growth in enrollment in LIHP. Exhibit 13 also shows the rate of outpatient services measured as number of services per 1,000 active enrollees per month, which ranged from 2,195 in Quarter 1 to 1,745 in Quarter 3.

Exhibit 13: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Outpatient Services by Quarter, LIHP, as of March 31, 2012

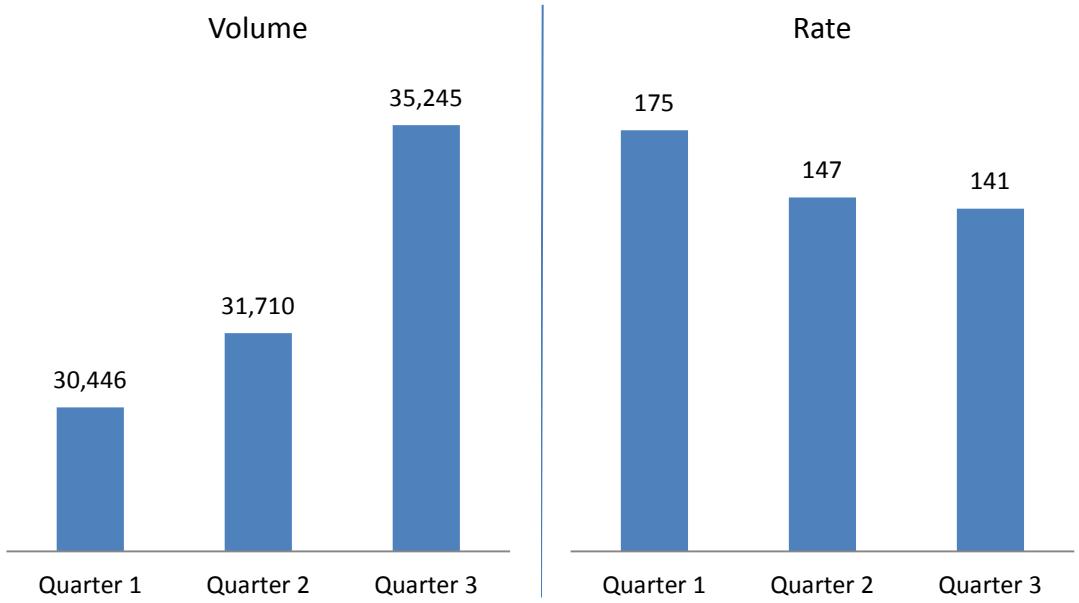


Note: Outpatient services are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Emergency Room Visits

The total volume and the rate of ER visits (the number of visits per 1,000 active enrollees per month) are displayed in Exhibit 14. The frequency of ER visits is influenced by demographics, chronic conditions, and other characteristics that are not examined in this report.

Exhibit 14: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Emergency Room Visits by Quarter, LIHP, as of March 31, 2012

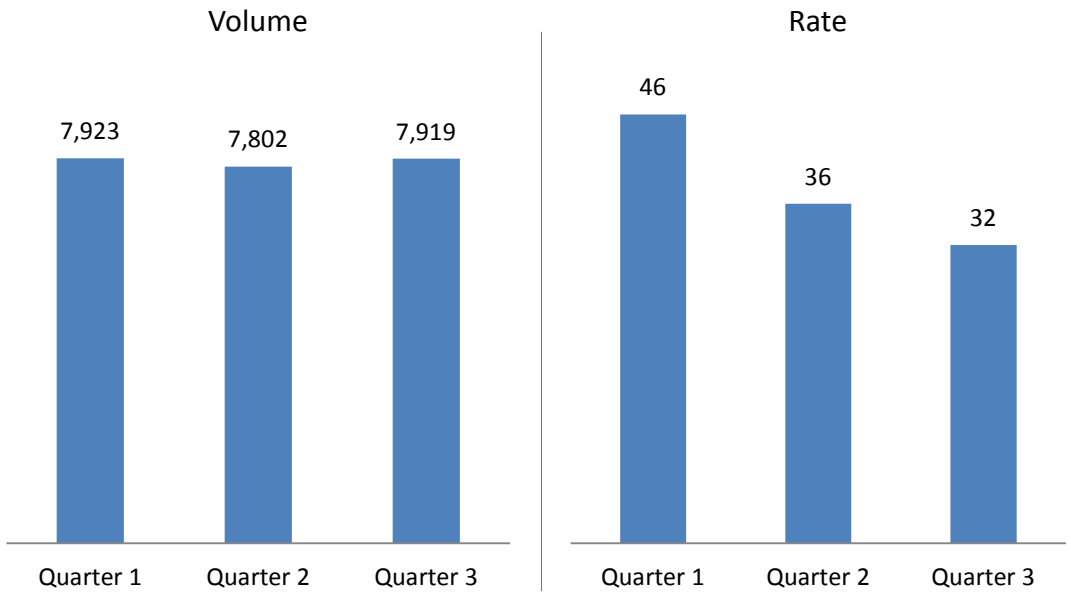


Note: Emergency room data are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Hospitalizations and Inpatient Days

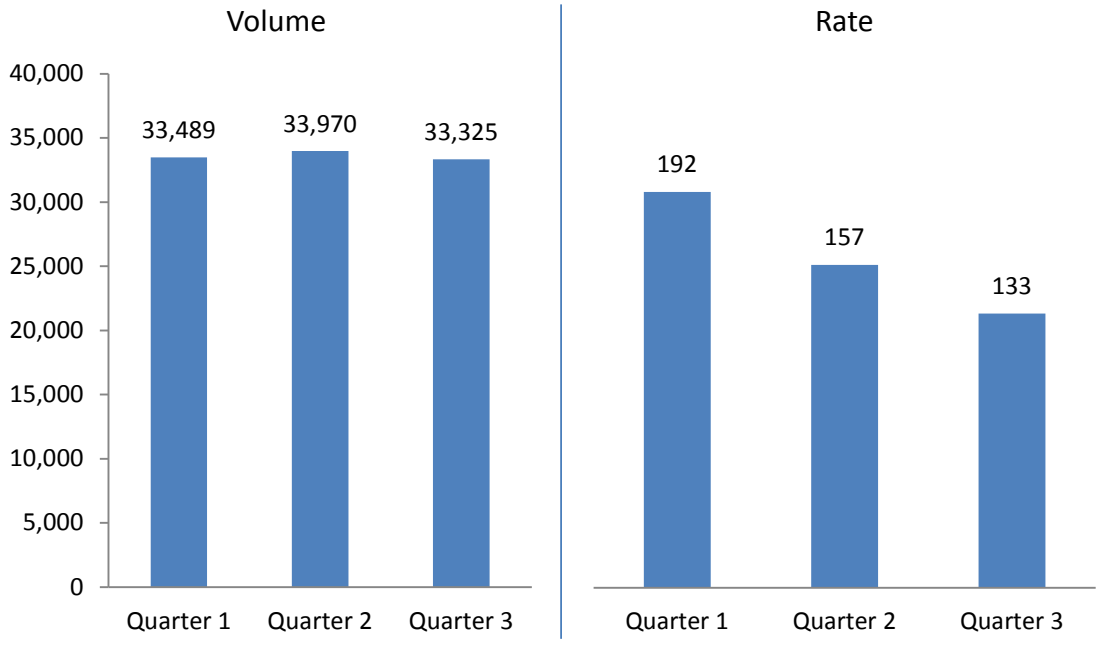
Exhibit 15 shows the total volume and the rate of hospitalizations (the number per 1,000 active enrollees per month), which ranged from 46/1,000 enrollees in Quarter 1 to 32/1,000 enrollees in Quarter 3. The total number of inpatient days ranged from 33,489 in Quarter 1 to 33,325 in Quarter 3, with rates ranging from 192/1,000 enrollees to 133/1,000 enrollees, respectively (Exhibit 16).

Exhibit 15: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Hospitalizations by Quarter, LIHP, as of March 31, 2012



Note: Hospitalization data are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Exhibit 16: Total Volume and Rate (Number per 1,000 Active Enrollees per Month) of Inpatient Days by Quarter, LIHP, as of March 31, 2012



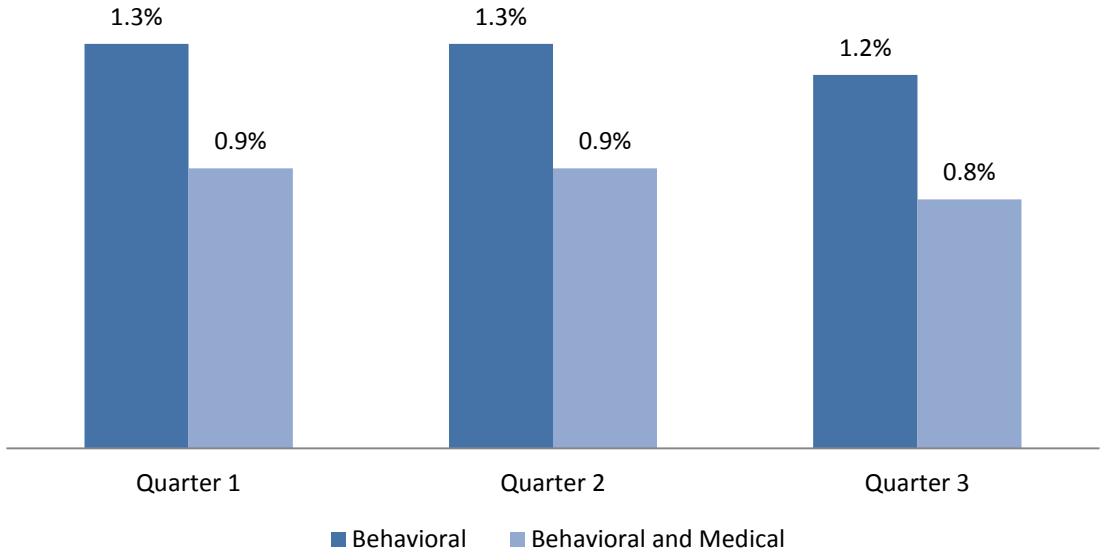
Note: Data on inpatient days are displayed for the 10 legacy counties: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Behavioral Health Services

Some counties provided mental health services under the previous HCCI, but a core set of mental health services is a new requirement for MCE LIHP enrollees. Some local LIHPs also provide services to HCCI enrollees and more extensive mental health services and substance abuse services generally, though these are not requirements. Information presented here is limited to those LIHPs that submitted behavioral health utilization data. Additional data are expected in upcoming quarters as more processed claims are received.

Exhibit 17 shows that the proportion of active enrollees who had used any behavioral health services ranged from 1.3 percent to 1.2 percent in the program's first three quarters. The total claims submitted for these services were 1,711; 2,055; and 3,865 in quarters 1, 2, and 3, respectively (data not shown). In addition, the proportion of active users who used both behavioral and medical health services ranged from 0.9 percent to 0.8 percent in the first three quarters. These proportions corresponded to 1,247; 1,402; and 2,506 in quarters 1, 2, and 3, respectively (data not shown).

Exhibit 17: Proportion of Active Enrollees Who Used Behavioral Health Services and Proportion Who Used Behavioral *and* Medical Health Services by Quarter, LIHP, as of March 31, 2012



Note: Data represent the four local LIHPs – Alameda, Contra Costa, Kern, and Los Angeles – for which sufficient behavioral health claims data were available. Other LIHPs either did not submit behavioral health claims data or had fewer than five "active user" enrollees in a given period.
Source: UCLA analysis of Low Income Health Program enrollment and claims data.

Quality of Care

In accordance with their DHCS contracts, LIHPs agree to report on quality of care and to address any needed improvements during the program. Specific quality measures are not identified in STCs or LIHP contracts, and LIHPs have flexibility in selection and implementation of quality improvement activities.

For this report, quality of care is assessed based on the structure of the delivery system, process of care delivery, and patient outcomes. At the time of this report, some data on the structural measures, including health IT, chronic disease registries, and clinical guideline development, were available. Additionally, some LIHPs also submitted self-reported data on process measures, such as receipt of timely preventive services and chronic disease performance indicators that provide insight into how local LIHPs are confronting quality-of-care issues. These data are included in this section. However, outcome measures were not available at the time of this report and thus are not included.

Structural Measures

The 10 legacy LIHPs that had HCCI programs had established several structural measures of quality of care at the local level by the beginning of LIHP. Eight legacy LIHPs had a partially electronic health information system, and the same number were using data on utilization patterns and clinical outcomes to plan and implement quality improvement efforts. Nine of the 10 legacy LIHPs had established evidence-based clinical guidelines for diabetes, and six had electronic diabetes registries. Fewer had established registries for other common chronic conditions.[5]

Other LIHPs had also begun to implement structural quality improvements at the time of this report. The San Bernardino LIHP launched a pilot electronic referral system in early 2012 and was close to implementing software to facilitate providers' ability to coordinate services and review enrollee utilization data. These health IT improvements were to augment San Bernardino's existing capacity to monitor utilization trends, patient satisfaction, and grievance monitoring for the physical and behavioral health benefits in the program.

Process of Care Measures

Several LIHPs reported tracking process performance indicators.

[5]Pourat N, Salce E, Davis AC, Hilberman D. *Achieving System Integration in California's Health Care Safety Net.* Los Angeles, CA: UCLA Center for Health Policy Research, September 2012.

Riverside County LIHP began tracking and documenting the Healthcare Effectiveness Data and Information Set (HEDIS) for comprehensive diabetes process measures from its launch in January 2012, with a 90th percentile goal. Riverside collects low-density lipoprotein (LDL) and HbA1c test completion rates, and it also identifies the proportion of LIHP enrollees with diabetes who receive an annual retinal exam (Appendix B, Exhibit 31).

San Mateo County also tracks some HEDIS comprehensive diabetes process measures, as well as the proportions of females over age 50 who had a mammogram in the past 24 months and of enrollees over age 50 who had received a flu shot. In the behavioral health arena, San Mateo uses HEDIS measures to assess seven- and 30-day outpatient follow-up (target 75th and 90th percentile, respectively) after psychiatric hospital discharge. Based on a review of national performance on longer-term follow-up metrics, San Mateo also tracks progress toward established goals of 70 percent of second follow-up visits occurring within 14 days of an initial treatment visit, and 55 percent of third and fourth follow-up visits occurring within 30 days of a second treatment visit. San Mateo has achieved or fallen just short of both goals in all four quarters of Program Year 1 (Appendix B, Exhibit 32 and Appendix B, Exhibit 33). San Mateo County Behavioral Health and Recovery Services also collect data on substance abuse and mental health services overlap, and on substance abuse service use by Medi-Cal Expansion enrollees.

The San Diego County LIHP used a range of benchmarks from national Medicaid percentiles and the California statewide collaborative Right Care Initiative, among others, to establish goals (Appendix B, Exhibit 34). San Diego also used a collaborative process involving the county's quality improvement committee and health centers to consider current performance in calibrating the aforementioned benchmarks. San Diego collects data on treatment, medication, and general care for enrollees with diabetes, hypertension, asthma, and cardiovascular conditions, including beta-blocker treatment for those diagnosed with acute myocardial infarction. It also tracks smoking cessation assistance and the HEDIS behavioral health measure of a seven-day follow-up after a hospitalization related to mental illness.

These LIHPs collect quality-of-care data at the clinic level. Riverside and San Diego collect data for LIHP enrollees specifically, and San Mateo aggregates data for all beneficiaries, regardless of program affiliation. The ability to collect data at the clinic level allows these LIHPs to better target their quality improvement efforts.

Future Analyses

Findings in this interim report are based on program-to-date data and are limited by data availability, lags in claims processing, and transmission of data to UCLA by LIHPs. Indicators of LIHP progress by the end of the first program year are not representative of all local programs operating due to variations in launch dates, rapid changes in enrollment and the subsequently changing demographics, and health status of enrollees. The final LIHP evaluation report will account for many of these data limitations. To the degree possible, plans for further analyses include:

- Examining how county or program networks were strengthened and expanded to meet the needs of LIHP.
- Evaluation of additional services available to MCE and HCCI enrollees that were not available through previous HCCI programs or county indigent care programs; examination of how these services are being utilized and coordinated.
- Examining increased access to care for the target population in the MCE and HCCI programs; additional analysis on how the volume of services provided changed during the program implementation period.
- Comprehensive analysis of the utilization of medical and behavioral health services, including visits to primary and specialty care providers, emergency room visits followed by discharge, and hospitalizations for enrollees with chronic conditions.
- Size and structure of provider networks in LIHP, and enrollee utilization of different providers within the network.
- Patient adherence to medical home assignment when seeking care; whether medical home providers were able to expand services to better support self-management of chronic illnesses.
- Changes in rates of use of outpatient services, emergency room visits, and hospitalizations, with specific focus on whether the MCE and HCCI programs were able to reduce avoidable ER visits and hospitalizations over the program period.
- Improvements in enrollee's health status as assessed through clinical measures.
- Changes in rates of use of preventive services (e.g., cancer screenings, well exams, and immunizations) as a result of the new services available through LIHP.

- Trends in quality of care as indicated by process measures available in claims data, such as cancer screening and self-assessed health.

- Self-reported data on health care service and administrative expenditures and trends in reimbursements for services during LIHP.

Summary and Conclusions

By March 2013, 19 LIHPs were operating in California, covering 53 counties. As of December 2012, 680,946 low-income individuals had been enrolled in the program since its inception. This enrollment exceeded the projections for the program, most likely due to innovative efforts initiated at the local level, including community outreach and partnerships, effective use of IT systems, increased efficiency, cost-control measures, staff training, and successful retention and redetermination efforts. The LIHP provider network included close to 5,000 primary care providers and almost 200 hospitals statewide.

The interim data on utilization of outpatient services, behavioral health services, and emergency room visits indicated an increase in the volume of services provided during the program. However, it is premature to attempt to discern the reliability of trends in these utilization patterns due to significant limitations in the availability of data for all participating LIHPs, the rapid growth in enrollment, and changes to newly implemented LIHPs in this time period. The current patterns of utilization are likely to be complicated by the potential pent-up demand for care on the part of previously uninsured enrollees, as well as by demographic characteristics and the health status of enrollees. Self-reported quality of care data indicated progress of LIHPs in establishing data systems and benchmarks for tracking quality performance measures and quality improvement efforts. Chronic disease registries and electronic health information systems were frequently available, and additional emphasis on population health management was reported.

Overall, available data indicate that the program is succeeding in preparing California for the upcoming transition of a significant portion of the state's population toward coverage under Medi-Cal and Covered California. The final LIHP evaluation will provide a comprehensive overview of the successes and challenges of the program during its two and a half years of operation.

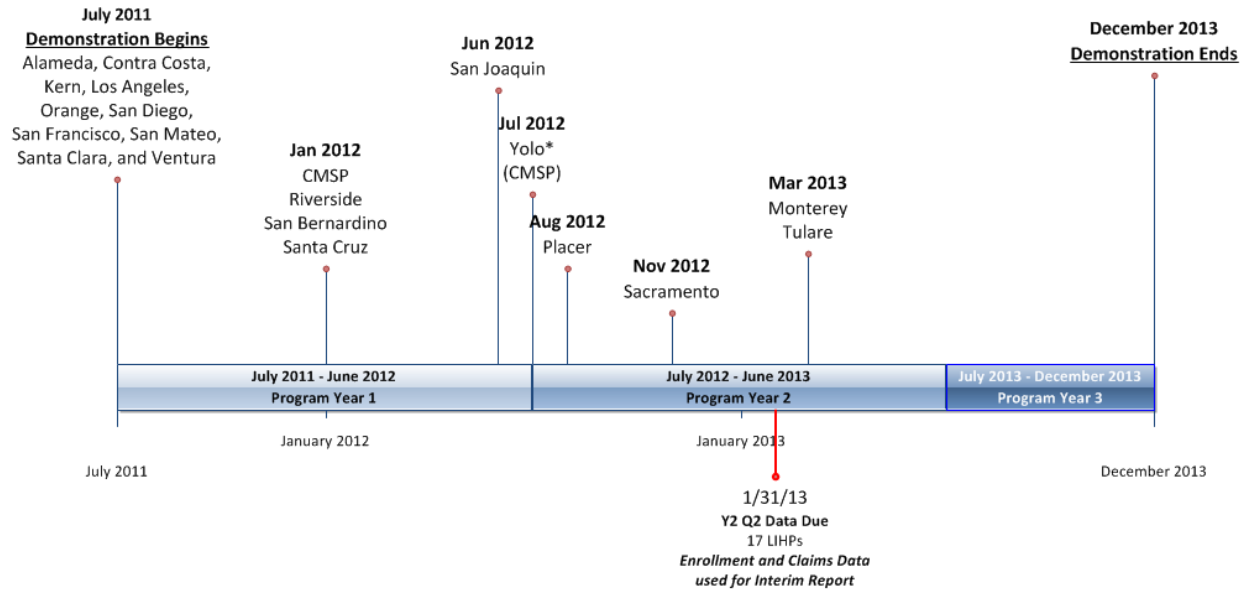
Appendices

Appendix A: Available Data and Methods

Data

The data for the analyses included in this report are received on a rolling basis from LIHPs. The phased implementation of LIHP has affected the timing of data delivery from local LIHPs. Legacy counties were able to submit claims and enrollment data from the beginning of LIHP implementation in July 2011 (Appendix A, Exhibit 1). Counties with newer LIHPs began providing data as early as January 2012 (CMSP, Riverside, San Bernardino, and Santa Cruz) and as late as June 2012 (San Joaquin). Therefore, the analysis for Program Year (PY) 1, Quarters (Q) 1 and 2 includes data for the 10 legacy counties only. Claims and enrollment data for the 10 legacy counties and seven LIHPs that launched in 2012 are demonstrated in PY 1 Q3-4 and PY2 Q1-2 data (except for utilization data, which account for the 10 legacy counties only).

Appendix A, Exhibit 1: LIHP Implementation and Data Delivery Timeline



Notes: (1) Yolo joined CMSP on July 1, 2012. Implementation dates are current as of March 31, 2013. (2) Data delivery dates were established by UCLA for evaluation purposes.
Source: Low Income Health Program contracts with Department of Health Care Services.

Methods

Monthly Cumulative Enrollment Figures

The unduplicated cumulative enrollment numbers by month for the entire LIHP program were calculated for this report. When cumulative enrollment was reported quarterly rather than monthly, the unduplicated cumulative total for those months was estimated. In these instances, the net increase in cumulative enrollment between consecutive quarters was divided into three equal parts representing each month in that quarter. For example, an increase of 900 enrollees from Quarter 1 to Quarter 2 was assumed to be an increase of 300 enrollees per month during Quarter 1.

Small Area Estimation

The estimates of the size of the adult population potentially eligible for LIHP in each area were based on small area estimation (SAE) methodology using the 2007 and 2009 California Health Interview Survey (CHIS) and the American Community Survey (ACS). SAE analysis was not needed for the combined CMSP counties, because the direct estimate using CHIS 2009 was stable and reliable.

The SAE methodology was developed by UCLA and has been validated over the past 10 years. SAE is a design-oriented and model-based synthetic estimation method that uses CHIS and ACS data to build models predicting variables of interest in smaller geographic areas included in CHIS. Predicted values for the variables of interest in CHIS data are calculated and then aggregated to derive the final estimates for the desired small area of interest. For the SAEs reported in this brief, the model was based on CHIS 2007 and 2009 data, accounting for year-to-year differences. The model parameter estimates were then applied to decennial U.S. Census population data from ACS, representing the population from which the CHIS 2009 survey was drawn. The variance for the estimates was derived through the bootstrapping method. Confidence intervals and coefficients of variation of the final estimates were also calculated and presented.

Chronic Conditions

The prevalence of five of the most common chronic conditions, using the ninth revision of the International Classification of Diseases (ICD-9) diagnostic codes, was calculated. An enrollee was considered to have the specific chronic condition if s/he had at least one claim with specific ICD-9 diagnostic codes. The three-digit root of the ICD-9 codes was used in the absence of the complete code (Appendix A, Exhibit 2). Enrollees were assigned multiple chronic conditions if claims had codes for more than one condition.

Appendix A, Exhibit 2: ICD-9 Diagnostic Codes for the Five Most Chronic Conditions

Condition	ICD-9 Diagnostic Codes
Diabetes	250, 357.2, 362.0, 366.41
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	492, 493, 496
Congestive Heart Failure (CHF)/ Coronary Artery Disease (CAD)	428, 410, 411, 412, 413, 414
Hypertension	401, 402, 403, 404
Dyslipidemia	272

Federal Poverty Level

FPL calculations in this report were consistent with the 2012 poverty guidelines issued in the Federal Register by the Department of Health and Human Services (DHHS). FPL values were calculated using family size and monthly or annual income and were grouped into the following categories: 0-25%, >25-50%, >50-75%, >75-100%, >100-133%, and >133-200%.

Data reporting problems may have led to inaccuracies in FPL data. Multiple counties reported missing or erroneous values in the "monthly/annual income" and "family size" variables used to calculate FPL. Additionally, some counties inconsistently listed "null" or "zero" values. Furthermore, some legacy counties continued to report FPL levels used under the HCCI demonstration, which were different from FPL levels mandated by LIHP for MCE and HCCI.

Utilization

All utilization data were reported for "active users," defined as the number of unique enrollees with at least one claim in the claims data for the given quarter.

The proportions of active users who had used outpatient or behavioral health services, had visited emergency rooms, and had been hospitalized were calculated. Rates of outpatient service use, emergency room visits, and hospitalizations per 1,000 active enrollees by quarter were also calculated.

The proportion of enrollees who were active users was calculated by dividing the number of enrollees using a particular service during a quarter by the total number of enrollees in LIHP during the quarter. Rates of utilization per 1,000 active enrollees were calculated by dividing the number of services per quarter by the number of active users and multiplying the result by 1,000 to reflect the "per 1,000" element of the measure.

Appendix B: Supplemental Findings and Analyses

Appendix B, Exhibit 1: Monthly Unduplicated Cumulative Enrollment by LIHP, as of December 31, 2012

Local LIHP	Jul '11	Aug '11	Sep '11	Oct '11	Nov '11	Dec '11	Jan '12	Feb '12	Mar '12	Apr '12	May '12	Jun '12	Jul '12	Aug '12	Sept '12	Oct '12	Nov '12	Dec '12
Alameda	22,690	25,315	27,825	30,131	32,103	34,286	39,222	42,651	45,746	48,463	51,097	53,548	55,725	58,218	60,267	62,525	64,293	66,147
CMSP	-	-	-	-	-	-	46,592	52,532	58,226	63,545	68,553	73,541	79,462	84,342	88,272	91,788	93,229	93,305
Contra Costa	12,487	13,255	13,951	14,561	15,134	15,595	16,240	16,802	17,471	18,079	18,658	19,149	19,553	20,057	20,482	21,004	21,424	21,725
Kern	6,783	7,090	7,414	7,705	7,913	8,079	8,307	8,584	8,893	9,201	9,561	9,869	10,216	10,570	10,873	11,160	11,397	11,658
Los Angeles	65,233	74,627	84,021	93,046	102,071	111,096	120,215	129,335	138,454	164,438	190,422	216,406	221,381	226,356	231,331	236,305	241,280	246,255
Orange	35,480	37,311	39,014	40,784	42,482	43,986	45,766	47,475	49,355	51,107	52,892	54,556	56,249	57,949	59,457	61,051	62,276	62,769
Placer	-	-	-	-	-	-	-	-	-	-	-	-	-	1,247	1,617	1,946	2,216	2,443
Riverside	-	-	-	-	-	-	7,997	15,312	16,700	17,907	19,128	20,910	22,311	23,632	24,854	26,127	27,060	27,693
Sacramento	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,662	2,287
San Bernardino	-	-	-	-	-	-	4,370	7,221	10,380	16,058	18,888	21,456	23,808	25,783	27,672	29,240	30,288	30,663
Santa Clara	6,115	6,554	6,930	7,410	7,911	8,454	9,028	9,690	10,459	11,242	12,029	12,750	13,484	14,257	14,951	15,741	16,336	16,886
Santa Cruz	-	-	-	-	-	-	851	1,154	1,366	1,601	1,764	1,947	2,102	2,271	2,386	2,440	2,440	2,440
San Diego	13,372	15,321	17,404	19,904	22,039	24,091	26,394	28,459	30,608	32,638	34,744	36,854	38,851	40,932	42,719	44,718	46,075	46,642
San Francisco	10,801	11,462	12,137	12,869	13,247	13,639	14,076	14,466	14,882	15,334	15,716	16,078	16,422	16,758	17,023	17,360	17,632	17,886
San Joaquin	-	-	-	-	-	-	-	-	-	-	-	-	199	662	980	1,176	1,442	1,753
San Mateo	8,059	8,500	8,891	9,266	9,579	9,932	10,255	10,632	10,966	11,334	11,741	12,116	12,489	12,862	13,189	13,572	13,882	14,119
Ventura	8,269	8,755	9,213	9,664	10,113	10,509	10,994	11,491	12,055	12,526	13,034	13,558	14,129	14,676	15,088	15,574	15,984	16,275
Total	**189,289**	**208,190**	**226,800**	**245,340**	**262,592**	**279,667**	**360,307**	**395,804**	**425,561**	**473,473**	**518,227**	**562,738**	**586,381**	**610,572**	**631,161**	**651,727**	**668,916**	**680,946**

Notes: (1) "-" denotes that the local LIHP was not operating at that point in time. (2) Data for Los Angeles County are self-reported.
Source: UCLA analysis of Low Income Health Program enrollment data.

Appendix B, Exhibit 2: Monthly Point-in-Time Enrollment by LIHP, as of December 31, 2012

Local LIHP	Jul '11	Aug '11	Sep '11	Oct '11	Nov '11	Dec '11	Jan '12	Feb '12	Mar '12	Apr '12	May '12	Jun '12	Jul '12	Aug '12	Sept '12	Oct '12	Nov '12	Dec '12
Alameda	22,690	24,221	25,734	27,041	28,056	29,622	34,176	37,012	39,002	40,794	42,476	44,002	44,711	46,096	46,895	48,169	48,956	49,687
CMSP	-	-	-	-	-	-	46,592	47,655	49,343	51,048	52,667	54,241	55,874	57,083	56,846	56,564	52,344	43,474
Contra Costa	12,487	12,797	12,836	12,966	12,925	12,974	12,968	12,985	12,958	12,928	12,886	12,717	12,358	12,229	12,038	12,225	12,254	12,124
Kern	6,783	6,968	6,696	6,619	6,451	6,266	6,104	5,994	6,001	6,079	6,260	6,357	6,472	6,673	6,623	6,677	6,700	6,807
Los Angeles	65,233	73,680	83,689	94,131	101,506	110,345	117,447	127,317	137,557	142,862	129,628	198,020	198,373	204,878	218,719	214,432	213,101	213,434
Orange	35,480	36,156	36,682	37,250	37,714	38,037	38,542	39,094	39,731	40,381	41,163	41,840	42,424	43,015	43,533	44,006	44,063	43,173
Placer	-	-	-	-	-	-	-	-	-	-	-	-	-	1,247	1,594	1,910	2,161	2,344
Riverside	-	-	-	-	-	-	7,997	15,278	16,332	17,489	18,696	20,465	21,854	23,042	24,114	25,239	26,065	26,593
Sacramento	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,662	2,274
San Bernardino	-	-	-	-	-	-	4,370	7,204	10,302	15,673	18,234	20,440	22,361	23,880	25,285	26,330	26,817	25,946
Santa Clara	6,115	6,365	6,538	6,817	7,178	7,619	8,129	8,639	9,269	9,926	10,556	11,140	11,745	12,206	12,622	13,153	13,478	13,718
Santa Cruz	-	-	-	-	-	-	851	1,145	1,330	1,549	1,678	1,839	1,953	2,079	2,167	2,197	2,167	2,140
San Diego	13,372	15,125	16,419	18,488	20,074	21,621	23,269	25,084	26,977	28,739	30,559	29,947	31,064	32,134	32,867	33,286	33,356	32,339
San Francisco	10,801	10,900	10,862	10,979	10,765	10,688	10,727	10,658	10,675	10,796	11,009	11,149	10,943	10,771	10,628	10,471	10,455	10,306
San Joaquin	-	-	-	-	-	-	-	-	-	-	-	345	199	662	980	1,176	1,442	1,753
San Mateo	8,059	8,138	8,180	8,210	8,184	8,193	8,097	8,051	8,123	8,118	8,202	8,268	8,315	8,426	8,520	8,659	8,723	8,671
Ventura	8,269	8,548	8,688	8,859	9,076	9,266	9,505	9,769	10,071	10,234	10,445	10,657	10,970	11,224	11,284	11,460	11,590	11,564
Total	**189,289**	**202,898**	**216,324**	**231,360**	**241,929**	**254,631**	**328,774**	**355,885**	**377,671**	**396,616**	**394,459**	**471,427**	**479,616**	**495,645**	**514,715**	**515,954**	**515,334**	**506,347**

Notes: (1) "-" denotes that the local LIHP was not operating at that point in time. (2) Data for Los Angeles County are self-reported.
Source: UCLA analysis of Low Income Health Program enrollment data.

Appendix B, Exhibit 3: LIHP Current Enrollment and Estimated ACA-Eligible Population, as of December 31, 2012

LIHP	Current FPL	Currently Enrolled (as of December 31, 2012)	Estimated Potential Eligible Population at 200% FPL (95% Confidence Interval)
Alameda	200%	49,687	52,000 (26,000 - 77,000)
County Medical Services Program (CMSP)	100%	43,787	153,000 (142,000 - 177,000)
Contra Costa	200%	12,124	34,000 (16,000 - 51,000)
Kern	133%	6,807	62,000 (35,000 - 90,000)
Los Angeles	133%	213,434	637,000 (490,000 - 783,000)
Monterey	100%	N/A	23,000 (12,000 - 33,000)
Orange	200%	43,173	147,000 (78,000 - 216,000)
Placer	100%	2,344	9,000 (4,000 - 14,000)
Riverside	133%	26,593	157,000 (88,000 - 225,000)
Sacramento	67%	2,274	61,000 (28,000 - 94,000)
San Bernardino	100%	25,946	127,000 (70,000 - 184,000)
San Diego	133%	32,339	133,000 (101,000 - 166,000)
San Francisco	25%	10,306	30,000 (15,000 - 45,000)
San Joaquin	80%	1,753	40,000 (21,000 - 58,000)
San Mateo	133%	8,671	21,000 (10,000 - 32,000)
Santa Clara	133%	13,718	47,000 (23,000 - 71,000)
Santa Cruz	100%	2,140	15,000 (8,000 - 23,000)
Tulare	75%	N/A	33,000 (18,00 - 47,000)
Ventura	200%	11,564	32,000 (16,000 - 48,000)

Sources: The estimated number of ACA-eligible individuals is based on small area estimation using the 2007 and 2009 California Health Interview Survey (CHIS) data, with the exception of CMSP, which used the CHIS 2009 direct estimate. The methodology for these estimates can be found in Data Sources and Methods. Current enrollment

estimates are based on enrollment data submitted to UCLA by operating Low Income Health Programs as of March 31, 2012. Methods used to develop small area estimates can be found in Appendix A: Available Data and Methods.

Appendix B, Exhibit 4: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Age, as of December 31, 2012

	Age							
Local LIHP	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55 +**
Alameda	7,150	7,544	6,011	4,713	5,684	7,485	9,124	18,436
Contra Costa	1,730	2,723	2,055	1,466	1,807	2,607	3,248	6,089
CMSP	12,139	13,151	9,796	7,055	8,613	11,292	13,082	18,177
Kern	966	1,139	929	683	931	1,565	1,952	3,493
Los Angeles	27,448	22,022	17,186	13,485	16,421	23,085	30,966	62,821
Orange	5,609	6,310	4,016	3,226	4,468	6,323	9,205	23,612
Placer	229.0	245.0	195.0	194.0	242.0	340.0	455.0	543.0
Riverside	2,376	2,624	2,033	1,574	2,068	3,299	4,682	9,035
Sacramento	187	231	205	143	214	292	428	587
San Bernardino	3,725	3,094	2,444	1,962	2,480	3,768	4,992	8,198
Santa Clara	1,120	1,534	1,238	933	1,200	1,715	2,477	6,669
Santa Cruz	203	254	215	170	223	287	376	712
San Diego	4,407	4,762	3,710	2,950	3,736	5,351	7,466	14,226
San Francisco	1,362	2,130	1,736	1,408	1,727	2,101	2,372	5,050
San Joaquin	170	184	118	98	148	238	313	484
San Mateo	1,212	1,653	1,195	868	1,025	1,534	1,950	4,682
Ventura	1,586	1,712	1,180	977	1,243	1,771	2,406	5,400
LIHP Total	**71,619**	**71,312**	**54,262**	**41,905**	**52,230**	**73,053**	**95,494**	**188,214**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 5: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Age, as of December 31, 2012

	Age							
Local LIHP	**<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55 +**
Alameda	10.8	11.4	9.1	7.1	8.6	11.3	13.8	27.9
Contra Costa	8.0	12.5	9.5	6.7	8.3	12.0	14.9	28.0
CMSP	13.0	14.1	10.5	7.6	9.2	12.1	14.0	19.5
Kern	8.2	9.7	7.9	5.8	7.9	13.3	16.6	29.7
Los Angeles	12.9	10.3	8.1	6.3	7.7	10.8	14.5	29.4
Orange	8.9	10.1	6.4	5.1	7.1	10.1	14.7	37.6
Placer	9.4	10.0	8.0	7.9	9.9	13.9	18.6	22.2
Riverside	8.5	9.4	7.3	5.6	7.4	11.8	16.8	32.4

Sacramento	8.2	10.1	9.0	6.3	9.4	12.8	18.7	25.7
San Bernardino	12.1	10.1	7.9	6.4	8.1	12.3	16.2	26.7
Santa Clara	6.6	9.1	7.3	5.5	7.1	10.2	14.7	39.5
Santa Cruz	8.3	10.4	8.8	7.0	9.1	11.8	15.4	29.2
San Diego	9.4	10.2	8.0	6.3	8.0	11.5	16.0	30.5
San Francisco	7.6	11.9	9.7	7.9	9.6	11.7	13.3	28.2
San Joaquin	9.7	10.5	6.7	5.6	8.4	13.6	17.9	27.6
San Mateo	8.6	11.7	8.5	6.1	7.3	10.9	13.8	33.2
Ventura	9.7	10.5	7.2	6.0	7.6	10.9	14.8	33.1
LIHP Total	**11.0**	**11.0**	**8.4**	**6.5**	**8.1**	**11.3**	**14.7**	**29.0**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 6: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Gender and Race/Ethnicity, as of December 31, 2012

	Gender		Race/Ethnicity					
Local LIHP	**Male**	**Female**	**White**	**African-American**	**Asian/PI**	**Latino**	**Other**	**Unavailable**
Alameda	35,067	31,080	12,215	19,926	16,126	10,563	2,955	4,362
Contra Costa	11,165	10,562	8,980	4,088	2,277	4,507	1,860	15
CMSP	54,118	39,187	61,478	6,151	3,170	16,313	3,647	2,415
Kern	6,232	5,544	4,607	974	310	4,594	72	1,219
Los Angeles	117,901	95,532	31,103	54,763	11,266	83,433	32,869	
Orange	30,189	32,580	16,019	1,166	17,552	16,301	2,743	8,988
Placer	1,342	1,095				210	2,223	
Riverside	14,059	13,764	7,918	2,445	856	8,946	945	6,764
Sacramento	1,257	1,030	918	418	327	279	345	
San Bernardino	16,168	14,584	14,588	4,864	1,102	7,369	202	2,627
Santa Clara	8,208	8,678	4,161	852	5,353	5,222	1,111	187
Santa Cruz	1,374	1,066	1,354	56	34	539	19	438
San Diego	24,997	21,645	14,513	4,571	2,697	9,948	1,893	13,020
San Francisco	10,869	7,030	5,595	4,091	4,265	2,923	885	140
San Joaquin	850	903	624	256	343	495	35	
San Mateo	7,364	6,755	4,267	219	3,205	5,001	182	1,245
Ventura	7,820	8,491	4,320	299	860	6,951	405	3,476
LIHP Total	**348,980**	**299,526**	**192,660**	**105,139**	**69,743**	**183,594**	**52,391**	**44,906**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 7: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Gender and Race/Ethnicity, as of December 31, 2012

	Gender		Race/Ethnicity					
Local LIHP	**Male**	**Female**	**White**	**African-American**	**Asian/PI**	**Latino**	**Other**	**Unavailable**
Alameda	53.0	47.0	18.5	30.1	24.4	16.0	4.5	6.6
Contra Costa	51.4	48.6	41.3	18.8	10.5	20.7	8.6	0.1
CMSP	58.0	42.0	65.9	6.6	3.4	17.5	3.9	2.6
Kern	52.9	47.1	39.1	8.3	2.6	39.0	0.6	10.4
Los Angeles	55.2	44.8	14.6	25.7	5.3	39.1	15.4	
Orange	48.1	51.9	25.5	1.9	28.0	26.0	4.4	14.3
Placer	54.9	44.8				8.6	91.0	
Riverside	50.4	49.4	28.4	8.8	3.1	32.1	3.4	24.3
Sacramento	55.0	45.0	40.1	18.3	14.3	12.2	15.1	
San Bernardino	52.6	47.4	47.4	15.8	3.6	24.0	0.7	8.5
Santa Clara	48.6	51.4	24.6	5.0	31.7	30.9	6.6	1.1
Santa Cruz	56.3	43.7	55.5	2.3	1.4	22.1	0.8	18.0
San Diego	53.6	46.4	31.1	9.8	5.8	21.3	4.1	27.9
San Francisco	60.7	39.3	31.3	22.9	23.8	16.3	4.9	0.8
San Joaquin	48.5	51.5	35.6	14.6	19.6	28.2	2.0	
San Mateo	52.2	47.8	30.2	1.6	22.7	35.4	1.3	8.8
Ventura	47.9	52.1	26.5	1.8	5.3	42.6	2.5	21.3
LIHP Total	**53.8**	**46.2**	**29.7**	**16.2**	**10.8**	**28.3**	**8.1**	**6.9**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 8: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by Language, as of December 31, 2012

	Language				
Local LIHP	**English**	**Spanish**	**Asian/PI**	**Other**	**Unavailable**
Alameda	50,955	4,657	4,593	5,942	
Contra Costa	19,224	1,985	44	278	
CMSP	87,314	5,112	252	527	
Kern	9,534	1,731	67	28	371
Los Angeles	163,301	38,166	7,924	3,940	
Orange	42,009	9,047	947	10,658	
Placer	2,368	35	15	15	
Riverside	23,273	4,501	51		49
Sacramento	1,987	60	71	139	

San Bernardino	26,898	3,454	105	288	
Santa Clara	12,223	1,127	46	3,187	
Santa Cruz	2,204	230			
San Diego					
San Francisco	14,376	1,061	40	2,348	
San Joaquin	1,481	102		169	
San Mateo	10,994	2,166	255	598	69
Ventura	12,189	4,122			
LIHP Total	**480,330**	**77,556**	**14,412**	**28,122**	**500**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 9: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by Language, as of December 31, 2012

	Language				
Local LIHP	**English**	**Spanish**	**Asian/PI**	**Other**	**Unavailable**
Alameda	77	7	6.9	9	
Contra Costa	88.5	9.1	0.2	1.3	
CMSP	93.6	5.5	0.3	0.6	
Kern	81	14.7	0.6	0.2	3.2
Los Angeles	76.5	17.9	3.7	1.8	
Orange	66.9	14.4	1.5	17	
Placer	96.9	1.4	0.6	0.6	
Riverside	83.5	16.1	0.2		0.2
Sacramento	86.9	2.6	3.1	6.1	
San Bernardino	87.5	11.2	0.3	0.9	
Santa Clara	72.4	6.7	0.3	18.9	
Santa Cruz	90.3	9.4			
San Diego					
San Francisco	80.3	5.9	0.2	13.1	
San Joaquin	84.5	5.8		9.6	
San Mateo	77.9	15.3	1.8	4.2	0.5
Ventura	74.7	25.3			
LIHP Total	**74.1**	**12.0**	**2.2**	**4.3**	**0.1**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 10: Sociodemographic Characteristics of LIHP Enrollees: Number of Enrollees by FPL, December 31, 2012

	FPL						
Local LIHP	**Below 25%**	**>25-50%**	**>50-75%**	**>75-100%**	**>100-133%**	**>133-200%**	**Unavailable**
Alameda	24,423	15,609	4,417	4,673	6,474	10,360	
Contra Costa	3,489	8,214	1,585	1,923	2,773	3,724	
Kern	7,010	651	936	888	620	711	92
Los Angeles	108,480	1,901	122	90	93		
Orange	5,641	22,757	5,588	6,076	8,542	14,041	112
Placer	370	695	196	226	42	58	32
Riverside	19,507	1,234	1,840	2,069	2,887	125	31
Sacramento	1,589						693
San Bernardino	19,832	3,846	2,506	2,315	808	699	416
Santa Clara	13,196	757	1,059	343	464	745	131
Santa Cruz	1,498	329	330	283			
San Diego	17,450	12,364	4,640	5,101	5,912	690	
San Francisco	11,293	892	1,195	1,317	1,320	1,882	
San Joaquin	1,383	139	183	30			
San Mateo	6,793	946	1,281	1,553	2,275	1,174	57
Ventura	4,505	2,543	1,294	1,575	2,309	3,694	346
LIHP Total	**246,459**	**72,877**	**27,173**	**28,462**	**34,524**	**37,915**	**1,488**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 11: Sociodemographic Characteristics of LIHP Enrollees: Percentage of Enrollees by FPL, as of December 31, 2012

	FPL						
Local LIHP	**Below 25%**	**>25-50%**	**>50-75%**	**>75-100%**	**>100-133%**	**>133-200%**	**Unavailable**
Alameda	36.9	23.6	6.7	7.1	9.8	15.7	
Contra Costa	16.1	37.8	7.3	8.9	12.8	17.1	
Kern	59.5	5.5	7.9	7.5	5.3	6.0	0.8
Los Angeles	50.8	0.9	0.1	0.0	0.0		
Orange	9.0	36.3	8.9	9.7	13.6	22.4	0.2
Placer	15.1	28.4	8.0	9.3	1.7	2.4	1.3
Riverside	70.0	4.4	6.6	7.4	10.4	0.4	0.1
Sacramento	69.5						30.3
San Bernardino	64.5	12.5	8.1	7.5	2.6	2.3	1.4
Santa Clara	78.1	4.5	6.3	2.0	2.7	4.4	0.8
Santa Cruz	61.4	13.5	13.5	11.6			

San Diego	37.4	26.5	9.9	10.9	12.7	1.5	
San Francisco	63.1	5.0	6.7	7.4	7.4	10.5	
San Joaquin	78.9	7.9	10.4	1.7			
San Mateo	48.1	6.7	9.1	11.0	16.1	8.3	0.4
Ventura	27.6	15.6	7.9	9.7	14.2	22.6	2.1
LIHP Total	**38.0**	**11.2**	**4.2**	**4.4**	**5.3**	**5.8**	**0.3**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 12: Number of LIHP Enrollees with Chronic Disease, by Number of Conditions, as of December 31, 2012

	Number of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Alameda	47,582	10,715	5,147	2,379	314	
Contra Costa	13,215	4,200	2,467	1,488	327	30
CMSP	64,215	15,349	7,954	4,341	1,250	160
Kern	6,604	2,137	1,428	1,265	294	48
Los Angeles	158,945	42,993	10,453	999	42	2
Orange	30,590	22,930	9,899	7,152	1,918	280
Placer	2,395	33	12			
Riverside	16,334	5,402	3,538	2,143	403	54
San Bernardino	23,895	5,218	1,405	202	30	
Santa Clara	9,691	3,078	2,262	1,553	276	26
Santa Cruz	1,369	562	311	154	44	
San Diego	26,991	8,427	6,023	4,010	1,056	135
San Francisco	11,959	3,820	1,698	383	35	
San Mateo	8,492	2,435	1,699	1,247	228	18
Ventura	10,686	3,790	1,544	265	24	
Total	**432,963**	**131,089**	**55,840**	**27,583**	**6,242**	**771**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 13: Chronic Disease Prevalence Among LIHP Enrollees, by Number of Conditions, as of December 31, 2012

	Prevalence of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Alameda	71.9	16.2	7.8	3.6	0.5	
Contra Costa	60.8	19.3	11.4	6.8	1.5	0.1
CMSP	68.8	16.5	8.5	4.7	1.3	0.2

	Prevalence of Chronic Conditions					
Local LIHP	**0**	**1**	**2**	**3**	**4**	**5**
Kern	56.1	18.1	12.1	10.7	2.5	0.4
Los Angeles	74.5	20.1	4.9	0.5	0.0	0.0
Orange	42.0	31.5	13.6	9.8	2.6	0.4
Placer	98.0	1.4	0.5			
Riverside	58.6	19.4	12.7	7.7	1.4	0.2
San Bernardino	77.7	17.0	4.6	0.7	0.1	
Santa Clara	57.4	18.2	13.4	9.2	1.6	0.2
Santa Cruz	56.1	23.0	12.7	6.3	1.8	
San Diego	57.9	18.1	12.9	8.6	2.3	0.3
San Francisco	66.8	21.3	9.5	2.1	0.2	
San Mateo	60.1	17.2	12.0	8.8	1.6	0.1
Ventura	65.5	23.2	9.5	1.6	0.1	
Total	**66.2**	**20.0**	**8.5**	**4.2**	**1.0**	**0.1**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 14: Number of LIHP Enrollees with Chronic Disease, by Condition, as of December 31, 2012

	Number of LIHP Enrollees with Chronic Disease, by Condition				
Local LIHP	**Diabetes**	**Asthma/COPD**	**Dyslipidemia**	**Hypertension**	**CHF/CAD**
Alameda	6,248	2,505	7,176	12,383	1,140
Contra Costa	2,840	1,876	3,761	5,861	718
CMSP	8,188	8,552	12,472	17,992	2,876
Kern	2,039	1,097	2,535	4,002	531
Los Angeles	23,020	4,564	8,322	28,771	2,397
Orange	12,308	4,751	21,648	20,420	4,129
Placer	13	11	11	27	
Riverside	4,749	1,812	4,778	8,365	1,085
San Bernardino	3,073	787	1,296	2,999	609
Santa Clara	2,800	926	4,276	4,952	541
Santa Cruz	270	278	573	587	114
San Diego	7,752	3,674	9,668	13,604	2,704
San Francisco	1,811	852	1,626	3,672	564
San Mateo	1,961	914	3,605	3,740	356
Ventura	2,436	516	1,395	3,105	327
LIHP Total	**79,508**	**33,115**	**83,142**	**130,480**	**18,096**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 15: Chronic Disease Prevalence Among LIHP Enrollees, by Condition, as of December 31, 2012

	Prevalence of Chronic Disease, by Condition				
Local LIHP	**Diabetes**	**Asthma/COPD**	**Dyslipidemia**	**Hypertension**	**CHF/CAD**
Alameda	9.4	3.8	10.8	18.7	1.7
Contra Costa	13.1	8.6	17.3	27.0	3.3
CMSP	8.8	9.2	13.4	19.3	3.1
Kern	17.3	9.3	21.5	34.0	4.5
Los Angeles	10.8	2.1	3.9	13.5	1.1
Orange	19.6	7.6	34.5	32.5	6.6
Placer	0.5	0.5	0.5	1.1	
Riverside	17.0	6.5	17.1	30.0	3.9
San Bernardino	10.0	2.6	4.2	9.8	2.0
Santa Clara	16.6	5.5	25.3	29.3	3.2
Santa Cruz	11.1	11.4	23.5	24.1	4.7
San Diego	16.6	7.9	20.7	29.2	5.8
San Francisco	10.1	4.8	9.1	20.5	3.2
San Mateo	13.9	6.5	25.5	26.5	2.5
Ventura	14.9	3.2	8.6	19.0	2.0
LIHP Total	**12.3**	**5.1**	**12.9**	**20.2**	**2.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 16: Number of LIHP Enrollees with Diabetes, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	832	1,506	1,954	1,596	327	33
Contra Costa	826	543	413	844	214	
CMSP	4,107	462	427	2,608	404	180
Kern	588	130	79	1,098	13	131
Los Angeles	1,845	2,239	1,439	12,241	5,256	
Orange	2,553	201	2,949	4,674	634	1,297
Placer						
Riverside	980	377	177	2,194	179	842

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Bernardino	1,359	361	132	979	19	223
Santa Clara	465	121	976	1,023	183	32
Santa Cruz	96			90		69
San Diego	1,663	646	533	2,581	289	2,040
San Francisco	245	431	610	449	65	11
San Mateo	395	35	581	790	27	133
Ventura	420	47	161	1,431	61	316
LIHP Total	**16,374**	**7,107**	**10,437**	**32,601**	**7,682**	**5,307**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 17: Diabetes Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	6.8	7.6	12.1	15.1	11.1	0.8
Contra Costa	9.2	13.3	18.1	18.7	11.5	
CMSP	6.7	7.5	13.5	16.0	11.1	7.1
Kern	12.8	13.3	25.5	23.9	18.1	10.7
Los Angeles	5.9	4.1	12.8	14.7	16.0	
Orange	15.9	17.2	16.8	28.7	23.1	14.4
Placer						
Riverside	12.4	15.4	20.7	24.5	18.9	12.4
San Bernardino	9.3	7.4	12.0	13.3	9.4	8.5
Santa Clara	11.2	14.2	18.2	19.6	16.5	17.1
Santa Cruz	7.1			16.7		15.8
San Diego	11.5	14.1	19.8	25.9	15.3	15.7
San Francisco	4.4	10.5	14.3	15.4	7.3	7.9
San Mateo	9.3	16.0	18.1	15.8	14.8	10.7
Ventura	9.7	15.7	18.7	20.6	15.1	9.1
LIHP Total	**8.5**	**6.8**	**15.0**	**17.8**	**14.7**	**11.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 18: Number of LIHP Enrollees with Asthma/ COPD, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	581	1,038	379	349	129	29
Contra Costa	856	443	135	296	144	
CMSP	6,271	515	169	1,079	291	227
Kern	621	119	21	265		63
Los Angeles	854	1,211	186	1,496	817	
Orange	1,997	135	786	973	217	643
Placer					11	
Riverside	762	211	33	344	58	404
San Bernardino	436	135	13	139		57
Santa Clara	288	68	239	264	60	
Santa Cruz	168			42		59
San Diego	1,493	447	127	564	106	937
San Francisco	269	288	134	116	38	
San Mateo	336	27	150	293		98
Ventura	216		21	168	24	79
LIHP Total	**15,148**	**4,648**	**2,396**	**6,388**	**1,923**	**2,612**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 19: Asthma/ COPD Prevalence Among LIHP Enrollees, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	4.8	5.2	2.4	3.3	4.4	0.7
Contra Costa	9.5	10.8	5.9	6.6	7.7	
CMSP	10.2	8.4	5.3	6.6	8.0	8.9
Kern	13.5	12.2	6.8	5.8		5.2
Los Angeles	2.7	2.2	1.7	1.8	2.5	
Orange	12.5	11.6	4.5	6.0	7.9	7.2
Placer						
Riverside	9.6	8.6	3.9	3.8	6.1	6.0
San Bernardino	3.0	2.8	1.2	1.9		2.2
Santa Clara	6.9	8.0	4.5	5.1	5.4	
Santa Cruz	12.4			7.8		13.5

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	10.3	9.8	4.7	5.7	5.6	7.2
San Francisco	4.8	7.0	3.1	4.0	4.3	
San Mateo	7.9	12.3	4.7	5.9		7.9
Ventura	5.0		2.4	2.4	5.9	2.3
LIHP Total	**7.9**	**4.4**	**3.4**	**3.5**	**3.7**	**5.8**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 20: Number of LIHP Enrollees with CAD/CHF, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	280	369	255	161	65	
Contra Costa	321	138	98	102	59	
CMSP	1,984	166	109	435	103	79
Kern	256	55	17	173		27
Los Angeles	462	405	178	837	515	
Orange	1,392	109	787	1,082	249	510
Riverside	391	115	34	284	46	215
San Bernardino	298	91	22	129		66
Santa Clara	155	25	147	169	35	
Santa Cruz	72			17		20
San Diego	934	247	130	550	106	737
San Francisco	156	151	134	89	28	
San Mateo	135		98	85		23
Ventura	121	12	22	104	12	56
LIHP Total	**6,957**	**1,894**	**2,031**	**4,218**	**1,237**	**1,759**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 21: CAD/CHF Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of June 30, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	2.3	1.9	1.6	1.5	2.2	
Contra Costa	3.6	3.4	4.3	2.3	3.2	
CMSP	3.2	2.7	3.4	2.7	2.8	3.1
Kern	5.6	5.6	5.5	3.8		2.2
Los Angeles	1.5	0.7	1.6	1.0	1.6	
Orange	8.7	9.3	4.5	6.6	9.1	5.7
Riverside						
San Bernardino	4.9	4.7	4.0	3.2	4.9	3.2
Santa Clara	2.0	1.9	2.0	1.8		2.5
Santa Cruz	3.7	2.9	2.7	3.2	3.2	
San Diego	5.3			3.2		4.6
San Francisco	6.4	5.4	4.8	5.5	5.6	5.7
San Mateo	2.8	3.7	3.1	3.0	3.2	
Ventura	3.2		3.1	1.7		1.8
Alameda	2.8	4.0	2.6	1.5	3.0	1.6
LIHP Total	**3.6**	**1.8**	**2.9**	**2.3**	**2.4**	**3.9**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 22: Number of LIHP Enrollees with Dyslipidemia, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	1,099	1,006	3,180	1,541	329	21
Contra Costa	1,271	659	632	912	286	
CMSP	7,740	500	580	2,940	404	308
Kern	931	142	94	1,208	13	147
Los Angeles	1,023	586	784	3,994	1,935	
Orange	4,305	288	8,034	5,996	1,076	1,949
Placer						
Riverside	1,250	323	190	1,937	201	877
San Bernardino	614	128	100	349		98
Santa Clara	735	141	2,027	1,078	260	35
Santa Cruz	297			120		136

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	2,430	667	866	2,645	468	2,592
San Francisco	297	159	768	341	55	
San Mateo	915	50	1,067	1,342	37	194
Ventura	389	18	122	682	32	152
LIHP Total	**23,296**	**4,675**	**18,454**	**25,086**	**5,115**	**6,516**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 23: Dyslipidemia Prevalence Among LIHP Enrollees, by Race/Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	9.0	5.0	19.7	14.6	11.1	0.5
Contra Costa	14.2	16.1	27.8	20.2	15.4	
CMSP	12.6	8.1	18.3	18.0	11.1	12.1
Kern	20.2	14.6	30.3	26.3	18.1	12.1
Los Angeles	3.3	1.1	7.0	4.8	5.9	
Orange	26.9	24.7	45.8	36.8	39.2	21.7
Placer						
Riverside	15.8	13.2	22.2	21.7	21.3	13.0
San Bernardino	4.2	2.6	9.1	4.7		3.7
Santa Clara	17.7	16.5	37.9	20.6	23.4	18.7
Santa Cruz	21.9			22.3		31.1
San Diego	16.7	14.6	32.1	26.6	24.7	19.9
San Francisco	5.3	3.9	18.0	11.7	6.2	
San Mateo	21.4	22.8	33.3	26.8	20.3	15.6
Ventura	9.0	6.0	14.2	9.8	7.9	4.4
LIHP Total	**12.1**	**4.4**	**26.5**	**13.7**	**9.8**	**14.5**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 24: Number of LIHP Enrollees with Hypertension, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	1,890	4,023	3,849	2,047	499	75
Contra Costa	2,115	1,346	749	1,229	420	
CMSP	11,092	1,240	762	3,773	686	439
Kern	1,565	361	134	1,661	29	252
Los Angeles	3,176	5,280	2,342	11,705	6,268	
Orange	4,993	437	6,212	5,855	862	2,061
Placer					24	
Riverside	2,275	888	304	2,980	327	1,591
San Bernardino	1,303	551	146	759	21	219
Santa Clara	1,032	276	1,898	1,416	297	33
Santa Cruz	295	22		119		140
San Diego	3,833	1,403	890	3,241	545	3,692
San Francisco	679	1,103	1,091	657	119	23
San Mateo	961	80	1,072	1,267	42	318
Ventura	820	88	254	1,507	68	368
LIHP Total	**36,029**	**17,098**	**19,711**	**38,219**	**10,210**	**9,213**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 25: Hypertension Prevalence Among LIHP Enrollees, by Race/ Ethnicity, as of December 31, 2012

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
Alameda	15.5	20.2	23.9	19.4	16.9	1.7
Contra Costa	23.6	32.9	32.9	27.3	22.6	
CMSP	18.0	20.2	24.0	23.1	18.8	17.2
Kern	34.0	37.1	43.2	36.2	40.3	20.7
Los Angeles	10.2	9.6	20.8	14.0	19.1	
Orange	31.2	37.5	35.4	35.9	31.4	22.9
Placer					1.1	
Riverside	28.7	36.3	35.5	33.3	34.6	23.5
San Bernardino	8.9	11.3	13.2	10.3	10.4	8.3
Santa Clara	24.8	32.4	35.5	27.1	26.7	17.6
Santa Cruz	21.8	39.3		22.1		32.0

	Race/Ethnicity					
Local LIHP	**White**	**African-American**	**Asian and PI**	**Latino**	**Other**	**Unavailable**
San Diego	26.4	30.7	33.0	32.6	28.8	28.4
San Francisco	12.1	27.0	25.6	22.5	13.4	16.4
San Mateo	22.5	36.5	33.4	25.3	23.1	25.5
Ventura	19.0	29.4	29.5	21.7	16.8	10.6
LIHP Total	**18.7**	**16.3**	**28.3**	**20.8**	**19.5**	**20.5**

Notes: (1) Indices with sample size of 10 or smaller have been redacted with grey shading. (2) Descriptive statistics are based on available data; the number of observations may therefore vary from measure to measure. (3) Denominators can be found in the previous table.
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 26: Volume and Rate of Emergency Room Visits (number of emergency room visits per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Emergency Room Visits			Rate of Emergency Room Visits per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	4,193	4,409	5,188	253.4	213.4	213.6
Contra Costa	2,981	2,911	3,251	282.4	254.7	275.1
Kern	1,058	1,052	1,038	219.1	211.3	221.4
Los Angeles	8,046	8,900	10,718	108.2	108.2	108.2
Orange	6,807	6,326	5,917	236.2	201.1	190.5
San Diego	3,013	3,626	4,326	243.1	222.2	222.2
San Francisco	1,456	1,613	1,727	174.2	175.2	182.3
San Mateo	1,768	1,676	1,748	289.9	257.9	267.1
Santa Clara	497	482	501	91.5	77.0	70.0
Ventura	627	715	831	95.5	97.0	104.4
LIHP Total	**30,446**	**31,710**	**35,245**	**175.0**	**146.6**	**141.0**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 27: Volume and Rate of Outpatient Services (number of outpatient services per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Outpatient Services			Rate of Outpatient Services per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	50,614	49,968	51,064	3,059.3	2,418.5	2,102.4
Contra Costa	21,317	21,787	22,824	2,019.4	1,906.0	1,931.6
Kern	11,454	8,790	8,644	2,372.4	1,765.3	1,843.9
Los Angeles	146,400	159,960	181,318	1,968.1	1,565.5	1,421.4
Orange	56,973	57,652	46,369	1,976.7	1,832.5	1,493.1

San Diego	29,472	37,971	47,361	975.4	942.5	1,035.0
San Francisco	32,992	33,134	34,608	3,527.0	4,125.5	5,000.1
San Mateo	4,898	3,125	3,136	5,408.8	5,098.1	5,287.7
Santa Clara	12,088	15,378	20,147	901.9	499.1	437.9
Ventura	15,619	18,022	20,880	2,378.9	2,444.9	2624.0
LIHP Total	**381,827**	**405,787**	**436,351**	**2,194.7**	**1,875.5**	**1,745.3**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 28: Volume and Rate of Hospitalizations (number of hospitalizations per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Hospitalizations			Rate of Hospitalizations per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	408	425	508	24.7	20.6	20.9
Contra Costa	657	595	537	62.2	52.1	45.4
Kern	255	218	262	52.8	43.8	55.9
Los Angeles	1,612	1,586	1,658	21.7	15.5	13.0
Orange	2,436	2,315	2,073	84.5	73.6	66.8
San Diego	1,612	1,737	1,799	130.0	106.4	92.4
San Francisco	428	423	474	51.2	46.0	50.0
San Mateo	174	155	166	28.5	23.8	25.4
Santa Clara	124	131	204	22.8	20.9	28.5
Ventura	217	217	238	33.1	29.4	29.9
LIHP Total	**7,923**	**7,802**	**7,919**	**45.5**	**36.1**	**31.7**

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 29: Volume and Rate of Inpatient Days (number of inpatient days per 1,000 active enrollees per month), by Quarter, as of March 31, 2012

	Total Inpatient Days			Rate of Inpatient Days per 1,000 Active Enrollees		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	1,726	2,237	2,296	104.3	108.3	94.5
Contra Costa	1,730	1,745	1,583	163.9	152.7	134.0
Kern	1,047	976	1,331	216.9	196.0	283.9
Los Angeles	6,298	6,459	6,373	84.7	63.2	50.0
Orange	11,347	11,192	9,634	393.7	355.7	310.2
San Diego	8,203	8,598	9,081	661.9	527.0	466.5
San Francisco	1,708	1,386	1,470	207.5	153.5	163.1
San Mateo	365	334	480	59.8	51.4	73.3
Santa Clara	153	192	207	28.2	30.7	28.9
Ventura	912	851	870	138.9	115.4	109.3
LIHP Total	**33,489**	**33,970**	**33,325**	**192.4**	**157.0**	**133.3**

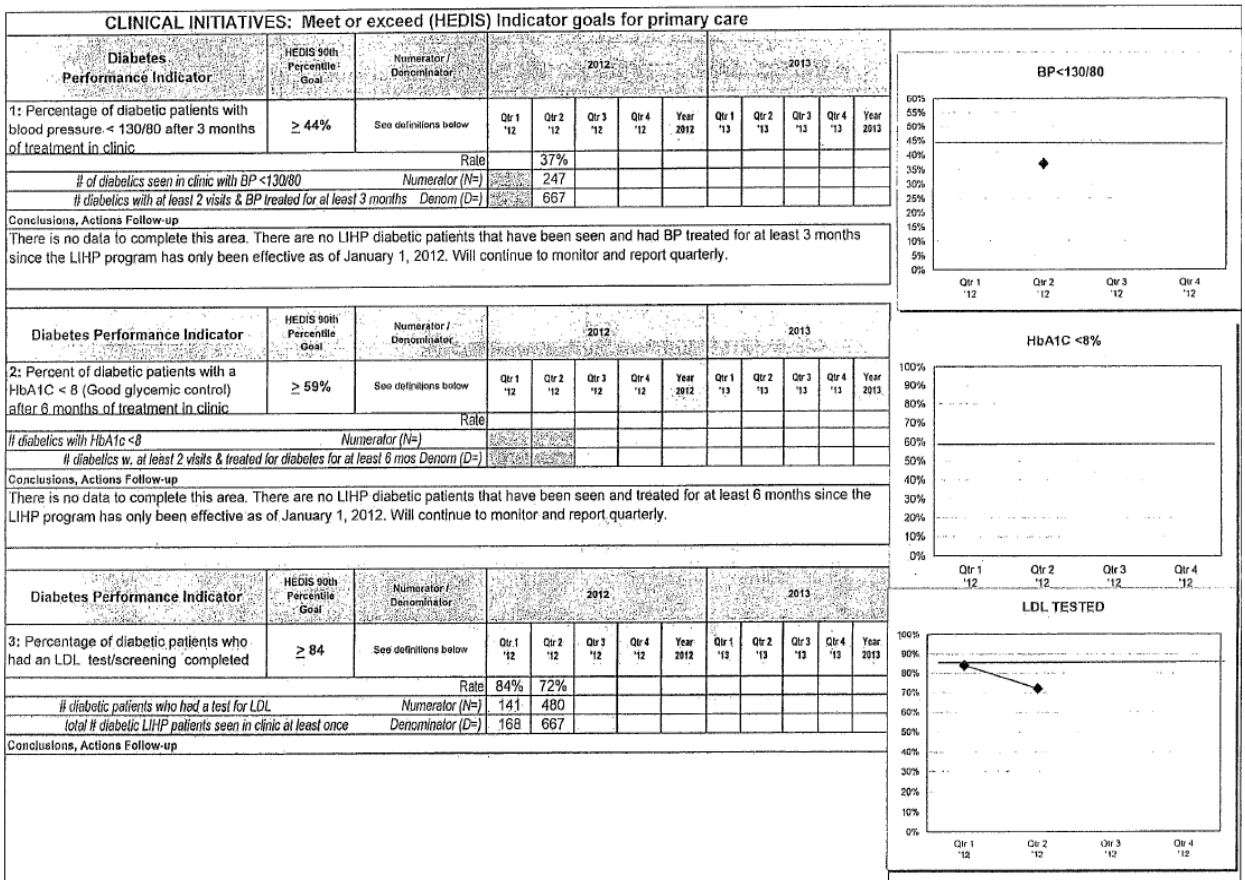
Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 30: Proportion of Active Enrollees Who Used Behavioral Health Services and Proportion Who Used Behavioral *and* Medical Health Services, by Quarter, as of March 31, 2012

	"Active Users" of Behavioral Health Services			"Active Users" of Behavioral and Medical Health Services		
Local LIHP	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
Alameda	2.3%	3.0%	2.7%	1.1%	1.3%	1.2%
Contra Costa	5.9%	6.0%	6.4%	5.5%	5.5%	6.0%
Kern	0.2%	0.2%	0.1%	0.2%	0.1%	0.1%
Los Angeles	0.3%	0.2%	0.3%	0.2%	0.2%	0.2%

Source: UCLA analysis of LIHP enrollment and claims data.

Appendix B, Exhibit 31: Riverside County LIHP Diabetes Performance Indicators, Quarter 2, Fiscal Year 2011-12



CLINICAL INITIATIVES: Meet or exceed (HEDIS) Indicator goals for primary care

Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
1: Percentage of diabetic patients with blood pressure < 130/80 after 3 months of treatment in clinic	≥ 44%	See definitions below										
		Rate		37%								
		# of diabetics seen in clinic with BP <130/80 — Numerator (N=)		247								
		# diabetics with at least 2 visits & BP treated for at least 3 months — Denom (D=)		667								

Conclusions, Actions Follow-up

There is no data to complete this area. There are no LIHP diabetic patients that have been seen and had BP treated for at least 3 months since the LIHP program has only been effective as of January 1, 2012. Will continue to monitor and report quarterly.

BP<130/80

Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
2: Percent of diabetic patients with a HbA1C < 8 (Good glycemic control) after 6 months of treatment in clinic	≥ 59%	See definitions below										
		Rate										
		# diabetics with HbA1c <8 — Numerator (N=)										
		# diabetics w. at least 2 visits & treated for diabetes for at least 6 mos — Denom (D=)										

Conclusions, Actions Follow-up

There is no data to complete this area. There are no LIHP diabetic patients that have been seen and treated for at least 6 months since the LIHP program has only been effective as of January 1, 2012. Will continue to monitor and report quarterly.

HbA1C <8%

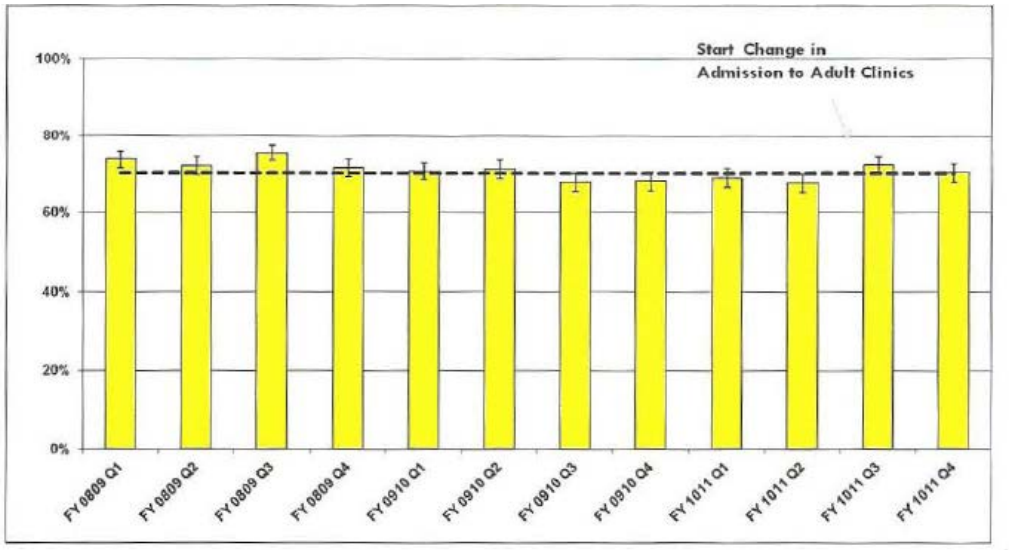
Diabetes Performance Indicator	HEDIS 90th Percentile Goal	Numerator / Denominator	2012 Qtr 1 '12	2012 Qtr 2 '12	2012 Qtr 3 '12	2012 Qtr 4 '12	2012 Year 2012	2013 Qtr 1 '13	2013 Qtr 2 '13	2013 Qtr 3 '13	2013 Qtr 4 '13	2013 Year 2013
3: Percentage of diabetic patients who had an LDL test/screening completed	≥ 84	See definitions below										
		Rate	84%	72%								
		# diabetic patients who had a test for LDL — Numerator (N=)	141	480								
		total # diabetic LIHP patients seen in clinic at least once — Denominator (D=)	168	667								

Conclusions, Actions Follow-up

LDL TESTED

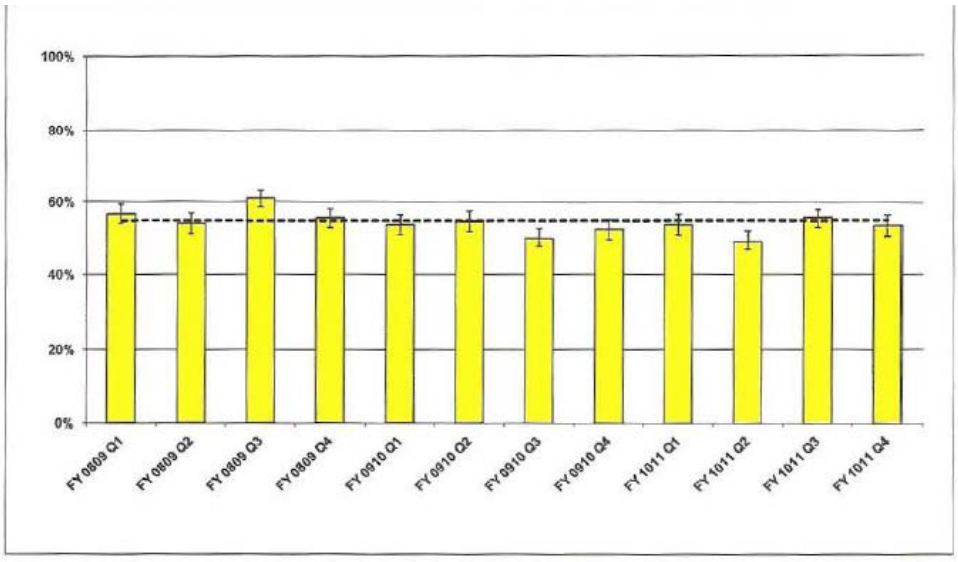
Notes: Riverside County collects data at the clinic level and has similarly styled reports for all health centers participating in LIHP. Indicators for Riverside County Health Care Centers are offered here as an example.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 32: San Mateo County Behavioral Health Outpatient Initiation Quality Performance Relative to County-Established Benchmark, Fiscal Years 2008/09-2010/11



Notes: Initiation refers to a client receiving a second follow-up visit within 14 days of an initial treatment visit. The dotted black line refers to the county-established 70 percent benchmark. All county beneficiaries are included because San Mateo does not collect quality data for individual programs.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 33: San Mateo County Behavioral Health Outpatient Engagement Quality Performance Relative to County-Established Benchmark, Fiscal Years 2008/09-2010/11



Notes: Engagement refers to a client's receiving third and fourth follow-up visits within 30 days of a second treatment visit. The dotted black line refers to the county-established 55 percent benchmark. All county beneficiaries are included because San Mateo does not collect quality data for individual programs.
Source: Voluntary LIHP reporting.

Appendix B, Exhibit 34: San Diego County LIHP Quality-of-Care Benchmark Goals, Quarter 4, Fiscal Year 2011-12

ALLHEART Age 50+ Focus on CV Risk	Right Care Initiative	National Medicaid Benchmark (90th percentile goal)	National Threshold (50th percentile) NCQA Medicaid	HEDIS/UDS Measure	LIHP Benchmark Goals Q4 F11-12
20% or less	19%	**29% or** less	43%	**Comprehensive Diabetes Care: HbA1cPoor Control (>9%)** ***(a lower rate indicates better performance)***	**29% or less**
65%	52%		**34.6% (For DM 2010 Medicaid HMO)**	**Comprehensive Diabetes Care: Cholesterol Management**	**35%**
65%	N/A		**60.4% (For DM 2010 Medicaid HMO)**	**Comprehensive Diabetes Care: Controlling High Blood Pressure**	**60%**
65%	70%	**64%**	54%	**Controlling High Blood Pressure**	**64%**
	70%	87%	86%	**Cholesterol Management for Patients with Cardiovascular Conditions**	**70%**
50% Meaningful Use Goal	N/A	76%	**68%**	**Medical Assistance with Smoking Cessation: Advising Smokers to Quit**	**68%**
N/A	N/A	N/A (Medicare)	**78%**	**Persistence of Beta-Blocker Treatment After a Heart Attack**	**78%**
N/A	N/A	91%	**85% (Medicaid 2010 for >11y/o)**	**Use of Appropriate Medication for People with Asthma**	**85%**
N/A	N/A	64%	**43% (44.6%2010 Medicaid HMO)**	**Follow-Up After Hospitalization for Mental Illness — 7-Day Rate**	**43%**

Source: Voluntary LIHP reporting.

Appendix B, Exhibit 35: San Mateo County Diabetes Care Quality Metrics, Quarters 1-2, Fiscal Year 2011-12

	Quarter 1	Quarter 2
Total Patients with Diabetes, Ages 18-75	4,244	4,301
Total Patients with Diabetes, Ages 41+	3,840	3,886
A1c<8	1,990	2,039
% with A1c<8	47%	47%
LDL<100	2,179	2,253
% with LDL< 100	51%	52%
BP<140/90	3,187	3,063
% With BP<140/90	75%	71%
BP<130/80	2,246	2,112
% with BP<130/80	53%	49%
No Tobacco	3,699	3,794
% with No Tobacco	87%	88%
ASA for Age Above 41	2,873	2,989
% Above Age 41 on ASA	75%	77%
DSRIP Perfect	782	754
% DSRIP Perfect	18%	18%
Internal Perfect	574	538
% Internal Perfect	14%	13%

Source: Voluntary LIHP reporting.

Appendix B, Exhibit 36: San Mateo County Preventive Care Quality Metrics, Fiscal Year 2011-12

Female Patients 50-74	Patients with Mammogram in Last 24 Months	Percent with Mammogram	Patients over Age 50	Patients over Age 50 with Flu Shot	Percent with Flu Shot
5,433	3,393	62%	10,166	4,130	41%

Source: Voluntary LIHP reporting.

UCLA CENTER FOR HEALTH POLICY RESEARCH

The views expressed in this report are those of the authors and do not necessarily represent the UCLA Center for Health Policy Research, the Regents of the University of California, or collaborating organizations or funders.

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Q1 What is the name of your Tribal Health Program?

Answered: 20 Skipped: 0

#	Responses	Date
1	Tuolumne MeWuk Indian Health Center, Inc.	12/9/2014 3:33 PM
2	Chapa-De Indian Health Program, Inc.	12/9/2014 3:32 PM
3	Redding Rancheria Tribal Health	12/9/2014 3:32 PM
4	Feather River Tribal Health, Inc.	12/9/2014 3:31 PM
5	United Indian Health Services, Inc.	12/9/2014 3:08 PM
6	Tule River Indian Health Center, Inc.	12/9/2014 3:07 PM
7	Lake County Tribal Health Clinic	12/9/2014 3:06 PM
8	Shingle Springs Tribal Health Program	12/9/2014 3:05 PM
9	Greenville Rancheria Tribal Health Program	12/9/2014 3:05 PM
10	Santa Ynez Tribal Health Clinic	12/9/2014 3:04 PM
11	ANAV Tribal Health Clinic	12/9/2014 3:03 PM
12	Lassen Indian Health Center	12/4/2014 12:17 PM
13	Northern Valley Indian Health	12/3/2014 9:16 AM
14	Central Valley Indian Health, Inc.	12/2/2014 3:02 PM
15	Southern Indian Health Council, INC.	12/2/2014 10:34 AM
16	MACT Health Board, Inc,	11/24/2014 11:22 AM
17	Karuk Tribe	10/30/2014 3:33 PM
18	Riverside-San Bernardino Indian Health Inc	10/29/2014 1:10 PM
19	Sonoma County Indian Health project, Inc.	10/22/2014 1:36 PM
20	Indian Health Council, Inc.	10/22/2014 12:29 PM

Q2 What percentage of your overall budget did Medi-Cal (including CRIHB Care/Options) payments represent?

Answered: 20 Skipped: 0

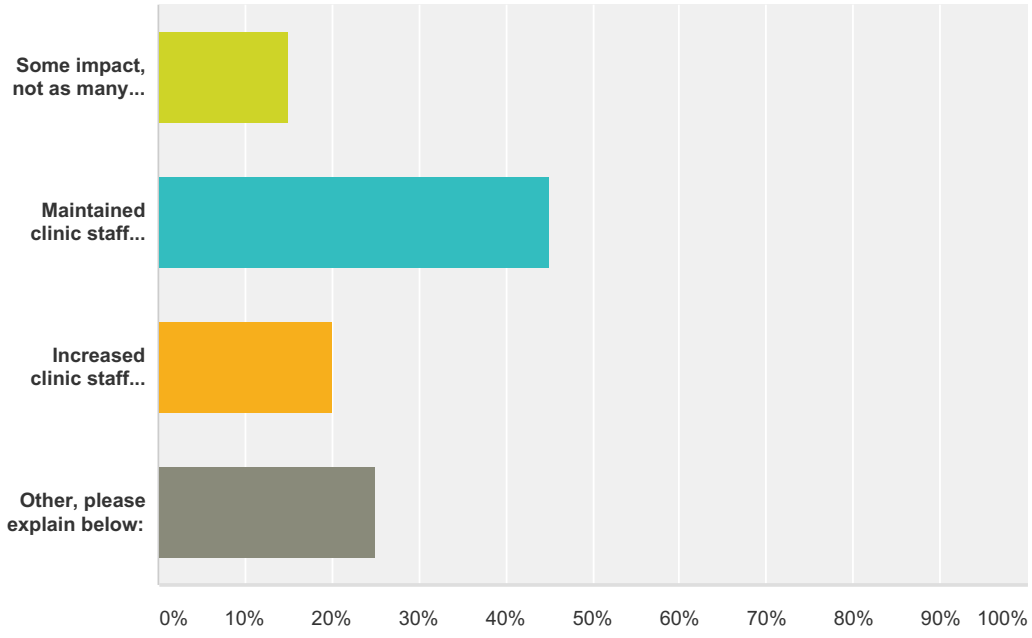
Answer Choices	Responses	
% 2013	**100.00%**	20
% 2014	**100.00%**	20

#	% 2013	Date
1	40%	12/9/2014 3:33 PM
2	30%	12/9/2014 3:32 PM
3	50%	12/9/2014 3:32 PM
4	37%	12/9/2014 3:31 PM
5	14%	12/9/2014 3:08 PM
6	24%	12/9/2014 3:07 PM
7	74%	12/9/2014 3:06 PM
8	75%	12/9/2014 3:05 PM
9	85%	12/9/2014 3:05 PM
10	60%	12/9/2014 3:04 PM
11	40%	12/9/2014 3:04 PM
12	50%	12/4/2014 12:18 PM
13	47%	12/3/2014 9:18 AM
14	Less than 1 %	12/2/2014 3:03 PM
15	5%	12/2/2014 10:51 AM
16	50%	11/24/2014 1:00 PM
17	8%	10/30/2014 3:41 PM
18	10%	10/29/2014 1:25 PM
19	5%	10/22/2014 5:50 PM
20	less than 5%	10/22/2014 1:38 PM
#	**% 2014**	**Date**
1	45%	12/9/2014 3:33 PM
2	40%	12/9/2014 3:32 PM
3	71%	12/9/2014 3:32 PM
4	40%	12/9/2014 3:31 PM
5	30%	12/9/2014 3:08 PM
6	27%	12/9/2014 3:07 PM
7	74%	12/9/2014 3:06 PM

8	75%	12/9/2014 3:05 PM
9	75%	12/9/2014 3:05 PM
10	60%	12/9/2014 3:04 PM
11	50%	12/9/2014 3:04 PM
12	67%	12/4/2014 12:18 PM
13	48%	12/3/2014 9:18 AM
14	Less than 1%	12/2/2014 3:03 PM
15	3%	12/2/2014 10:51 AM
16	72%	11/24/2014 1:00 PM
17	3%	10/30/2014 3:41 PM
18	11%	10/29/2014 1:25 PM
19	5%	10/22/2014 5:50 PM
20	less than 5%	10/22/2014 1:38 PM

Q3 What impact have CRIHB Care/Options uncompensated care payments had on your Tribal Health Program clinic staffing levels?

Answered: 20 Skipped: 0



Answer Choices	Responses	
Some impact, not as many clinic staff had to be laid off	**15.00%**	3
Maintained clinic staffing levels	**45.00%**	9
Increased clinic staffing levels	**20.00%**	4
Other, please explain below:	**25.00%**	5
Total Respondents: 20		

#	Other/Comment:	Date
1	Allowed us to add more in-house services & expand our pain mgmt program to include acupuncture.	12/9/2014 3:31 PM
2	NONE	12/9/2014 3:05 PM
3	Some impact due to large volume of non-native visits	12/3/2014 9:18 AM
4	elimitate programs	12/2/2014 10:51 AM
5	Supports a Call Center thereby allowing clinic front desk staff to concentrate on patient services.	11/24/2014 1:00 PM
6	None	10/30/2014 3:41 PM

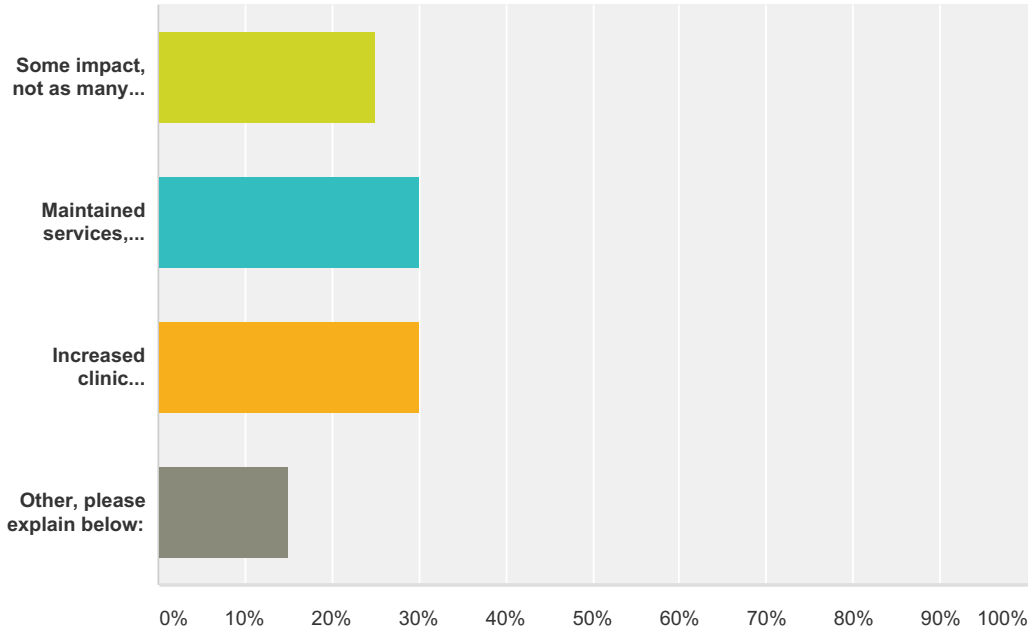
Q4 What service reductions were you prepared to make at your Tribal Health Program due to the 2009 Medi-Cal Optional Benefit reductions?

Answered: 20 Skipped: 0

#	Responses	Date
1	Reduction to the Dental Program was imminent.	12/9/2014 3:33 PM
2	Behavioral Health Some Dental Podiatry	12/9/2014 3:32 PM
3	None	12/9/2014 3:32 PM
4	Looking at reduction in staffing & level of care due to lack of funding - hardest hit were dental & BHS.	12/9/2014 3:31 PM
5	none	12/9/2014 3:08 PM
6	Services would have been reduced and would have to make some staffing adjustment.	12/9/2014 3:07 PM
7	Acupuncture and chiropractic	12/9/2014 3:06 PM
8	Lay offs if needed	12/9/2014 3:05 PM
9	WE PICKED UP MORE CHILDRENS SERVICES AND OFFERED ADULT SERVICES ON A CASH BASIS FOR NON COVERED SERVICES	12/9/2014 3:05 PM
10	absorb the cost under our IHS contract; only offer it on a cash basis for those not eligibleor a covered benefit	12/9/2014 3:04 PM
11	Reduced dental services	12/9/2014 3:04 PM
12	We had to close our Substance Abuse and Alcohol recovery programs. We reduced our psychologist hours form 40/wk to 8/wk. Laid off 2 dentists. Lost 175,000.00 revenue in 2010.	12/4/2014 12:18 PM
13	Fortunately we didn't make any reductions and managed the operations and growth	12/3/2014 9:18 AM
14	None	12/2/2014 3:03 PM
15	Dental	12/2/2014 10:51 AM
16	In 2009 MACT reduced dental staff, behavioral health staff and associated clinical and overhead costs	11/24/2014 1:00 PM
17	Nothing	10/30/2014 3:41 PM
18	We lost $1.7 million in funding from the federal government. We were prepared to reduce our outreach staff(CHRs, PHN, Patient Escorts) by 70 FTEs. The $200,000 we received from the program resulted in us saving 8 FTEs of CHR and Patient Escorts.	10/29/2014 1:25 PM
19	Considered restructuring dental services with loss of adult dental	10/22/2014 5:50 PM
20	Staffing and maybe programmatic reductions	10/22/2014 1:38 PM

Q5 What impact has CRIHB Care/Options had on the types of services offered at your clinic?

Answered: 20 Skipped: 0

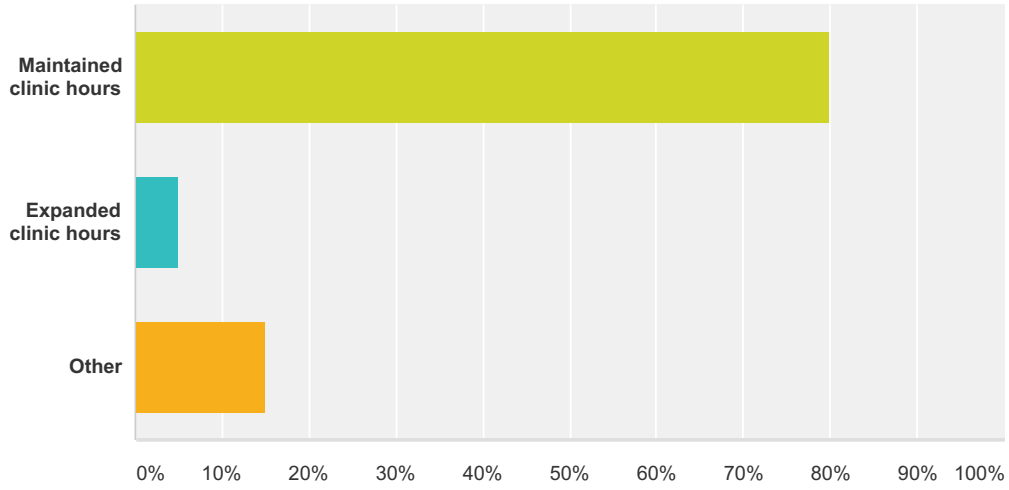


Answer Choices	Responses	
Some impact, not as many services had to be eliminated.	**25.00%**	5
Maintained services, clients did not see a reduction in services offered.	**30.00%**	6
Increased clinic services, expanded types of services offered.	**30.00%**	6
Other, please explain below:	**15.00%**	3
Total		**20**

#	Other/Comment:	Date
1	Able to add acupuncture for pain management.	12/9/2014 3:31 PM
2	VERY LITTLE, WE HAVE USED IT ONLY SLIGHTLY	12/9/2014 3:05 PM
3	The funding allowed us to maintain our outreach staff who have the closest contact with our patients in the field. We were able to provide an additional 606 visits in Podiatry, Wound Care, Pain Management and some dental services	10/29/2014 1:25 PM
4	Much needed funds	10/22/2014 1:38 PM

Q6 What impact have CRIHB Care/Options payments had on your clinic hours of operation?

Answered: 20 Skipped: 0



Answer Choices	Responses	
Maintained clinic hours	**80.00%**	16
Expanded clinic hours	**5.00%**	1
Other	**15.00%**	3
Total		**20**

#	Comment	Date
1	We had opened up on Wednesday evenings - allowed us to maintain that schedule for expanded access to services.	12/9/2014 3:31 PM
2	NONE	12/9/2014 3:05 PM
3	none	12/9/2014 3:04 PM
4	None	12/3/2014 9:18 AM

TITLE:

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

Section 1115 Annual Report

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

INTRODUCTION:

The Department of Health Care Services (DHCS) submits this Annual Report for Demonstration Year (DY) 9 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),* 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. 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.

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, 2013 through June 30, 2014.

I. General Reporting Requirements

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

1. *Rural Managed Care Expansion Amendment:*

   On August 29, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow the Department of Health Care Services (DHCS) to expand Medi-Cal managed care to beneficiaries currently receiving Medi-Cal services on a Fee-For-Service (FFS) basis in the following 28 rural California counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

2. *Medi-Cal Expansion to Newly Eligible Individuals / Integration of Medi-Cal Outpatient Mental Health Services into Medi-Cal managed care:*

   On December 24, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow DHCS to:

   a. Extend Medicaid services to the childless adult population described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, many of who are already enrolled in the Low-Income Health Program.

   b. Provide a seamless transition for Low-Income Heath Plan (LIHP)

beneficiaries into Medi-Cal managed care.

c. Enroll newly eligible populations who qualify for Medi-Cal based on expanded income eligibility criteria.

d. Require Medi-Cal managed care health plans to cover outpatient mental health services provided by licensed health care professionals acting within the scope of their license.

3. *Coordinated Care Initiative (CCI) Amendment:*

On March 19, 2014, CMS approved an amendment to the 1115 Demonstration Waiver that enables DHCS to implement the State of California's CCI to mandate managed care enrollment for dual eligibles in eight select counties. In addition, this amendment allows DHCS to integrate Medicare and Medicaid benefits for individuals eligible for Medicare and Medicaid (Duals), and integrate Managed Long Term Services and Supports (MLTSS) as managed care benefits.

The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than April 1, 2014.

After receiving feedback from the CCI counties, enrollment was divided into two separate categories; one for enrollment of Duals and one for MLTSS. Implementation dates vary by county and are summarized below.

	County	Cal MediConnect (CMC)	MLTSS
ii.	Alameda	7/1/2015	7/1/2015
iii.	Los Angeles	7/1/2014	4/1/2014
iv.	Orange	7/1/2015	7/1/2015
v.	Riverside	5/1/2014	4/1/2014
vi.	San Bernardino	5/1/2014	4/1/2014
vii.	San Diego	5/1/2014	4/1/2014
viii.	San Mateo	4/1/2014	4/1/2014
ix.	Santa Clara	1/1/2015	7/1/2014

4. *Community-Based Adult Services (CBAS)*

On June 13, 2014, DHCS submitted an amendment to the 1115 Demonstration Waiver to CMS to allow for a seamless transition of CBAS to continue beyond the initial Demonstration Waiver implementation and transitional phase from Adult Day Health Care that was effective on April 1, 2014. In addition, this amendment allows for ongoing services beginning September 1, 2014.

5. *Supplemental Payments to IHS and 638 Facilities:*

   On December 24, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the Demonstration to extend payments to the end of calendar year 2014 for tribal providers for eliminated optional benefits provided to Medi-Cal beneficiaries.

6. *Non Designated Public Hospital (NDPH) Safety Net Care Pool (SNCP) Uncompensated Care Pool Amendment:*

   On August 12, 2014 DHCS sent a letter to CMS withdrawing the request to add NDPHs to the SNCP. DHCS intends to propose the NDPHs be included in the subsequent 1115 waiver.

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

1. Rural Managed Care Expansion Amendment –

   Public Notice:

   - Stakeholder meetings. Meeting agendas and summaries are available on DHCS's Medi-Cal Managed Care Rural Expansion website at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDRuralExpansion.aspx

   - Webinars.

     - Stakeholders were invited to participate in person or over the internet. Webinars were recorded and posted on DHCS's website (see link above).

     - Post rural managed care implementation and additional stakeholder activity can be found at the following link: http://www.dhcs.ca.gov/services/Pages/PostImpManagedCareExp.aspx.

   Tribal Notice:

   - On February 22, 2013, DHCS issued a tribal notice regarding this amendment and the Medi-Cal managed care rural county expansion.

- On March 7, 2013, DHCS conducted a presentation on this amendment and the Medi-Cal managed care rural county expansion at the annual Tribal and Designees Advisory meeting/training.

2. CCI Amendment -

Public Notice:

- Public budget hearings held in 2012 and 2013, as well as inclusion in the state budget in these years.

- Numerous stakeholder meetings regarding the policy development of CCI with beneficiaries, advocates, health plans, providers and their representatives, and county representatives. Stakeholder meeting events, agendas and summaries are maintained on the DHCS's website at: http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx.

- The development of a stakeholder distribution list. DHCS developed and continues to maintain a stakeholder list that includes beneficiaries, advocates, health plan representatives and other interested parties. This list currently has over 3,500 participants and is ongoing.

Tribal Notice:

- On April 13, 2012, DHCS issued a Tribal Notice regarding the first major component of the CCI.

- On August 24, 2012, DHCS issued a second notice discussing the second and third components of CCI, which are the mandatory enrollment of Duals into Medi-Cal managed care, and the inclusion of MLTSS as a Medi-Cal managed care benefit.

- On February 22, 2013, DHCS issued a third notice with updates on the status the CCI resulting from the development of the Memorandum of Understanding (MOU) with CMS.

3. Medi-Cal Expansion to Newly Eligible Individuals / Integration of Medi-Cal Outpatient Mental Health Services into Medi-Cal managed care –

Public Notice:

- Various stakeholder meetings, including but not limited to Stakeholder Advisory Committee meetings, through in-person meetings, webinars, and teleconferences.

- Legislative and budget hearings.
- Published Governor's Budget.

Tribal Notice:

- On August 21, 2013 DHCS issued a tribal notice regarding the State's intention to request a Demonstration Waiver amendment for the inclusion of newly eligible individuals into Medi-Cal managed care and the carve-in of outpatient mental health services into the managed care delivery system.
- On August 30, 2013, DHCS presented on this Demonstration Waiver amendment proposal at the "Medi-Cal Tribal and Designee Quarterly Webinar Regarding Proposed Changes to the Medi-Cal Program."

4. CBAS -

Public Notice:

a. Stakeholder Meetings beginning in October 2013, including Stakeholder Workgroup meetings, through April 2014. Meetings conducted were in-person meetings, webinars, and teleconferences. All information and PowerPoints have been posted on the California Department of Aging (CDA) website, available at:
   http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Stakeholder_Process/

b. A two-week Public Comment period was available for comments on the draft STCs and SOPs from April 24 through May 8, 2014. A summary of comments is also posted on the CDA website at the above link.

c. June 10, 2014, a webinar review of updates made from Public Comment period was presented, with a public posting of all submitted Amendment draft documents available after being submitted to CMS.

Tribal Notice:

d. DHCS's Primary, Rural, and Indian Health Division submitted a request to CMS and received approval on March 27, 2014, for no Tribal Notice.

5. Supplemental Payments to IHS and 638 Facilities –

Tribal Notice

- On October 4, 2013, DHCS issued a tribal notice regarding this amendment and the Medi-Cal managed care rural county expansion.
- On October 22, 2013, DHCS held a conference call regarding this amendment where interested parties could call in and ask questions.

6. Non Designated Public Hospital (NDPH) Safety Net Care Pool (SNCP) Uncompensated Care Pool Amendment –

Nothing to report.

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

Medi-Cal Managed Care/Rural Managed Care Expansion –

Pursuant to Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), the health omnibus budget trailer bill, DHCS expanded 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. The following contracts were entered into for the purposes of this expansion.

On September 1, 2013, DHCS entered into a contract with Partnership Health Plan of California (PHC) to provide services to Medi-Cal beneficiaries in the eight rural counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

On November 1, 2013, DHCS entered into contracts with Anthem Blue Cross and California Health and Wellness Plan to provide services to Medi-Cal beneficiaries in the 18 rural counties of: Alpine, Amador, Butte, Calaveras, Colusa, El dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. In addition, DHCS contracted with Kaiser Foundation Health Plan in the following rural counties to ensure continuity of care for beneficiaries: Amador, El Dorado, and Placer.

On November 1, 2013, DHCS entered into contracts with California Health and Wellness Plan and Molina Health Care of California to provide services to Medi-Cal beneficiaries in the rural county of Imperial.

On November 1, 2013, DHCS entered into a contract with Anthem Blue Cross to provide services to Medi-Cal beneficiaries in the rural county of San Benito.

California Children's Services (CCS)

In the course of DY 9, SCD completed a 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.

During the end of DY 9, SCD began development of a Family Satisfaction Phone Survey and a Provider Satisfaction email Survey to satisfy one of several components of the operational review for the Health Plan San Mateo (HPSM) California Children's Services (CCS) Demonstration Pilot (DP). The surveys will be administered in DY 10. This Survey will help the Department improve the services provided to CCS clients and to determine how the program is functioning for CCS clients enrolled within the CCS Program.

- **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. Four reports for DY 9 were submitted to CMS electronically on the following dates:

  - Quarter 1 (7/1/13-9/30/13) – Submitted November 27, 2013
  - Quarter 2 (10/1/13-12/31/13) – Submitted February 28, 2014
  - Quarter 3 (1/1/14-3/31/14) – Submitted May 30, 2013
  - Quarter 4 (4/1/14-6/30/14) – Submitted August 29, 2014

- **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**

  Low Income Health Program (LIHP) –

  DHCS received approval from CMS on August 11, 2014 for the LIHP evaluation plan.

  During the third year, UCLA continued to successfully conduct the planned evaluation activities. Evaluation areas include assessment of program implementation, enrollment and retention, coverage expansion, access to and quality of care, and the administrative transition of enrollees into Medi-Cal or Covered California in 2014. The evaluation focuses on rapid reporting via multiple evaluation publications and products, including monthly and quarterly reports to DHCS, quarterly performance dashboards for use by LIHPs, and regular publications on key aspects of the evaluation.

  SPD-

  DHCS is currently finalizing an evaluation proposal to be submitted to CMS pertaining to the SPD Demonstration Waiver program. The time period for the evaluation will be 12 months with the start date of 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 SPDs in managed care 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 (CHCF), focusing on satisfaction and enrollee experience. DHCS is currently finalizing the methodology to be used to evaluate each of the five focus areas mentioned above.

  During Calendar Years 2013 and 2014, SPD beneficiaries were/will be transferred from FFS to Medi-Cal managed care in 27 rural counties (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 a similar evaluation as described above for the SPD Demonstration Waiver population in those rural counties.

  CCS -

  In DY 9, UCLA facilitated an introductory meeting at HPSM on July 12, 2013. UCLA's site visit included meeting with various HPSM departments (IT, legal, etc.). Since August 2013 the interagency agreement (IA) has not progressed further since only two of the original five proposed plans will most likely be implemented.

DSRIP –

The DSRIP evaluation plan will assess whether the projects implemented during DSRIP met the requirements of the program and the intended milestones. In addition, the evaluation plan will examine whether the projects resulted in an impact beyond the program requirements, including improved experiences of care (better care), population's health (better health), and fiscal impact (lower costs/cost avoidance) for the program overall (Exhibit 1). These program outcomes are expected to be achieved through implementation of changes in infrastructure, system redesign, and delivery of care to patients with complex conditions, those in the inpatient care setting, and those with HIV/AIDS.

DSRIP categories are interconnected in order to lead to the overall goal of the DSRIP in helping Designated Public Hospitals (DPH) to become more integrated, coordinated systems of care. Attachment Q of the Waiver's Special Terms and Conditions explain this connection[1]:

- "While they are highly related projects, each improvement project is distinct;
- All of the proposed improvement projects are oriented to create more integrated, coordinated delivery systems; and
- Being an integrated delivery system allows DPHs to more fully enact improved patient experience, population health and cost control."

Accordingly, the evaluation plan proposed that infrastructure development will increase the likelihood of achieving integrated, coordinated delivery systems by providing the resources for redesign of care delivery and delivery of services in the inpatient setting and to complex or HIV/AIDS populations. Similarly, system redesign will increase the likelihood of improved care delivery in the inpatient setting and to complex or HIV/AIDS populations. Improved care delivery in turn will increase the likelihood of achieving better outcomes. The conceptual framework highlights the anticipated relationships of DSRIP interventions and is used to guide the analyses in this proposal. However, the types of projects implemented by participating DPHs are diverse and a direct link between the interventions and the Triple Aim cannot be established in all cases.

- **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 (the Quality Strategy). All Divisions and Offices have been asked to update their

[1] Special Terms and Conditions for California's 1115 Medicaid Waiver, "Bridge to Reform," Attachment Q, page 134, http://www.dhcs.ca.gov/provgovpart/Documents/California%20STCs.pdf

respective quality improvement projects. In addition, new initiatives 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 2014 Quality Strategy will be released by December. It will be the third 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)(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.

In DY 9 DHCS worked with the Department of Finance, the Universities of California, California State Universities, and California Community Colleges to finalize a claiming methodology for Workforce Development Programs (WDP). On September 16, 2014, DHCS sent a plan to CMS outlining a proposed claiming methodology for WDPs. This proposal is pending CMS review.

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

Safety Net Care Uncompensated Care Pool

On May 21, 2014, CMS approved revisions to Attachment F-Supplement 4 "Determination of Allowable Costs to Uninsured Individuals for Mental Health Services," and Attachment F –Supplement 6 "Determination of Allowable Costs for Contracted Services to the Uninsured."

Supplemental Payments to IHS and 638 Facilities

An update to the IHS/638 supplemental payments program is provided in response to STC 7 above. On December 24, 2013, CMS approved an amendment to extend supplemental payments to IHS/638 facilities through December 31, 2014.

Designated State Health Programs (DSHP)

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

Workforce Development in Low Income/Underserved Communities

An update to the WDP is provided in response to STC 39 above. On September 16, 2014, DHCS sent a plan to CMS outlining a proposed claiming methodology for WDPs.

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

DHCS submitted a revised county specific cost claiming protocol for Alameda on November 18, 2013 and San Bernardino on April 23, 2014, to add other governmental entities, under Attachment G, Supplement 1, Section K. Alameda's revised protocol would allow Alameda County Medical Center, a designated public hospital, to report Certified Public Expenditures (CPE) to Alameda LIHP for the period of November 1, 2010 – June 30, 2011. San Bernardino's revised protocol would add three district hospitals.

DHCS has developed an annual reconciliation process per Attachment G, Supplement 1 of the Special Terms and Conditions – LIHP Cost Claiming Protocol and has begun the implementation of that process.

DHCS initially submitted the LIHP Attachment G, Supplement 2, "Cost Claiming Protocol for Health Care Services Provided under the LIHP-Claims Based on Capitation" to CMS on April 25, 2012. In response to CMS comments, the revised Attachment G, Supplement 2 was submitted to CMS on July 1, 2014 for review and approval.

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

DHCS is working with each local LIHP to determine compliance with the MOE requirements for LIHP that total non-Federal expenditures in each Demonstration Year meets or exceeds the annual MOE amount through December 31, 2014.

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

"The Low Income Health Program (LIHP) Attachment J Administrative Cost Claiming Protocol" and "Low Income Health Program Administrative Costs Claiming Protocol Implementation Plan" (Implementation Plan) received CMS approval December 12, 2013. Shortly after receiving the final approval, all local LIHPs completed time studies that are being used to calculate reimbursement amounts based on the Implementation

Plan. DHCS has begun processing claims and continues to do so as contractors submit them to LIHP. DHCS anticipates LIHP Administrative Activities (AA) claims will continue to be submitted, and processed through FY 2014/2015.

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

  Nothing to Report.

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

  Medi-Cal Managed Care Division (*MMCD)* –

  During DY 9, MMCD worked collaboratively with its External Quality Review Organization (EQRO) to conduct an encounter data validation study of its contracted Managed Care Organizations (MCOs). Year two of this study included a comparison of the encounter data stored in the State's data warehouse with the associated medical records procured from MCO provider networks. This comparison was used to assess the completeness and accuracy of DHCS's managed care encounter data. The results of this study will be published in MCO-specific reports and a statewide aggregate report in DY 11.

  In addition, DHCS continued the Encounter Data Improvement Project (EDIP) to improve the timeliness, reasonableness, accuracy and completeness of encounter data. The Encounter Data Quality Unit within MMCD continued to develop the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP is DHCS's plan for measuring encounter data, tracking encounter data from submission to storage in DHCS's data warehouse, and reporting on data quality internally and externally.

  CCS –

  Nothing to Report.

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

  MMCD-

  During DY 8, DHCS submitted encounter data to the Medicaid Statistical Information System (MSIS) in accordance with Federal law, policy and regulation. DHCS shares MCO-specific eligibility data with its contracted plans to ensure that encounters are properly linked with Medi-Cal beneficiary identifiers when submitted to DHCS.

- **Item 60 of the Special Terms and Conditions- Network Adequacy (CCS, SPD, 1915 (b) Waiver Populations**

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

  MMCD requires health plans to submit quarterly reports that include network adequacy data and notice of significant changes. Data summaries are included with 1115 Demonstration Waiver Quarterly Reports to CMS. MMCD contract managers actively work with the health plans to resolve any concerns identified. No significant changes to report for DY9.

  CCS –

  During Demonstration Year (DY) 8, the Health Plan San Mateo (HPSM) contract was executed and became operational on April 1, 2013. The Department of Health Care Services (DHCS) sent a letter to the Federal Centers for Medicare and Medicaid Services (CMS) on March 22, 2013 addressing HSPM's network adequacy, along with San Mateo County network certification executive summary. At that time, DHCS had conducted a comprehensive review of the health plans' network adequacy and had concluded that HPSM met the network adequacy Special Terms and Conditions (STCs) requirements as stipulated by CMS.

  No network adequacy has been conducted for RCHSD this DY, the Department is currently in the process of contract and rate negotiations.

II. Waiver Demonstration Program Updates

LOW INCOME HEALTH PROGRAM (LIHP)

Low Income Health Program (LIHP) is a county based elective program that consists of two components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). The MCE is not subject to a cap on federal funding, and provides a broader range of medical assistance than the HCCI. Ten legacy HCCI counties implemented their LIHP program July 1, 2011. Since July 2011, additional LIHPs implemented programs for a total representation of 53 of 58 California Counties. The program will sunset December 2013, when it will provide a bridge to the Affordable Health Care Act that will begin implementation January 1, 2014.

ACCOMPLISHMENTS

The county specific cost claiming protocol for Monterey County was approved by Centers for Medicare & Medicaid Services (CMS), July 9, 2013. County specific cost claiming protocols for all 19 LIHPs have now been approved.

CMS approved Tulare County's amendment A-01 to increase add-on health care services for their LIHP on July 24, 2013.

DHCS held the LIHP Conference, "At the Forefront: LIHP Transition Prepares California for Health Care Reform" on August 14-15, 2013, at the Sacramento Convention Center. There were over 150 attendees from numerous State agencies and stakeholder groups, including: Department of Managed Health Care, Legislative Analyst's Office, Covered California, local LIHP representatives, county social services department representatives, advocates, healthcare consultants, health plan representatives, CMS and other interested stakeholders.

In preparation for the LIHP transition to Medi-Cal and Covered California eligibility on January 1, 2014, DHCS offered a series of educational webinars during the year for physicians and other providers. The webinars offered were:

- General Provider Training for the LIHP Transition – November 14, 2013
- Navigating the LIHP Transition in a County Operated Health System (COHS) – November 20, 2013
- LIHP Patients, Providers, and Managed Care Assignment – November 21, 2013
- Mental Health & Substance Use Disorder Treatment Needs During the LIHP Transition – November 26, 2013
- Complex & Chronic Conditions: Managing the LIHP Transition – December 3, 2013

LIHP provided health care coverage to approximately 1,084,000 unique individuals throughout the July 1, 2011 through December 31, 2013, duration of the

program. Starting January 1, 2014, DHCS successfully transitioned over 717,000 former LIHP enrollees to Medi-Cal under the Affordable Care Act.

On March 26, 2014, DHCS held a LIHP Administrative Activities webinar for local LIHPs which provided them with instructions on how to claim their LIHP administrative costs, including their back casting period administrative claims.
With the May 21, 2014, technical corrections to the Special Terms and Conditions (STCs), DHCS received CMS approval of an edit to Attachment G, Supplement 1 to make necessary revisions regarding the cost claiming process for mental health services, including services provided in a subcontract, provided by non-designated public hospital (DPH)-based LIHPs which are other than mental health services provided at a hospital operated by a non DPH-based LIHP. This specific edit is required pursuant to Attachment G, Supplement 1, Section F, of the STCs.

With the May 21, 2014 technical corrections to the STCs, DHCS received CMS approval to correct the close-out period date reference from 2013 to 2014 in the Attachment J administrative costs claiming protocol.

On May 27, 2014, University of California – Los Angeles (UCLA) Center for Health Policy Research organized the 2014 "Looking Back at the Bridge to Reform: Innovative Strategies from the Low Income Health Program" convening in Sacramento, which included a retrospective look at the program's history, data, and achievements. In addition to DHCS, this convening was attended by local LIHPs and other stakeholders.

All 19 local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state populations determined eligible for LIHP by DHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

DHCS worked with California Department of Social Services (CDSS) on the completion of the IA for the LIHP State Fair Hearings and Appeals. The IA was executed on June 27, 2014.

A revised LIHP Inmate Program Policy Letter (PPL) was released October 25, 2013. The PPL reflected overall changes and developments in the inmate program and language to align the services with those described in Attachment G, Supplement 1, of the Bridge to Reform Demonstration waiver.

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 the year:

- DHCS reviewed the aggregate annual report.

- California Health Care Safety Net Institute submitted their aggregate annual report for DY8.
- DHCS worked to clarify the Category 5 HIV carry-forward process for milestones not fully achieved by DPHs in a particular demonstration year
- Plan modifications for the purpose of adding each DPH's identified Category 5b performance targets to the DPHs Category 5 plan for Alameda, Contra Costa, Kern, Los Angeles, Riverside, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties were approved by CMS.

PROJECT STATUS

Effective January 1, 2014, local LIHPs no longer provided health care services to LIHP enrollees, but have been focusing on LIHP administrative close-out activities.

DHCS worked with local LIHPs on the increase in FPL for Placer County from 100% to 133% effective July 24, 2013, and Monterey and San Joaquin counties from 100% and 80% respectively, to 133% effective August 1, 2013.

The Department approved requests for enrollment caps for Santa Cruz County, effective July 1, 2013, and Tulare County, effective September 23, 2013.

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.

The Department is awaiting CMS' decision on the request submitted December 27, 2013, regarding the exclusion of HCCI for the Primary Care Provider (PCP) increased payment per the CMS ruling on 42 CFR Part 438, 441, and 447 which entitles the LIHP PCPs to receive the increased amount for certain services provided during calendar year 2013.

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

DHCS continued to conduct and/or participate in the following stakeholder engagement processes during the year. 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:

- Monthly teleconferences with the local LIHP counties to address important questions relating to the LIHP operational and transition activities.

- Quarterly teleconferences with advocacy groups to address questions and concerns regarding the LIHP.

- Bi-weekly meetings of DHCS/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, DHCS meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

- Weekly LIHP Division/Medi-Cal Eligibility Division/Safety Net Financing Division, CCHCS, and California Department of Corrections and Rehabilitation (CDCR), 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.

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					
(DY9Q1) CDCR	$12,673,848	$0	$25,347,696	DY7	$3,014,532
				DY8	$9,659,316
(DY9Q1) Health Care	$257,563,572	$0	$515,127,144	DY7	$13,364,087
				DY8	$244,199,485
(DY9Q1) Administrative	$982,902	$0	$1,965,804	DY7	$982,902
(DY9Q2) CDCR	$28,628	$0	$57,256	DY7	$28,628
	$2,782,967	$0	$5,565,934	DY8	$2,782,967
	$1,145,730	$0	$2,291,460	DY9	$1,145,730
(DY9Q2) Health Care	-$845,041	$0	-$1,690,082	DY7	-$845,041
	$112,086,652	$0	$224,173,304	DY8	$112,086,652
	$172,295,221	$0	$344,590,442	DY9	$172,295,221
	$34,502,252	$34,502,252	$0	DY7	$69,004,504
	$2,774,641	$2,774,641	$0	DY8	$5,549,281
(DY9Q3) CDCR	$981,624	$0	$1,963,248	DY7	$981,624
	$4,529,615	$0	$9,059,230	DY8	$4,529,615
	$687,230	$0	$1,274,460	DY9	$687,230
(DY9Q3) Health Care	-$489,228	$0	-$978,456	DY6	-$489,228
	$851,975	$0	$1,703,950	DY8	$851,975
	$128,175,825	$0	$256,351,650	DY9	$128,175,825
	$900,000	$900,000	$0.00	DY7	$1,800,000
	$35,671,379	$35,671,379	$0.00	DY8	$71,342,758
(DY9Q4) CDCR	$109,109	$0	$218,218	DY7	$109,109
	$2,928,913	$0	$5,857,826	DY8	$2,928,913
	$6,481,750	$0	$12,963,500	DY9	$6,481,750
(DY9Q4) Health Care	$1,983,528	$0	$3,967,056	DY7	$3,901,022
	$12,344,016	$0	$24,688,032	DY8	$12,344,016
	$116,278,570	$0	$232,557,140	DY9	$116,278,570
	$1,950,511	$1,950,511	$0	DY7	$3,901,022
	$6,528,773	$6,528,773	$0	DY8	$13,057,546
	$656,070	$656,070	$0	DY9	$1,312,140
Total	**$646,323,612**	**$82,983,626**	**$729,307,238**		**$1,001,462,151**

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Nothing to report.

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 wither: 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.

ACCOMPLISHMENTS:

Nothing to report.

PROJECT STATUS:

Nothing to report.

QUANTITATIVE FINDINGS:

ENROLLMENT (July 2013 through June 2014)

Managed care enrollment in Two-Plan and GMC counties rose from 4,516,435 beneficiaries in July 2013 to 5,710,970 in June 2014, representing a 26 percent increase. Total SPD enrollment in Two-Plan and GMC counties was 481,678 beneficiaries in July 2013 and rose to 492,630 beneficiaries in June 2014, representing a 2.27 percent increase. While the SPD population grew slightly, the percentage of the total population increased greatly. In July 2013, SPDs represented 10.67 percent of the population while in June 2014, SPDs represented 8.63 percent of the population. [NOTE: Enrollment numbers for the Regional, Imperial and San Benito models are not included in this report since SPDs are not currently mandatory populations in these models. In COHS models, all populations are mandatory; therefore, the Demonstration Waiver amendment for the mandatory enrollment of SPDs was not necessary for the COHS health plans. Therefore, only enrollment numbers for Two-Plan and GMC are included for this reporting period]

There were 23,595 instances of SPDs disenrolling from Medi-Cal managed care plans during this period. The stated reasons for 95.17 percent of the disenrollments were due to issues regarding beneficiary choice (beneficiary could not choose the doctor they wanted, plan did not meet beneficiary needs, doctors did not meet beneficiary needs, too far away, did not choose this plan, moving out of county, other reason).

CONTINUITY OF CARE (July 2013 through June 2014)

There was a total of 2,797 extended continuity of care requests submitted to health plans between July 2013 and June 2014. Eighty-one percent or 2,263 of these requests were approved, 29 were in process at the time of reporting, and 505 (18 percent) were denied. For those denied, 85 were due to no link between SPD and provider; 1 was due to quality of care issues; 119 were because the provider would not accept the reimbursement rate; 12 were because the provider refused to work with managed care and 288 were due to other reasons.

MEDICAL EXEMPTION REQUESTS (MERs) (July 2013 through June 2014)

For July 2013 through June 2014, 17,244 unique SPDs submitted 21,255 MERs indicating an average of 1.23 MERs being submitted per unique SPD that submitted

MERs. The top diagnosis code was Complex with 2,480 MERs (11.67 percent) between July 2013 and June 2014.

Of the MERs received, 15,113 (71.1 percent) were approved, 421 (1.98 percent) were incomplete and 5,721 (26.92 percent) were denied.

RISK DATA (July 2013 through June 2014)

Through a risk stratification process, 38,604 SPDs were identified as High Risk by health plans and 81,174 SPDs were identified as Low Risk. Approximately 80 percent (98,616 SPDs) of the 122,717 SPDs in High or Low Risk categories were successfully contacted by health plans to participate in a risk assessment survey. The survey asks health questions that further assist the plans in assessing the needs of the beneficiary and assure that the beneficiaries are seen by the appropriate providers. 32,680 SPDs completed the risk assessment survey (27 percent of SPDs that were determined as High or Low Risk). As a result of the risk assessment survey, 10 percent of SPDs (12,557 of respondents) were determined to belong in a different risk category than what was determined through the stratification process.

OMBUDSMAN DATA (July 2013 through June 2014)

There were 6,548 calls regarding mandatory SPD enrollment into managed care (7.73 percent of total calls to the MMCD Office of the Ombudsman). There were 20 SPD calls (0.18 percent of total SPD calls) compared to 14 calls from other members (0.03 percent of total other member calls) regarding access issues.

PLAN GRIEVANCES (July 2013 through June 2014)

Approximately 13 percent out of 8,051 total SPD grievances, or 1,029 were related to access issues.

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA:

Enrollment of SPDs grew from 518,416 in the third quarter of 2012 to 525,828 in the second quarter of 2013. For this time period, of the SPD population, approximately 47 percent had outpatient visits, 5 percent had inpatient visits, 68 percent had pharmacy claims, 6 percent had hospital admissions, and 13 percent had emergency room visits.

On average, each SPD that utilized the services had 6.18 outpatient visits, 2.99 inpatient visits, 13.43 pharmacy claims, 2.17 hospital admissions, and 1.67 emergency room visits. This demonstrates that a small portion of the SPD population has a high usage of each service.

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.

2013 MANAGED CARE EXPANSION

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

MMCD contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure 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. The General Fund cost savings of this expansion were projected at $2.7 million in 2012-2013 and $8.8 million in 2013-2014.

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 Health Plan of California, 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 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 Medi-Cal managed care health plans 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: California Health and Wellness Plan 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 a result of this expansion effort, as of June 2014, which is the end of the reporting period, approximately 7.7 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.

PROJECT STATUS:

Noted in "Accomplishments" above

QUANTITATIVE FINDINGS:

ENROLLMENT (September/November 2013 through June 2014)

In September 2013, enrollment in the eight COHS counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity was approximately 110,024. In June 2014, enrollment increased to approximately 152,706, which is a 38.79 percent increase.

In November 2013, enrollment in the 20 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 174,001. In June 2014, enrollment increased to approximately 266,406, which is a 53 percent increase.

CONTINUITY OF CARE (September 2013 through April 2014)

A total of 1,493 extended continuity of care requests were submitted to health plans between September 2013 and April 2014. Eighty-nine percent or 1,327 of these requests were approved, 112 (8 percent) were in process at the time of reporting, and 53 (less than 4 percent) were denied. For those denied, one was due to quality of care issues; three were because the provider would not accept the reimbursement rate; three were because to the provider refused to work with managed care and 48 were due to other reasons.

MEDICAL EXEMPTION REQUESTS (September 2013 through April 2014)

For September 2013 through April 2014, a total of 756 MERs were received, 429 (56.75 percent) were approved and 244 (32.28 percent) were denied.

RISK DATA (July 2013 through June 2014)

Nothing to report.

OMBUDSMAN DATA (July 2013 through June 2014)

Nothing to report.

PLAN GRIEVANCES (July 2013 through June 2014)

Approximately 8.31 percent of 311 total rural grievances, or 27 were related to access issues.

QUALITATIVE FINDINGS/CASE STUDIES:

Nothing to report.

UTILIZATION DATA:

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Nothing new to report.

DESIGNATED STATE HEALTH PROGRAMS (DSHP)

INTRODUCTION :

Designated State Health Programs: 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 9 DHCS completed the following DY 6 final reconciliations for Safety Net Care Pool Designated State Health Programs (DSHP).

- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)

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 June 2014, DHCS has claimed a total of $326,355,257 for DSHPs in DY 9. The table below lists the claim detail for each program:

State Only Medical Programs	
California Children Services (CCS)	$76,953,182
Genetically Handicapped Persons Program (GHPP)	$44,276,143
Medically Indigent Adult Long-Term Care (MIA/LTC)	$18,932,427
Breast & Cervical Cancer Treatment Program (BCCTP)	$1,914,925
AIDS Drug Assistance Program (ADAP)	$56,509,702

County Mental Health Services Program	$44,583,820
Department of Developmental Services (DDS)	$63,713,848
Every Woman Count (EWC)	$0
Prostate Cancer Treatment Program (PCTP)	$906,687
State Only Medical Programs Total	**$307,790,734**
Workforce Development Programs	
Song Brown HealthCare Workforce Training	$7,278,000
Steven M. Thompson Physician Corp. Loan Repayment Program	$6,193,621
Mental Health Loan Assumption	$5,092,902
Workforce Development Programs Total	**$18,564,523**
Grand Total for DSHPs	**$326,355,257**

QUALITATIVE FINDINGS/CASE STUDIES

Not Applicable

UTILIZATION DATA:

Not Applicable

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Not Applicable

COMMUNITY BASED ADULT SERVICES (CBAS) AND ENHANCED CASE MANAGEMENT (ECM)

The Department of Health Care Services amended this Waiver to include CBAS, which was approved by CMS on March 30, 2012, for the period of April 1, 2012, through August 31, 2014. Adult Day Health Care (ADHC) services were being eliminated from the Medi-Cal program under Assembly Bill 97 (Chapter 3, Statutes of 2011); however, a class action lawsuit, Esther Darling, et al. v. Toby Douglas, et al., challenged the elimination. A Settlement Agreement was reached with ADHC benefit being eliminated under the Medi-Cal program effective March 31, 2012, and being replaced with a new CBAS program effective April 1, 2012.

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

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/from the program, to Medi-Cal beneficiaries that meet CBAS eligibility 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 1115 Demonstration Waiver; and 4) exhibit ongoing compliance with above requirements.

CBAS is a managed care benefit in all but four counties that have CBAS Centers (26 of California's 52 counties have Centers). The final four counties - Butte, Humboldt, Imperial and Shasta - will transition CBAS to a managed Care benefit on December 1, 2014. If any individual is exempt from Managed Care, CBAS is available, and will continue to be available, as a Fee-for-Service benefit.

PROJECT STATUS

Enrollment Information for CBAS:
Enrollment for CBAS remains steady as it continues as a managed care benefit in 22 counties. Approximately 1,700 participants remain in fee-for-service CBAS.

The annual preliminary CBAS Enrollment data is broken down Quarterly (below) for both Managed Care organizations (MCO) and Fee-for-Service (FFS) beneficiaries in each county of participation. This Annual data is updated from the previous Demonstration Year 9, *Preliminary* Quarterly 4 Enrollment Data Report. The data source for the prior Quarter 4 Enrollment data used self-reported Center data that differed from the managed care data source used previously and below. This data for

the DY 9 Annual Report, is consistent with the data used in previous quarters and is consistent with all previous reported data from the managed care plans, along with claims data for FFS enrollment.

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**		
County	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%
Butte	46		45%	42		41%	39		38%	35	-	34%
Contra Costa	12	193	64%	14	185	62%	10	119	40%	9	194	63%
Fresno	10	615	68%	9	604	67%	7	659	69%	9	590	62%
Humbolt	234		60%	116		30%	110		28%	109	-	28%
Imperial	394		70%	389		70%	380		68%	369	-	66%
Kern		113	34%		85	26%		89	26%	-	119	35%
Los Angeles	1,193	15,255	55%	1,039	15461	55%	1,020	15177	54%	1,000	14,898	52%
Merced		99	54%		110	60%		101	55%		105	57%
Monterey			0%		66	35%		66	35%		77	41%
Orange	12	1,870	60%	9	1899	61%	5	2515	81%	8	2,217	69%
Riverside	22	386	38%	21	425	41%	18	389	38%	14	388	37%
Sacramento	28	578	68%	25	398	47%	30	549	65%	20	532	62%
San Bernardino	20	412	80%	19	477	92%	14	411	78%	14	418	80%
San Diego	41	1,549	47%	33	1418	43%	36	1403	42%	33	1,448	47%
San Francisco	68	666	50%	58	746	55%	53	659	49%	55	688	51%
San Mateo		142	70%		146	72%		136	67%		147	64%
Santa Barbara		4	4%		4	5%		3	3%		9	10%
Santa Clara	2	728	56%	4	592	46%		559	43%		588	41%
Santa Cruz		104	72%		105	73%		100	66%		101	66%
Shasta	82		57%	40		28%	40		28%	40	-	28%
Ventura	8	486	36%	7	959	71%	10	911	67%	7	893	66%
Yolo*	3	227	61%	3	225	60%	2	220	59%	1	215	57%
Marin, Napa, Solano**		271	54%		220	44%		224	45%		235	47%
Total	**2,185**	**24,227**	**54%**	**1,837**	**24,660**	**54%**	**1,782**	**24,791**	**54%**	**1,731**	**24,326**	**53%**
Combined Totals	**26,412**			**26,497**			**26,573**			**26,057**		

** 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 area.

*Yolo updated data

DHCS / CDA Enrollment Data 9/2014

Enrollment Information for ECM:

The ECM participant data has continued to drop during this past year. The ECM Table below, indicates those ECM-eligible individuals that were found not eligible for CBAS as of April 2012 and have continued to remain eligible for ECM. ECM-eligible class members enrolled with managed care health plans receive ECM through their plans case management services.

The ECM Table below tracks the ECM participant data for individuals eligible to receive ECM services through the FFS system over this reporting period of July 2012 through June 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
DY8 - Q3			
Jan.-Mar'13	453	19	25
DY8 - Q4			
April-June'13	**414**	**11**	**50**
			DHCS ECM Data 07/01/2014

Outreach/Innovative Activities:

Stakeholder Process -

The CBAS Stakeholder workgroup began in September 2013, with monthly webinars and in-person meetings to develop recommendations and essential CBAS components for the waiver amendment. The purpose of these meetings were to work on reaching consensus on priorities and objectives for CBAS, establish parameters for provider input, and identify key stakeholders for further workgroup activities so the Waiver Amendment can be submitted timely. Some of the key issues included facilitating diversification of CBAS by population or service focus (e.g. dementia or DD populations, chronic care management to post- acute rehabilitation), allowing managed care payment by services, population or level-of-care, and changing existing laws and oversight mechanisms.

Stakeholders include representatives from Managed Care Plans, Medical Directors, Providers and various advocates, consumers, legislative staff members. The monthly meeting concluded with the submission of the Waiver Amendment, in June 2014. Follow-up meetings will occur with the finalization of the Waiver Amendment.

Operational/Policy Development/Issues

CBAS Transition to Managed Care –

While there are a total of 26 counties in California that have CBAS Centers, Managed

Care has transitioned to all 58 counties in California. Of the 26 counties that have CBAS Centers, fee-for-service benefits remains in four of those counties (Shasta, Humboldt, Butte, and Imperial). These four counties are the only rural counties that have CBAS Centers with the CBAS benefit being carved out, until December 1, 2014. CBAS will move to a Managed Care benefit in the above four counties, making CBAS a fee-for-service benefit, only if the participant is exempt from Managed Care.

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 for DY 9, an average of four CBAS cases (out of the approximate 26,000 participants) per quarter were filed/heard, for a total of 16 CBAS cases for the entire Demonstration Year. Several of the Hearings have been related to Managed Care enrollment; other Hearings relate to increases in service days or authorization of days of attendance.

Consumer Issues:

DHCS continues to regularly respond to issues and questions, in writing or by telephone, from CBAS consumers, CBAS providers, managed care plans, members of the Press, and members of the Legislature on various aspects of the CBAS program, if 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.

Complaints –

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA, for the most part, the complaints are from CBAS providers. Summarized below, are the complaints that came in during DY 9:

Demonstration Year 9 - Data on CBAS Complaints					
Year	**Demo Year 9 Quarters**	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
2013	DY9 - Qrt 1 (Jul 1 - Sep 30)	7	3	10	0.46%
2013	DY9 - Qrt 2 (Oct 1 - Dec 31)	8	9	17	0.93%
2014	DY 9 - Qrt 3 (Jan 1 - Mar 31)	6	2	8	0.44%
2014	**DY 9 - Qt 4** (Apr 1 - Jun 30)	**5**	**18**	**23**	**0.08%**
				CDA data - Phone & Email Complaints	

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance / Monitoring Activity:

DHCS continues to monitor CBAS Center locations and accessibility, and the Department 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.

County	CBAS Centers Licensed Capacity										
	Apr- Jun 2012	Jul- Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	DY9-Q1 Jul-Sept 2013	DY9-Q2 Oct-Dec 2014	DY9-Q3 Jan-Mar 2014	DY9-Q4 Apr-Jun 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	415	355	355	355	**355**	**355**	**355**	**355**	0%	79%
Butte	60	60	60	60	60	**60**	**60**	**60**	**60**	0%	34%
Contra Costa	190	190	190	190	190	**190**	**190**	**190**	**190**	0%	63%
Fresno	590	590	530	530	547	**572**	**572**	**572**	**572**	0%	61%
Humboldt	229	229	229	229	229	**229**	**229**	**229**	**229**	0%	28%
Imperial	250	250	250	315	315	**315**	**330**	**330**	**330**	0%	66%
Kern	200	200	200	200	200	**200**	**200**	**200**	**200**	0%	28%
Los Angeles *	17,735	17,590	17,430	17,505	17,506	**17,613**	**17,810**	**18,084**	**18,184**	0.6%	52%
Marin	75	75	75	75	75	**75**	**75**	**75**	**75**	0%	22%
Merced	109	109	109	109	109	**109**	**109**	**109**	**109**	0%	53%
Monterey	290	290	290	-	-	**110**	**110**	**110**	**110**	0%	41%
Napa	100	100	100	100	100	**100**	**100**	**100**	**100**	0%	53%
Orange*	1,897	1,897	1,747	1,747	1,747	**1,847**	**1,847**	**1,847**	**1,910**	3%	69%
Riverside	640	640	640	640	640	**640**	**640**	**640**	**640**	0%	37%
Sacramento	529	529	529	529	529	**529**	**529**	**529**	**529**	0%	62%
San Bernardino	320	320	320	320	320	**320**	**320**	**320**	**320**	0%	80%
San Diego*	2,132	2,052	1,957	1,992	1,992	**2,007**	**2,007**	**1,923**	**1,873**	-2.6%	47%
San Francisco	803	803	803	803	803	**803**	**866**	**866**	**866**	0%	51%
San Mateo*	120	120	120	120	120	**120**	**120**	**120**	**135**	12.5%	64%
Santa Barbara	55	55	55	55	55	**55**	**55**	**55**	**55**	0%	5%
Santa Clara*	820	820	820	820	750	**770**	**770**	**770**	**840**	9.1%	41%
Santa Cruz	90	90	90	90	90	**90**	**90**	**90**	**90**	0%	66%
Shasta	85	85	85	85	85	**85**	**85**	**85**	**85**	0%	28%
Solano	120	120	120	120	120	**120**	**120**	**120**	**120**	0%	26%
Ventura	806	806	806	806	806	**806**	**806**	**806**	**806**	0%	67%
Yolo	224	224	224	224	224	**224**	**224**	**224**	**224**	0%	57%
SUM =	29,009	28,739	28,214	28,099	27,967	**28,344**	**28,619**	**28,809**	**29,007**	0.69%	53%

CDA Licensed Capacity as of 06-30-2014

Los Angeles - 3 centers increased license capacity

Orange - 1 center increased license capacity

San Diego - 1 center closed

San Mateo - 1 center increased license capacity

Santa Clara - 1 center opened

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

CBAS Research Study Comparing ADHC in 2010-11 to CBAS in 2012 through 2014:

The Table below further compares the annual participant health status of measurable areas for individuals enrolled in the ADHC program during 2012 as to those compared to being enrolled in the CBAS program as of 2012-13 and 2013-14. Since the CBAS program requires a higher level of medical necessity to determine eligibility, we expect the population to have a higher percentage of health needs and less percentage of independence. Over a longer period of time, research hopes to find that these frail individuals are maintained in the community at a lower-risk of hospitalization and higher quality of life.

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 will focus 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 and released Letters of Intent to Award a contract to the entities listed below.

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

ACCOMPLISHMENTS:

Program Timeline

Date	Action Items – Applies to the Remaining Pilots (CHOC/CalOptima, LA Care, and Alameda)
July 30, 2013	LA Care returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
August 6, 2013	Cal Optima / CHOC returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
August 19, 2013	Released cost utilization data (LA Care and Cal Optima) for analysis and rate discussion
On hold as of July 1, 2014	OIL to MMIS 0242 Table for CHOC/Cal Optima for Procedure and Accommodation codes
On hold as of July 1, 2014 (Originally established May 2012)	OIL to MMIS 0242 Table for Alameda for Procedure and Accommodation codes
Anticipated November 1, 2014	OIL (Operational Instruction Letter) to MMIS 0242 Table for RCHSD for Procedure and Accommodation codes
Date	**HPSM Pilot Action Items**
April 1, 2013	HPSM CCS Demonstration became operational under the DHCS Waiver
February 10, 2014	SCD received authorization from MCED, ITSD, and CA-MMIS to develop and implement a new aid code (9D) for CCS State-Only beneficiaries
April 2014	Health Code Plan (HCP) Request to include 27 new aid codes available for HPSM's use in the enrollment of children into the CCS DP
April 2014 (bi-weekly) Ongoing	SCD and HPSM conduct bi-weekly conference calls to discuss and resolve issues with the CCS DP operational phase
May 2014 (November 1, 2013, Retroactively)	9D Aid Code established for CCS-Only population
June - July 2014	SCD drafting a Family Satisfaction Phone Survey and work plan to satisfy the operational review component
June - July 2014	SCD drafting a Provider Satisfaction email Survey and work plan to satisfy the operational review component
June – July 2014	SCD drafting a Facility Site Visit questionnaire to satisfy another component to the operational review
Date	**RCHSD Pilot Action Items**

July 2012 – Present	Continuation of the Contracting Process – RCHSD (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
July 12, 2013	RCHSD returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
July 15, 2013	Released cost utilization data to RCHSD for analysis and rate discussion
July 2013 – Present	RCHSD began submission of Policies and Procedures (P&Ps) for review
March 13, 2014 - Weekly (Ongoing)	SCD and RCHSD conduct weekly conference calls to discuss and resolve issues with the contract and P&Ps
June 17, 2014	SCD Management and RCHSD in-person meeting (site-visit in San Diego)
June 26, 2014	Additional Conditions added to the CCS DP: Acute Lymphoblastic Leukemia and Diabetes Type I and II (ages 1 – 10 yrs of age)
Anticipated - Winter 2014	RCHSD pilot scheduled to be phased in
Committees / Advisory Groups / Stakeholders Meetings	
July 2013 – June 2014 (Bi-Monthly)	CMS Regional and State Conference Calls
September 2013 – September 2014 (Quarterly)	CCS Executive Committee Meetings
August 5, 2013; October 21, 2013; November 20, 2013; February 21, 2014; and May 7, 2014	DHCS Waiver Stakeholder Advisory Committee Meetings

The milestones listed below were achieved during DY 9 (July 1, 2013 through June 30, 2014).

- May 30, 2013: DHCS sent to RCHSD an updated version of the contract, (including the SOW, exhibits, and attachments) for their review.

- July 11, 2013: DHCS provided RCHSD a copy of the Readiness Review document for their review.

- July 12, 2013: An Evaluation meeting occurred between the Department of Health Care Services (DHCS) SCD staff met in-person with HPSM and County Staff and UCLA.

- July 12, 2013: RCHSD returned to SCD a signed Addendum that allows DHCS to release cost utilization data to the Demonstration contractor.

- July 15, 2013: DHCS released cost utilization data to RCHSD for analysis and rate discussion.

- July 18, 2013: DHCS received questions from RCHSD regarding the most current draft contract.

- July 19, 2013: DHCS sent to Mercer (Department's Actuary for rates) a copy of RCHSD's draft contract for their review.

- August 13, 2013: DHCS had a conference call with RCHSD to discuss the impact of the Knox-Keene Waiver and health plan requirements (i.e., network, ID cards, credentialing).

- September 4, 2013: DHCS sent to RCHSD a matrix containing answers to their questions/comments, along with a copy of a Knox-Keene Protection Quick Reference.

- February 10, 2014: SCD received the "go-ahead" from MCED, ITSD, and CA-MMIS to develop a new aid code "9D" for HPSM DP CCS State-Only beneficiaries.

- April 9, 2014: DHCS sent to RCHSD an updated version of the contract, (including the SOW, exhibits, and attachments), CMS Checklist, and Readiness Review document for their review.

- May 2014 (November 1, 2013 - retroactively): 9D Aid Code established for CCS-Only population for HPSM DP enrollment.

- May 20, 2014: RCHSD submitted to SCD drafts of the Member Services Handbook and Evidence of Coverage (EOC).

- June 2014: SCD developed a "DHCS Family Satisfaction Phone Survey" for the Department's use to improve services provided to CCS clients and determine how the DP is functioning for CCS clients.

- June 16, 2014: SCD completed a financial review on HPSM DP quarterly reports specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with 85%< being the target.

- June 17, 2014: DHCS Management and RCHSD site visit in San Diego (in-person meeting).

- June 30, 2014: SCD provided comments to RCHSD's Member Services Handbook/EOC for consideration.

PROJECT STATUS:

Department Communications with CMS

DHCS participated in pre-scheduled reoccurring meetings with the Centers for Medicare & Medicaid Services 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's SCD also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Evaluation Design and Implementation

UCLA conducted a site visit to HPSM on July 12, 2013. UCLA's visit included meeting with various HPSM departments (IT, legal, etc.), a review of how the HPSM programs worked, the integration of the CCS Demonstration, how the implementation of the pilot was working, and goals/objectives to measure progress over a time span.

Capitation Rate Data Library Confidentiality Agreement & Addendum

DHCS's Privacy Officer, Office of Legal Services (OLS), and upper management agreed upon an administrative vehicle that would allow the Department to provide to the Demonstration contractors cost utilization data that complied with HIPAA security and confidentiality requirements. In June 2013, the Office of HIPAA Compliance requested a two page Addendum to the existing Capitation Rate Data Library Confidentiality Agreement. The Addendum was required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk. This Addendum was emailed to the Contractors on June 21, 2013 and each Contractor was to sign and return to the Department. As of August 19, 2013, cost utilization data was released to RCHSD, CHOC/Cal Optima, and LA Care.

HPSM – Contract

The CCS Demonstration for HPSM became operational on April 1, 2013.

HPSM – Bi-Weekly Conference Calls

SCD implemented bi-weekly conference calls with HPSM, which began on April 25, 2014 to discuss and resolve any issues that have occurred during the operational phase of the CCS DP.

Topics discussed during these bi-weekly conference calls consisted of enrollment, financials, and required report deliverables. Additionally, as the bi-weekly conference calls progressed, issues discussed with HPSM ranged from the enrollment of the CCS-Only population to HPSM's rate negotiations.

HPSM - Outreach / Innovative Activities

On July 12, 2013, DHCS SCD staff met in-person with HPSM and County Staff and UCLA. The meeting consisted of the following: HPSM/UCLA reviewed the evaluation component of the CCS Demonstration Program. During this meeting, HPSM also provided a short review of the HPSM CCS Pilot for UCLA.

RCHSD – Weekly Conference Calls

DHCS implemented weekly conference calls with RCHSD on March 13, 2014 to discuss and resolve various issues such as:

- In an effort to control costs, especially those associated with blood factors, RCHSD is proposing to contract with preferred pharmaceutical vendors (three to five).
- RCHSD is analyzing data to consider the inclusion of additional CCS conditions into the CCS DP. Currently the conditions are 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).
- RCHSD historically has not operated as a health plan; as such, they are in the process of developing a Member Services Guide, a Provider Network Guide, and various policies and procedures.
- The process for disenrollment of eligible clients from five San Diego GMC plans and enrollment into the CCS demonstration.
- RCHSD is in the process of enhancing their provider network to include additional Federally Qualified Health Centers (FQHCs) that are currently serving the target population.

RCHSD - Capitation Rates

Continuing from the prior Demonstration Year (mid-October 2011), DHCS has been working on development of reimbursement rates with the Department's actuarial contractor, Mercer. RCHSD has requested that Mercer supply the rates for their review. SCD Management has had communications with Mercer regarding the development of the requested rates once the population is finalized.

RCHSD - Knox-Keene License / Requirements

DHCS was able to procure an exemption to the Knox-Keene licensure for RCHSD on March 4, 2013. This exemption to the Knox-Keene licensure would not waive conformance with Knox-Keene performance requirements. Conformance will be monitored through contract compliance and shall be administered by DHCS SCD staff. This request recognized that there was a large financial burden associated with pursuing licensure as well as acknowledging the nature of this project as a demonstration with specific timeframes. RCHSD has reviewed the Knox-Keene protections to ensure compliance with the requirements.

RCHSD – Contract

In preparation for a conference call that took place on July 18, 2013, SCD provided the Readiness Review document to RCHSD on July 11, 2013. The conference call allowed both the Department and RCHSD to discuss both the Contract and Readiness Review document, lessons learned with implementing HPSM DP, policies and procedures (P&Ps), identification card (ID card), and the thirty (30) and sixty (60) Day Notices to eligible enrollees into the DP.

On August 13, 2013, SCD and RCHSD had a conference call to review draft contract language for the following: Knox-Keene and health plan requirements (provider network, ID cards, credentialing), requirements for 24/7 coverage, process and timing of contract language and covered services (pharmacy, mental health, organ transplants, investigational services, long-term care, family planning services, and comprehensive perinatal services).

Ongoing discussions continued for the current draft contract language with RCHSD and SCD throughout Spring 2014 (March – June).

RCHSD Readiness Review Deliverables

The Department developed a Readiness Review Deliverables Matrix tool, which was originally used with the HSPM DP. This Matrix includes both outreach and readiness tools to operationalize RCHSD pilot. The Readiness Review Deliverables Matrix lists deliverables that the RCHSD pilot will need to submit to the Department's SCD prior to going live. These P&Ps ensure that the RCHSD DP has safeguards in place for access to care and family centered care practices. On July 11, 2013, SCD emailed the Readiness Review Matrix to RCHSD for their review and to refer to during the conference call for discussion purposes of the draft contract and Readiness Review Matrix. SCD and RCHSD held weekly conference calls from March 13, 2014 through April 29, 2014 to discuss the Readiness Review document, P&Ps, Member Services Handbook, EOC, and Provider Network Guide. On April 3, 2014, RCHSD provided sample deliverables required in the Readiness Review Matrix to SCD which consisted of P&Ps for SCD's review, feedback and suggestions. As of May 18, 2014, RCHSD was creating the Member Services Guide/EOC, Provider Network Guide, and P&Ps not currently in place. On May 22, 2014, RCHSD provided to SCD drafts of both the Member Services Guide and EOC to satisfy many deliverables in the Readiness Review. On June 26, 2014, SCD provided feedback for RCHSD's consideration on the Member Services Guide.

RCHSD – Site Visit

On June 17, 2014, in San Diego, the Department's SCD Management met in-person with RCHSD and San Diego County representatives. CCS DP implementation discussion topics consisted of the following: Patient population, patient identification (eligibility and enrollment), Imperial County (feasibility, timing, data analysis/rate

impact), medical home assignment, provider network and Medi-Cal rates, geo-mapping requirements, pharmaceutical needs and utilization information (factor purchasing for Hemophilia patients), rates, Family Advisory Council, outcomes regarding the recommended project evaluation approach, and a timeline for the critical components necessary to implement the DP.

QUANTITATIVE FINDINGS:

Enrollment

The monthly enrollment for Health Plan San Mateo (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 the Medi-Cal Eligibility Data System (MEDS) and forwarded to the Office of HIPAA Compliance (OHC) where the file is then sent to the HPSM and an invoice is generated from the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference Prior Month	Month	HPSM Enrollment Numbers	Difference Prior Month
July 2013	1,370		January 2014	1,468	-11
August 2013	1,364	-6	February 2014	1,469	1
September 2013	1,369	5	March 2014	1,468	-1
October 2013	1,375	6	April 2014	1,475	7
November 2013	1,413	38	May 2014	1,464	-11
December 2013	1,479	66	June 2014	1,438	-26

Aid Codes

As of January 1, 2014, a list of new ACA aid codes became available, SCD staff determined which aid codes should be available for HPSM's use in the enrollment of children into the CCS DP. Anticipating effective August 1, 2014, 27 additional enrollment aid codes will be available for HPSM's use in the enrollment of children into the CCS DP. In July 2014, SCD put in a Health Code Plan request for the Table 0242 to include three "foster care" aid codes (07, 43, and 49) for HPSM's use in in the enrollment of children into the CCS DP.

Financial/Budget

SCD has met with ITSD, Medi-Cal Eligibility Division (MCED) and OHC multiple times during the Demonstration Year 9 to enroll the CCS-Only children into San Mateo County

into the HPSM CCS DP. The goal is to have an automated process with invoicing occurring through the Capitated Payment System for Medi-Cal Managed Care (CAPMAN). This system provides a functionality that allows business users to manage the Capitation Payment process from end to end. However, the automated process will take several months to implement.

On October 10, 2013, SCD Management had a conference call with HPSM stating that SCD was working on an interim manual system. SCD drafted a "high-level" flow chart on how the division envisions this occurring. SCD Management agreed to share a copy of this flow chart, so HPSM could review and see if this appears to be feasible to them as well.

On February 10, 2014, SCD received the approved memorandum form Medi-Cal Eligibility Division (MCED) to ITSD and California Medicaid Management Information System (CA-MMIS) to request the development and implementation of a new aid code "9D" for CCS State-Only beneficiaries. The aid code will be identified as 9D, CCS State-Only, Child Enrolled in a Health Care Plan. The 9D aid code was established May 2014 and was made retroactive to November 1, 2013. In May 2014, the 9D aid code was activated for the CCS population and it is anticipated to be implemented in September 2014.

QUALITATIVE FINDINGS/CASE STUDIES

HPSM - Report Requirements

On June 4, 2013, SCD emailed HPSM a Deliverable timeline indicating when the required reports are due to DHCS (monthly, quarterly, or annually).

During the October 10, 2013 SCD Management conference call with HPSM, HPSM had provided a copy of proposed changes to the contractual report requirements. During this discussion, SCD Management stated they were willing to reduce the multiple reports (monthly, quarterly, and semi-annual).

UTILIZATION DATA

The Department of Health Care Services and the demonstration pilots experienced significant challenge in obtaining and providing cost utilization data stemming from the need to conform to HIPAA security requirements. In June 2013, the Office of HIPAA Compliance requested a two page Addendum to the Capitation Rate Data Library Confidentiality Agreement (an administrative vehicle required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk). On June 21, 2013, emails were sent to each of the Contractors, and they were asked to sign and return the Addendum, which was added to the original agreement. As of August 19, 2013, cost utilization data has been release by the Department to RCHSD, CHOC/Cal Optima, and LA Care.

HPSM DP has been submitting to the Department 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

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Competing priorities with other DHCS Demonstration Projects, such as Dual Project, SPDs, LIHP, etc. are vying for available resources.

As stated under the section heading "Utilization Data" access to cost utilization data impacted four of the five Demonstrations, this data was critical to the pilots in determining financial risk.

DHCS continues to collaborate with the Demonstration entities relative to issues and challenges specific to each of the model location. A challenge that impacts all demonstration entities is the capitation rate determinations. This largely results from the need to determine the specific population(s) to be included in the demonstration. This, in turn, delays the State's ability to develop capitation rates. Other challenges vary among the demonstration models but can include final determination of target population, final determination of disease specific groups, general organizational structure, reporting requirements, etc.

It should be noted that the project implementation time table for each of the Demonstration Projects is contingent on a number of factors including acceptance of reimbursement rates by the contracting entity, the ability of the contractor to demonstrate readiness to begin operations, and approval of the contract by CMS.

HEALTHY FAMILIES CHILDREN TRASITIONING TO THE DEMONSTRATION

California Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of approximately 850,000 HFP children in four Phases throughout 2013. Children in HFP will transition into Medi-Cal's new Optional Targeted Low Income Children's Program (OTLICP) covering children with income up to and including 250 percent of federal poverty level (FPL). California Health and Human Services Agency (CHHS), in collaboration with the Department of Health Care Services (DHCS) who administers the Medi-Cal program, the Managed Risk Medical Insurance Board (MRMIB) who administers HFP, and the Department of Managed Health Care (DMHC) who oversees health plans, have been working closely with the Legislature and stakeholder partners to ensure a successful transition of the children from HFP to Medi-Cal.

CMS granted federal approval for DHCS to begin the Phase 1 transition on January 1, 2013 via the Bridge to Reform 1115 Demonstration Waiver. Federal approval for subsequent phases was contingent upon compliance with the Special Terms and Conditions (STC) which requires: public engagement, notices to children and families, consumer assistance, beneficiary surveys, services, a State Plan Amendment, network adequacy, monthly monitoring reports, and evaluation design upon completion of the transition.

ACCOMPLISHMENTS

Eligibility

Based on the collective information contained in the monitoring reports and network adequacy assessments covering all four phases of the transition, the State has been successful in transitioning 751,293 children from the HFP program to Medi-Cal. For the Demonstration Year 9, this report focuses on the final 136,842 beneficiaries that transitioned in Phases 3 (August 1, 2013), 4A (September 1, 2013), and 4B (November 1, 2013).

Table 1: Transitioned Populations[1]

Phase 3 August	Phase 4A September	Phase 4B November
104,915	6,840	25,087
		Total 136,842

[1] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report December 18, 2013, http://www.dhcs.ca.gov/services/Documents/DHCS%20HFP%20Transition%20to%20Medi-Cal%20Monitoring%20Report%20December%202013.pdf*

All transitioned children receive comprehensive health, dental, mental health, and substance use disorder services under Medi-Cal. A majority of these children were able to maintain access to the same primary care providers that they had while enrolled in HFP.

For new beneficiaries enrolling into the program, the State established new OTLICP Medi-Cal aid codes and premium requirements for beneficiaries who would have previously qualified for HFP.

Table 2: New Aid Code Definitions

Aid Code	Age of Child *(up to the month of the 1st, 6th, or 19th birthday)*	FPL	Premium Requirement
H1	0 - 1	Above 200% - Up to and including 250%	None
H2	1 - 6	Above 133% - Up to and including 150%	None
H3	1 - 6	Above 150% - Up to and including 250%	$13 per child, max $39 per family
H4	6 - 19	Above 100% - Up to and including 150%	None
H5	6 – 19	Above 150% - Up to and including 250%	$13 per child, max $39 per family

For the duration of the transition, 286,679[2] total children gained access to services under Medi-Cal's new OTLICP. During the demonstration period (July 1, 2013 through December 31, 2013), 113,880 new beneficiaries enrolled into OTLICP coverage.

Table 3: OTLICP Enrollments and Percentage Distribution[3]

Month	***Total Children in OTLICP***	***H1***	**H2**	**H3**	**H4**	**H5**
Jul	17,378	1%	13%	17%	54%	16%
Aug	19,854	2%	12%	17%	52%	17%
Sept	19,680	2%	12%	18%	52%	17%
Oct	20,464	2%	11%	17%	52%	17%

[2] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

[3] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

Nov	18,424	2%	12%	18%	51%	17%
Dec	18,080	2%	11%	17%	50%	20%
TOTAL	**113,880**					

Health Care

In Phases 1 and 2, a minimal number of children had to change primary care providers (PCPs) because beneficiaries were assigned to the same health plan and in turn were able to stay with their same PCP. For the Phase 1A children, 1.04 percent changed PCP, 6.07 percent for Phase 1B, 14.81 percent for Phase 1C in the April 2012 transition, 27 percent for Phase 1C in the May 2012 transition, and 20.67 percent for Phase 2. Nearly all of the transitioned children had an assigned PCP. For children who are not assigned to their same PCP, they were provided 30 calendar days from the time of enrollment to choose a PCP before one was chosen for them.

In Phase 3, over half of the children coming into Medi-Cal were able to keep the same PCP, and a greater number (over 67 percent) had a PCP by linkage or assignment at the time of the transition. These children's families were able to choose a new plan ahead of the transition and had the option of choosing a PCP when they chose a plan.

The number of children that had to change PCPs in Phase 3 was higher than in Phases 1 and 2 because these children were coming from HFP plans that did not contract with Medi-Cal or have a subcontract with a Medi-Cal managed care health plan. For this reason, MRMIB provided the children's PCP information so that DHCS could make it available to the plans, which would allow plans to link children to their PCP whenever possible. Children who were not assigned to their same PCP were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

In Phases 4A and 4B, the vast majority of children were assigned to a PCP at the time of the transition. For Phase 4A, DHCS was not able to track whether these children were assigned to their same PCPs because the HFP plan in these counties, Anthem Blue Cross, operated an Exclusive Provider Organization (EPO) network and did not assign enrollees to PCPs. However, the Medi-Cal managed care health plan, Partnership HealthPlan, was able to contract with the majority of providers who had participated in the EPO network, so there was a high probability that children would be able to continue seeing their same providers.

In Phase 4B, two HFP plans that operated in these counties, Anthem Blue Cross and Kaiser, established a contractual relationship with DHCS to provide Medi-Cal services in these counties. Children who were in either Anthem Blue Cross or Kaiser were able to keep their plans when they transitioned to Medi-Cal. Since the children remained in the same plan, the expectation was that all children would be able to continue seeing their same providers. Kaiser was able to keep all of its HFP children and they remained with their same PCPs. The children's families that were not members of Anthem Blue Cross

or Kaiser were able to choose a new plan ahead of the transition. Per contractual requirements, these new members were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

Since the start of the transition in January 1 through November 30, 2013, health plans reported 182 requests for continuity of care. The following were common reasons for continuity of care requests:

- Member unable to remain with same PCP or health network;
- Provider not aware of existing prior authorization;
- Member requested to change PCP;
- Member does not qualify for specialty mental health; and,
- PCPs no longer accepting Medi-Cal due to reimbursement rates.

The health plans have resolved all cases by assisting beneficiaries with selecting new or changing PCPs, bridging information on prior authorizations, and clarifying the extent to which behavioral health services are covered.

Dental Care

For children who needed to secure a new dental provider, the beneficiary could contact Denti-Cal's Beneficiary Customer Service line or locate providers on the Denti-Cal website that are accepting new patients. DHCS has improved both sources to ensure beneficiaries can easily access providers and dental services. These changes included:

- Improved referral processes with the Beneficiary Customer Service line and providing for warm transfers (ensuring beneficiaries are connected to a provider and attempting to schedule an appointment before disconnecting from the call). As such, dental care successfully reached a 100 percent warm transfer rate each month.
- Improved ease of adding providers to the online list who are accepting new patients thus offering beneficiaries a wider selection of providers in their area. As such, 788 new FFS and dental plan providers were added during July – December 2013. The total number of dental providers added during the July 2013 through December 2013 period may include duplicated providers; and,
- Improved Denti-Cal website to include Denti-Cal provider network information allowing individuals to search for providers by State, name of provider, location of residence, specialty, accepting new patients, and other factors.

Mental Health

Children in the Medi-Cal program are eligible to receive the full range of Medi-Cal mental health services, and their specific mental health needs will determine the services they receive and the delivery system they will use to access such services. Most children previously in HFP that are seriously emotionally disturbed (SED) are already known to and served by the county MHPs; in these cases, the children continue to be served by the county MHP after they transition from HFP to Medi-Cal. The county MHPs will now receive new referrals from Medi-Cal managed care plans or self-referrals from former HFP enrollees for Medi-Cal specialty mental health services. The data in

the monitoring reports[4] illustrates that transitioned and OTLICP children are able to access Medi-Cal specialty mental health services following the transition.

Substance Use Disorder
Substance use disorder (SUD) treatment is a covered Medi-Cal benefit through the Drug Medi-Cal (DMC) program. Per regular communications with County Alcohol or Drug Program Administrators Association of California (CADPAAC) to ensure that transitioned children maintain access to treatment services, none of the transitioning children has experienced any break in the continuity of coverage or SUD treatment service thus far in the transition. From July 2013 – June 2014, 2880 transition and OTLICP children received SUD treatment services.

PROJECT STATUS

Reports
Monthly monitoring reports[5] were developed and submitted to CMS for purposes of satisfying the Bridge to Reform 1115 Demonstration Waiver, Special Terms and Conditions (STC) 117 and the statutory requirement to the California Legislature. The reports presented metrics that are relevant to the accomplishment of the HFP transition to Medi-Cal relative to the monitoring objectives, sources of data, and outcomes for the transition. The data provides state, Legislators, CMS, and stakeholders the ability to assess the ongoing success of the transition and the impact on children and families with regard to, maintaining coverage for transition children, the appropriate enrollment of new enrollees, timely access to care, continuity of care, provider capacity, and consumer satisfaction under each phase, consistent with Medicaid requirements. Monthly monitoring reports started on February 15, 2013 and continued through June 2014. Upon receipt of the each month's monitoring report, CMS and the State convened conference calls to discuss any questions or comments CMS had on the monitoring reports.

In addition, pursuant to W&I Code §14005.27(e)(10), the State developed and submitted a final comprehensive report[6] to the Legislature, CMS, and stakeholders on February 4, 2014. The information in this report summarizes:

- Populations of transitioned children and their integration into OTLICP, other Medi-Cal programs, or disenrollment from Medi-Cal;
- Children's ability to maintain services through the same/different providers and health plans (health, dental, mental health, and substance use disorder); and,
- Feedback from families via call centers, appeals, grievances, and surveys.

[4] *Healthy Families Program (HFP) Monitoring Reports* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx
[5] *Healthy Families Program (HFP) Monitoring Reports* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx
[6] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report*
http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

Federal Approval

On December 20, 2013, CMS approved State Plan Amendment (SPA) 13-005 effective November 1, 2013 for the transition of children from California's Children's Health Insurance Program (CHIP) to Medicaid under the Optional Targeted Low-Income Children's program. Specifically, this SPA disregards resources and family income above 200 percent of the federal poverty level and up to and including 250 percent of the federal poverty level for targeted low-income children. Also, this SPA imposes premiums for children whose family income is above 150 percent and up to and including 250 percent of the federal poverty level.

Administrative Vendor Contract

MRMIB had administered HFP enrollments, premium collection, data collection, and web services via an administrative vendor. Upon transitioning HFP to Medi-Cal, the State had developed and executed its own contract with the same administrative vendor to continue similar services for HFP beneficiaries under Medi-Cal effective January 1, 2013. The administrative vendor had been operative during the transition period with both MRMIB and DHCS. The newly established relationship with the DHCS has been collaborative and productive in providing a familiar source for former HFP families to obtain timely information during the transition phases.

Stakeholder Engagement

The State continued to convene regular meetings/webinars with stakeholders to provide updates and to review documents related to the HFP transition. Draft documents and final versions of documents are customarily posted on the HFP transition to Medi-Cal website[7] for public review and comment. An email address is posted on the website for questions and/or comments to be submitted to the State for response. Additionally, the various program areas: Eligibility, Managed Care, Dental, Mental Health, and Substance Use Disorders convened their own stakeholder meetings to have concentrated discussions on HFP transition efforts.

Beneficiary Notices

Per statutory requirements, beneficiaries subject to the transition must be notified in writing prior to the transition. A draft of these notices was provided to stakeholders and CMS for comment prior to mailing. Beneficiaries who transitioned in Phases 3, 4A, and 4B from July 1, 2013 through November 1, 2013 received all the required notices prior to their transition. The notices reminded children and families that the transitioning children would continue to receive coverage throughout their transition, what the changes to their health services would be if any and provided frequently asked questions and answers.

Information Systems Integration

Since the eligibility criteria for HFP and Medi-Cal are different, county information systems had to be changed to accommodate the new transition population and its information. The State led meetings with its county partners and technical stakeholders

[7] *HFP transition to Medi-Cal website http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx*

to define and execute the operational changes needed to transition HFP children to Medi-Cal. All transitioned children's case information has been successfully transferred to Medi-Cal for Phases 3, 4A, and 4B from July 1, 2013 through June 30, 2014.

Application and Enrollment Processes

Previously HFP enrollments were administered by the administrative vendor. Under Medi-Cal, applications would be processed by the county partners. Consequently, the State had a responsibility to establish policies and procedures for eligibility determinations, premium collection, cost sharing provisions, and performance metrics for application processing. The State worked closely with county partners, the administrative vendor, and stakeholders on these efforts. Ongoing communication and collaboration with these groups have yielded a mutual understanding of roles and responsibilities as well as new and continued coverage for beneficiaries.

Beneficiary Surveys

The State conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey was to provide direct feedback from impacted families on how the transition from HFP to Medi-Cal was going and to alert the State to any concerns. Beneficiaries' experiences were evaluated in areas of medical, dental, mental health, and substance use disorder services.

Evaluation Design

In compliance with the waiver amendment STCs, the State submitted a draft evaluation design to CMS on February 7, 2013. Subsequently, CMS provided comments and the State responded with revisions. The final evaluation design was submitted to CMS and shared with stakeholders on April 22, 20148. The evaluation design demonstrates the transition's successes with administrative efficiencies and minimal impact to beneficiaries.

QUANTITATIVE FINDINGS

The monthly monitoring reports[9] and the final comprehensive report[10] details the quantitative findings in various areas of the transition. Below are summaries of some of the results.

Eligibility

As of June 30, 2013, the State had successfully transitioned 614,495 children from HFP to Medi-Cal in Phases 1A, 1B, 1C, and 2, and enrolled 130,057 children into OTLICP. Upon completion of the transition for all phases, a total of 751,293 children transitioned from HFP to Medi-Cal with a total of 286,679 new children enrolled in OTLICP. Not all

[8] *HFP Transition to Medi-Cal Evaluation 4-22-14* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitionMedi-CalEval.pdf

[9] HFP Monitoring Reports http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx

[10] Healthy Families Program Transition to Medi-Cal Final Comprehensive Report http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

children initially identified to transition, actually did transition as a result of attrition and other factors such as failure to pay premiums or fulfill HFP reporting requirements.

In addition to the transitioned children and newly enrolled children, the State also processed annual renewals for transitioning beneficiaries. Table 4 shows the total number of children who underwent annual renewal in each month:

Table 4: Children in Annual Renewal[11]						
July 2013	**August 2013**	**September 2013**	**October 2013**	**November 2013**	**December 2013**	**Total Children**
22,700	22,740	22,747	22,748	22,753	22,762	***136,450***

Disenrollments were also captured during the transition as totals are shown for each month below[12]. There were no disenrollments in January 2013, as children would be evaluated for other Medi-Cal programs per Senate Bill 87. These children disenrolled from the transition population due to reasons of: eligibility for OTLICP, eligibility for other Medi-Cal programs, by request, failure to return annual eligibility redetermination, failure to respond to request for additional information, and other reasons.

Table 5: Disenrollment of Children[13]					
July 2013	**August 2013**	**September 2013**	**October 2013**	**November 2013**	**December 2013**
34,347	42,640	30,415	32,725	39,215	76,597

The high number of discontinuances in December 2013 shown in Table 5 was an accumulation of discontinuances not processed earlier in the year. For the period of January 2013 through March 2013, a manual process was implemented to disenroll children due to AERs not returned during those months. This manual process raised security concerns because it included emailing client data to counties via a secure email process. The manual process was ceased beginning with AERs due April 2013 and the automated process designed to disenroll children for non-receipt of AER forms was installed November 13, 2013. Because of the delay with the automated process, a large number of transitioned cases were not disenrolled until December 2013. The State sent discontinuance notices to beneficiaries and if responded to, beneficiaries

[11] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

[12] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

[13] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

were reinstated to Medi-Cal coverage and the counties processed their AERs as appropriate.

Moreover, the State tracked continuity of care requests reported by the plans, and between January 1 through June 30, 2013, the health plans reported 182 continuity of care requests, which were resolved by assisting beneficiaries with selecting new or changing PCPs, providing information on prior authorizations, and clarifying behavioral health services covered.

In addition to tracking continuity of care requests, the State also tracked plan reports on grievances and appeals for transitioned children (Table 6), and call center volume (Table 7). Transitioning HFP beneficiaries were entitled to all the same appeal and grievance rights as existing Medi-Cal plan members. Grievances and appeals are filed when a member has an issue with access to providers or health services. The amounts are summarized the table below.

In evaluating the number of grievances and appeals reported by the plans in relation to the overall numbers of transitioning children, DHCS was satisfied that there were no outstanding concerns with plans or access that affected a significant number of the transitioning population.

Table 6: Grievances/Appeals for Transitioned Children[14]

	Jul	Aug	Sept	Oct	Nov	Dec
Eligibility Appeals	5	10	2	2	9	11
Member Health Plan Grievances (quarterly)	21			13		
Dental Appeals	1	2	3	6	5	2
Dental Grievances	7	5	4	2	4	6

Table 7 shows total calls received by our administrative vendors such as the Single Point of Entry (SPE), Health Care Options (HCO), Office of Ombudsman, Denti-Cal Beneficiary Customer Service Line, and Mental Health Ombudsman.

[14] *HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through June 30, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

Table 7: HFP Transition Related Calls Received[15]						
Call Centers	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Single Point of Entry	8,862	10,155	6,409	6,042	3,603	1,214
Health Care Options (HCO)	25,017	15,583	12,341	13,299	11,671	8,274
Office of Ombudsman (Medi-Cal Managed Care Division)	102	156	36	33	28	9
Denti-Cal (FFS) (not specific to HFP)	17,894	20,385	17,593	18,149	16,083	17,770
Mental Health Ombudsman	85	37	28	18	16	1

As the families became more familiar with the transition and fewer cases were transitioned to the State, the call volumes significantly reduced. During an actual transition month, with the exception of November where there was an unusual increase, call volumes seem to correlate with the family noticing process.

Calls to HCO would have been for not only plan choice, but also questions about the Medi-Cal Managed Care plans in the area and requests for Medi-Cal Managed Care materials. HCO call volume began to rise significantly in March and then nearly doubled in April, the month in which the 30-Day notice for Phases 1C and 2 were sent out and the month of transition for both of those phases, respectively. Call volume remained high over the summer, which was expected considering these were the months leading up to Phase 3 which required enrollment packets to be sent out an a plan choice to be made. After the Phase 3 transition, call volume began to decline toward the end of the transition.

The Medi-Cal Managed Care Ombudsman Office showed peaks in the months during which a transition was scheduled: January, March, April, and August mainly, though call volume remained low for the Phase 4 transition months of September and November. By the end of the year, the call volume had tapered off significantly.

Dental

From July 2013 to December 2013, the average number of days between scheduling an appointment and the actual appointment date for dental services was 6 days; average number of newly enrolled providers was 50.5 per month; average number of disenrolled

[15] *HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

providers was 25.33 per month; number of warm phone call transfers started from 580 in July to 373 in December; the percentage of warm transfers with a successful referral to a provider is 100%; average percentage of successful referrals that resulted in a scheduled appointment averages 78.5% per month; and, there were no continuity of care requests reported.

Mental Health

The number of transitioned and OTLICP children who received Medi-Cal specialty mental health services are as follow for each month:

Table 8: Children Received Specialty Mental Health Services *(As of 10/23/14)*					
July 2013	***Aug 2013***	***Sept 2013***	***Oct 2013***	***Nov 2013***	***Dec 2013***
8,542	9,528	10,188	11,176	11,217	10,837

The data in Table 8 was refreshed on 10/23/14 to show access to services for the remainder of the demonstration period, as data previously reported may be under represented due to the lag in claims submission. Nonetheless, the data shows transitioned and OTLICP children are able to access Medi-Cal specialty mental health services following the transition.

Substance Use Disorder

As of June 30, 2014, there were 564 certified Drug Medi-Cal providers. No county reported a waiting list for youth treatment. Below is a breakdown in the number of beneficiaries that received services per claims data:

Table 9: Children Received SUD Services (per claims data)					
Medicaid Aid Code	**5C**	**5D**	**H4**	**H5**	**Total**
July 2013	32	52	75	38	**197**
August 2013	36	59	102	56	**253**
September 2013	32	43	113	58	**246**
October 2013	26	57	127	65	**275**
November 2013	28	57	128	80	**291**
December 2013	16	44	126	85	**267**

QUALITATIVE FINDINGS/CASE STUDIES

Beneficiaries' experiences were evaluated in areas of medical, dental, mental health, and alcohol and drug services. The State conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey is to provide the State with direct feedback from impacted families on how the HFP transition to Medi-Cal is going and to alert the department to any concerns. Generally, transitioned beneficiaries scored the following for overall satisfaction:

Beneficiary Survey Satisfactory Ratings[16]							
	Phase 1A	**Phase 1B**	**Phase 1C/2**	**Phase 1C**	**Phase 3**	**Phase 4A**	**Phase 4B**
5 - Highest	63.61%	56.81%	57.14%	47.83%	49.22%	31.53%	40.62%
1 - Lowest	2.6%	5.5%	5.2%	7.4%	7.6%	14%	10.6%

For dental services, the State sent a survey to providers to determine provider capacity, their ability to accept new Medi-Cal beneficiaries, and to identify barriers to enrollment. Surveys were sent to three provider groups: Denti-Cal only billing providers, HFP only providers, and HFP/Denti-Cal providers. Survey results allowed the State to assess the number of providers that planned to enroll in Denti-Cal or contract with Medi-Cal dental managed care plans and continue providing services to their HFP children.

The results were: 11,852 surveys were mailed to providers and a little over 7,000 phone calls to providers were made using this survey. The State received a total of 9,328 surveys of which 4,683 were completed. Of those that submitted a completed survey, 2,784 Denti-Cal providers indicated that they would continue to treat children who transitioned from HFP to Medi-Cal. Survey results demonstrated providers' ability to increase their practice by a self-reported 391,000 beneficiaries across all counties. In addition, of the providers surveyed, 92 percent of HFP children would be able to remain with their same provider.

UTILIZATION DATA

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

There were issues brought to the attention of the State regarding children diagnosed with autism and the access to applied behavioral analysis (ABA) services. Specifically, based on survey information provided by the health plans, approximately 500 children of

[16] *HFP Transition to Medi-Cal Beneficiary Surveys.* http://www.dhcs.ca.gov/services/hf/Pages/BeneficiarySurveys.aspx

the total transitioned population (.07 percent) were impacted. While ABA services are not discrete services available under Medi-Cal, other services used in the treatment of children with autism such as physical, speech or physical therapy are available based on the medical needs of the child and meeting medical necessity requirements for the identified services.

As previously mentioned regarding Table 5, there were a high number of discontinuances in December 2013 due to an accumulation of discontinuances not processed earlier in the year. The manual process to discontinue cases because of security concerns, beginning with AERs due April 2013 and the automated process designed to disenroll children for non-receipt of AER forms was installed November 13, 2013. As a result of the delay with the automated process, a large number of transitioned cases were not disenrolled until December 2013. The State sent discontinuance notices to beneficiaries and if responded to, beneficiaries were reinstated to Medi-Cal coverage and the counties processed their AERs as appropriate.

TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Ten (07/01/14-10/31/15)
Second Quarter Reporting Period: 10/01/2014-12/31/2014

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. The initial period for this amendment was through August 31, 2014. The Department submitted a Waiver amendment, after extensive stakeholder input regarding the continuation of CBAS. CMS approved short term extensions during the finalization of that amendment, and approved the amendment with a December 1, 2014 effective date.

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.

In September 2014 DHCS submitted an amendment to expand full-scope coverage to pregnant women 109%-138% of the federal poverty limit. In addition, in November 2014 DHCS submitted an amendment to offer our substance use disorder services through an organized delivery system that offers a full continuum of care. Both of these amendments are pending CMS approval.

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. The “SPDs in Rural Non-COHS Counties” consists of beneficiaries with certain aid codes who reside in all Non-COHS counties operating under the Regional, Imperial and San Benito models of managed care. The “SPDs in Rural COHS Counties” consists of beneficiaries with certain aid codes who reside in all COHS counties that were included in the 2013 rural expansion of managed care. The Rural counties are presented separately due to aid code differences between COHS and non-COHS models.

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
October 2014 – December 2014

County	Total Member Months
Alameda	92,196
Contra Costa	50,902
Fresno	70,191
Kern	56,524
Kings	7,765
Los Angeles	588,963
Madera	7,525
Riverside	94,338
San Bernardino	110,598
San Francisco	52,980
San Joaquin	51,174
Santa Clara	69,568
Stanislaus	37,363
Tulare	33,296
Sacramento	116,111
San Diego	118,842
Total	**1,558,336**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
October 2014 – December 2014

County	Total Member Months
Alameda	47,154
Contra Costa	19,312
Fresno	24,845
Kern	16,415
Kings	2,468
Los Angeles	495,220
Madera	2,423
Marin	18,962
Mendocino	17,643
Merced	47,643
Monterey	47,318
Napa	14,043
Orange	345,584
Riverside	79,897
Sacramento	44,360
San Bernardino	79,565
San Diego	121,230
San Francisco	28,551
San Joaquin	17,208
San Luis Obispo	25,149
San Mateo	70,503
Santa Barbara	44,863
Santa Clara	44,462
Santa Cruz	30,626
Solano	57,957
Sonoma	52,287
Stanislaus	8,360
Tulare	11,842
Ventura	81,730
Yolo	25,578
Total	**1,923,198**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
October 2014 – December 2014

County	Total Member Months
Alpine	56
Amador	635
Butte	9,409
Calaveras	954
Colusa	359
El Dorado	2,493
Glenn	833
Imperial	5,802
Inyo	417
Mariposa	435
Mono	134
Nevada	1,628
Placer	4,643
Plumas	546
San Benito	245
Sierra	83
Sutter	2,637
Tehama	2,578
Tuolumne	1,363
Yuba	2,950
Total	**38,200**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
October 2014 – December 2014

County	Total Member Months
Del Norte	7,981
Humboldt	26,919
Lake	18,719
Lassen	4,070
Modoc	2,054
Shasta	41,128
Siskiyou	11,001
Trinity	3,108
Total	**114,980**

Enrollment (October 2014 – December 2014)
During the quarter, mandatory SPDs had an average choice rate of 57.97%, an auto-assignment default rate of 14.33%, a passive enrollment rate of 20.59%, a prior-plan default rate of 0.66%, and a transfer rate of 6.51%. In December, overall SPD enrollment in Two-Plan and GMC counties was 537,185 (point-in-time), a 4% increase from September's enrollment of 516,527. For monthly aggregate and Medi-Cal managed care health plan (MCP)-level data, please see the attachment "DY10-Q2 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

Medi-Cal Managed Care Quarterly Performance Dashboard (October 2014 – December 2014)
During the reporting period, the Managed Care Quality and Monitoring Division (MCQMD) continued to update the Medi-Cal Managed Care Performance Dashboard (MMCPD). The MMCPD assists DHCS, Managed Care Plans (MCP), and other stakeholders to identify trends and better observe and understand the program on multiple levels—statewide, by managed care plan model (i.e., COHS, GMC, Two-Plan, Regional, San Benito and Imperial) and by individual MCP. On November 20, 2014, MCQMD released the fourth iteration of the dashboard via public webinar. It includes, but is not limited to, metrics that quantify and track quality of care, enrollee satisfaction, utilization and continuity of care. It also stratifies reported data by beneficiary populations including Medi-Cal-only SPDs, dual eligibles, children transitioned from the Healthy Families Program and the ACA optional expansion population. The most significant additions to the fourth dashboard iteration include Continuity of Care (COC) metrics related to the LIHP transition and mental health benefit. Also, year-to-date trend analyses were added to the COC and Medical Exemption Request metrics for all populations.

The fifth edition of the dashboard will be released in March 2015 and MCQMD will conduct a webinar to present the dashboard to MCPs and other stakeholders. The dashboard was originally developed with funding from the California Health Care Foundation (CHCF).

Operational/Policy Issues:

Network Adequacy
Between October 2014 and December 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. DHCS and DMHC conducted a joint review of each MCP's provider network and identified no systemic access to care issues. The two departments are working aggressively with the MCPs to ensure that all areas of network adequacy are addressed.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee

On December 3, 2014, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no specific discussions relating to SPDs. Full documentation from the meeting is available at: http://www.dhcs.ca.gov/Pages/SAC-12-3-Meeting-Materials.aspx

Office of the Ombudsman (October 2014 – December 2014)

The Office of the Ombudsman experienced an overall decrease in customer calls between the periods July-September 2014 (DY10-Q1) and October-December 2014 (DY10-Q2). During DY10-Q2, the Ombudsman received 43,113 total calls, of which 13,440 concerned mandatory enrollment and 2,147 were from SPDs. During DY10-Q1, the Ombudsman received 45,367 total calls, of which 14,490 concerned mandatory enrollment and 2,471 were from SPDs. This represents a 4.97% decrease in total calls, a 7.25% decrease in calls regarding mandatory enrollment, and a 13.11% decrease in calls regarding mandatory enrollment from SPDs.

For DY10-Q2, 0.10% of SPD and 0.02% of non-SPD calls concerned access issues. This is a small decrease in SPD and non-SPD calls from DY10-Q1, during which 0.13% of SPD calls and 0.05% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) decreased for overall measures, but increased slightly for SPD measures. Total SHRs decreased from 733 in DY10-Q1 to 594 DY10-Q2. The percentage of SHRs from SPDs increased slightly from 37% to 38%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs decreased from 214 in DY10-Q1 to 178 in DY10-Q2. The percentage of those requests from SPDs increased from 27% to 33%. 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 Q2 Ombudsman Report" and "DY10 Q2 State Hearing Report."

Medical Exemption Requests (MERs) (October 2014 – December 2014)

Nothing to report.

Health Risk Assessment Data (April 2014 – June 2014)

According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 39,051 SPDs between April 2014 and June 2014. Of those, MCPs stratified 16,155 (41.37%) as high-risk SPDs and 14,859 (38.05%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 25.94% by phone and 34.19% by mail. Of the total high-risk SPDS, 24.44% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 23.35% by phone and 73.79%by mail. Of the total low-risk SPDS, 25.35% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 2,640 SPDs to be in the other risk category, which is 6.76% of the total enrolled in the quarter.

Quarterly aggregate and MCP-level data is available in the attachment "Q2 2014 Risk Data."

Continuity of Care Data (July 2014 – September 2014)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,559 continuity-of-care requests between July and September 2014. Of these, MCPs approved 1,132 requests (72.61% of all requests); held 59 requests (3.78%) in process; and denied 368 requests (23.60%). Of the requests denied, 39.67% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 Continuity of Care."

Plan-Reported Grievances (July 2014 – September 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 2,892 grievances between July and September 2014. Of these grievances, 0.31% were related to physical accessibility, 9.89% were related to access to primary care, 3.98% were related to access to specialists, 1.83% were related to out-of-network services, and 83.99% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 SPD Grievance."

Medical Exemption Requests (MERs) Data (July 2014 – September 2014)
From July through September in 2014, 7,541 SPDs submitted 8,527 MERs, an average of 1.13 MERs per SPD who submitted a MER. MCQMD approved 6,364 MERs, denied 2,138, and found 25 to be incomplete. The top five MER diagnoses were Complex (662), Cancer (252), Neurological (145), Transplant (129), and Dialysis (74). Summary data is available in the attachment "Q3 2014 MERs Data."

Health Plan Network Changes (July 2014 – September 2014)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 990 primary care physicians (PCPs) and removed 747 PCPs across all networks, resulting in a total PCP count of 27,060. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (October 2014 – December 2014)
Nothing to report.

Encounter Data (October 2014 – December 2014)
DHCS initiated the Encounter Data Improvement Project (EDIP) in late 2012, with the goal of improving its 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 quality, tracking it from submission to its final destination in DHCS's data warehouse, and reporting data quality to internal data users and external stakeholders.

During the reporting period, the Encounter Data Quality Unit (EDQU), established by the EDIP, continued its efforts to implement 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, DHCS data users and other stakeholders.

EDQU also worked with Medi-Cal MCPs as they transitioned to DHCS' new encounter data processing system, PACES, which will enhance DHCS' ability to implement the EDQMRP. The first group of Medi-Cal MCPs successfully transitioned to the new system in December 2014 and the transition will continue through early 2015. Although these efforts did not specifically target SPDs, improving the quality of DHCS's encounter data will enable it to better monitor the services and care provided to this population.

Outcome Measures and All Cause Readmissions (October 2014 – December 2014)

Healthcare Effectiveness Data Information Set (HEDIS) Measures
As HEDIS rates are reported annually, there will be no new data until July 2015. MCPs will report the following indicators for SPDs versus other members: all cause readmissions to the hospital, ambulatory visits (outpatient and emergency department), monitoring for patients on persistent medications, and children and adolescents' access to primary care practitioners.

Consumer Assessment of Healthcare Providers and Systems
The Department of Health Care Services (DHCS) has approved and posted the 2013 CAHPS® Survey Summary Report on DHCS's Managed Care Quality and Monitoring Division's Quality Improvement & Performance Measurement Reports website: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#cahps.

The survey was conducted by DHCS's external quality review organization, Health Services Advisory Group. The report measures member satisfaction with four global ratings and five composite measures. For example, it measures members' satisfaction with the care provided by their personal doctors and the customer service provided by their MCPs. The MCPs' National Comparison results for the Global Ratings and Composite Measures either improved or stayed the same when compared to the 2010 CAHPS® Summary Report. However, the 2013 CAHPS® Survey Summary Report indicates that MCPs have the greatest opportunities for improvement on the following

measures: *Rating of Health Plan*, *Getting Care Quickly*, and *How Well Doctors Communicate*—suggesting that low performance in these areas may point to issues with access to and timeliness of care.

DHCS is utilizing CAHPS® performance data to drive improvement, such as by conducting data analysis related to Smoking and Tobacco Use Cessation and sharing the results with MCPs.

DHCS provides CAHPS® survey information to Medi-Cal beneficiaries through the Consumer Guide and the Office of Patient Advocacy Report Cards to assist them in making informed decisions when they select a health plan.

Utilization Data (October 2013 – December 2013)
During the period October through December 2013, MCPs in Two-Plan and GMC counties enrolled 531,421 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 13.83% (73,506) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.71 times.
- Each SPD who visited an ER generated an average of 2.71 ER claims.

Pharmacy Services:

- 67.83% (360,489) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 14.06 claims.

Outpatient Services:

- 48.25% (256,434) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.89 visits.
- Each SPD who accessed outpatient services generated an average of 10.91 claims.

Inpatient Services:

- 4.97% (26,424) 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 3.70 claims.

Hospital Admissions:

- 5.72% (30,396) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 1.96 visits.

Top Ten Services Accessed by SPDs

12,267,575 total claims

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

For the top ten diagnosis categories, MCPs submitted data for a total of 3,002,648 encounters. Mental Illness was in the top rank with 37.96% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 15.74%. In the third position, "Diseases of the nervous system and sense organs" was 8.14%. The remaining seven categories ranged from 8.03% to 2.99% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment "DY10 Q2 Utilization Data."

Enclosures/Attachments:

- "DY10 Q2 Defaults Transfers 2Plan GMC"
- "DY10 Q2 Ombudsman Report"
- "DY10 Q2 State Hearing Report.
- "Q2 2014 Risk Data"
- "Q3 2014 Continuity of Care"
- "Q3 2014 SPD Grievance"
- " Q3 2014 MERs Data"
- "Q3 2014 Network Adequacy"
- "DY10 Q2 Utilization Data"
- "MMCD AG Meeting Minutes 12 12 14"
- "Managed Care Enrollment Quarterly 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 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 Health Plan of San Mateo (HPSM) CCS Demonstration Project (DP) is shown in the table below. Eligibility of HPSM's CCS DP members 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 September 2014	1,435	
October 2014	1,413	-22
November 2014	1,405	-8
December 2014	1,421	16

Outreach/Innovative Activities:

During the months of July through September 2014, the Department of Health Care Services (DHCS) developed and administered a "Family Satisfaction Phone Survey" (survey) to HPSM CCS DP families. The Department conducted this survey to satisfy one of several components of the operational review for the CCS DP. DHCS was able to contact 385 HPSM families. Of those contacted, 380 families (98.7%) agreed to complete the survey. 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 survey 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 DP.

Operational/Policy Issues:

DHCS continued 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 of San Mateo Demonstration Project

Department Communications with HPSM

DHCS and HPSM conducted bi-weekly conference calls to discuss various issues,

inclusive of those related to finance, information technology, and report deliverables. On October 17, 2014, DHCS conducted site visits with HPSM and San Mateo County (SM County) for a first annual review of the demonstration project. Documents were provided for review and discussions were focused on what was working well and what were challenges with the CCS DP. Overall, the program was working well.

Capitation Rates
DHCS has been working on adjusting HPSM's capitated rate in compliance with the physician fee increase required by Section 1202 of the Affordable Care Act, Senate Bill 78 and Assembly Bill 1422.

The Department worked to implement a 9D aid code which will allow CCS State-Only children to enroll in CCS DPs. The goal is to be able to automate enrollment of CCS State-Only children into a CCS DP.[1] It is anticipated the 9D aid code for "CCS State-Only beneficiaries" will be active March 2015.

Aid Codes
HPSM DP began to enroll children into the pilot with eligibility codes 7U, 7W, and K1. The effective date for these codes was November 25, 2014.

Rady Children's Hospital of San Diego Demonstration Project

SCD had been working with Rady Children's Hospital of San Diego (RCHSD) towards commencing their CCS DP. Communications include review of contract documents (scope of work, reporting requirements etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, and other operational matters.

Cost Utilization Data
On November 6, 2014, the Department sent RCHSD a second Data Library Confidentiality Agreement (DUA) for review and approval. The DUA will allow DHCS to release cost utilization data for three fiscal years (FY) FY 2011 to 2012 through FY 2013 to 2014 for the three original conditions (Sickle Cell, Cystic Fibrosis, Hemophilia) and two additional conditions (Acute Lymphoblastic Leukemia and Diabetes Type I and II for ages 1-10 yrs). The DUA was signed by RCHSD and returned to the Department on November 25, 2014. A fully executed DUA was returned to RCHSD on December 11, 2014.

Capitated Rates
DHCS continued work on rate development. Development of rates was been delayed due to discussions regarding conditions covered, pharmaceuticals covered, and risk corridors.

[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
The Department participated in weekly conference calls with RCHSD to discuss and resolve various issues such as:

- **PHARMACEUTICALS / PMB**
  RCHSD was investigating partnerships with different Pharmaceutical Benefits Management (PBM) firms; however, this had been a challenge due to PBMs' reluctance to contract for services with a DP with an initial small population size. Until such time when a PBM is secured, the DP will initially include only Hemophilia associated pharmaceuticals such as blood factors.

- **MEMBER HANDBOOK / EVIDENCE OF COVERAGE (MH/EOC)**
  The revised Member Handbook (MH) and Evidence of Coverage (EOC) were submitted to DHCS on November 12, 2014. On, December 11, 2014, the Department returned the MH/EOC delineating corrective items needed per the SOW requirements.

- **FINANCIAL REPORTS**
  On October 2, 2014, RCHSD submitted financial reports for DHCS to review. On November 6, 2014, RCHSD submitted IBNR templates along with policies and procedures (P&Ps).

- **PROVIDER MANUAL**
  RCHSD continued development of their provider manual to satisfy a Readiness Review component.

- **SITE REVIEW TOOL**
  RCHSD continued development of their Site Review Tool to satisfy a Readiness Review component.

- **MEMBER ELIGIBILITY FILE**
  County, RCHSD Information Technology (RCHSD IT), and the Department's IT discussed the "flow and process" of member eligibility files. DHCS IT worked on providing an eligibility test file to RCHSD.

- **RCHSD READINESS REVIEW DELIVERABLES**
  On July 2, 2014, RCHSD began submitting their policies and procedures (P&Ps) to DHCS for review, as indicated in the Readiness Review document.[2] As of December 24, 2014, the Department approved 52 deliverables, 8 deliverables were not approved, and 7 deliverables were under DHCS review.

- **CONTRACT ITEMS**
  As of December 2014, contract terms being discussed include: clarification of provisions in Exhibit E such as data certification, appeals process, financial working

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

papers and in Exhibit B regarding the catastrophic coverage limitation provision.

- **NETWORK DEVELOPMENT**
  Throughout the months of October and November, discussions occurred between RCHSD and community clinics.

- **EVALUATION METRICS**
  On November 6, 2014, RCHSD submitted a proposed evaluation metrics that included objectives, baseline definitions, and measurement for all covered disease states.

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

DHCS drafted 90, 60, and 30-Day notices to patients, providers, and the GMC plans. These notices will be used to communicate the disenrollment of eligible clients from five Geographic Managed Care (GMC) plans into RCHSD CCS DP. Content within the notices consist of the following:

- Announcement of a pilot to CCS Member enrolled in a GMC Plans;
- Eligible 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, vision coverage and remain with current medical doctor;
- Enhanced benefits (coordination of health needs, community referrals, resources for parenting, education, and emotional support);
- Date automatic enrollment and health benefit coverage would occur;
- Receipt of an identification card for doctor visits, pharmacy, and hospital; and
- Phone number for questions.

DHCS will coordinate with the enrollment broker on the member and provider notice.

RCHSD – Site Visit

On November 4, 2014, DHCS met with RCHSD and San Diego County representatives. The CCS DP implementation discussion topics with RCHSD consisted of the following: Rates (pharmacy, risk corridor, data for the conditions); County Administration Allocation fund (components of the administration rate, responsibilities that would remain with San Diego 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); 90/60/30-Day notices; evaluation metrics (review metrics, time window for cohort study, patient/provider surveys); and catastrophic cases unrelated to CCS conditions. Discussion topics with San Diego County consisted of the following: update on the CCS DP, 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.

On December 30, 2014, the Department met with San Diego County representatives. Discussions focused on San Diego County administration allocation fund; health plan

Memorandum of Agreement (MOA); San Diego CCS Pre- and Post-Pilot Assessment/Evaluation; and CCS Tools such as Frequently Asked Questions (FAQs).

Pilot Schedule

It is anticipated RCHSD CCS DP will be operational in Spring 2015. It should be noted the projected implementation time table is contingent on a number of factors including, development and 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 starting 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

The Department has developed a Provider Satisfaction eMail Survey (Provider Survey) this quarter for the HPSM CCS DP. It is anticipated the Provider Survey will be e-Mailed to providers next quarter. The providers feedback will help evaluate the current level of success of the HPSM DP and identify those areas that need improvement.

On October 17, 2014, DHCS conducted site visits with both HPSM and San Mateo County. This first annual site review addressed the main goals of the DP, which focused on care coordination, medical home, and family centered-care.

Complaints, Grievances, and Appeals

On December 30, 2014, HPSM submitted a "Pending and Unresolved Grievances Quarterly Report" for the third quarter, April - June 2014. The Grievances Report showed during the quarter:

- 8 grievances were received; (Coverage/Benefit 2, Medical Necessity 1, Access 0, Customer Service 4, Privacy Issues 0, Fraud/Waste/Abuse 0, Other 1)
- 4 grievances were resolved timely
- 4 grievances not resolved timely
- 7 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 December 3, 2014, the Department presented an update on the CCS pilots to advisory board members of the CCS Redesign Stakeholder Process. A PowerPoint

presentation “Section 1115 Waiver Renewal Stakeholder Workgroup Update” gave a CCS Update. Attached below is the presentation link:
http://www.dhcs.ca.gov/Documents/Wvr_Rnwl_Sh_Wkgrp_Upd_MC_1-26.pdf

Quality Assurance/Monitoring Activities:

On December 30, 2014, HPSM submitted “Enrollment and Utilization Table” report. 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

HPSM deliverables submitted during this quarter are listed in the table below, in addition to the Department’s internal review and approval for each deliverable.

Report Name	Date Due	Received	Pending Review	DHCS Approved
Provider Network Report (Rpt #6)	10/30/2014	12/1/2014		YES
Grievance Log/Reports (Rpt #6)	10/30/2014	12/30/2014		YES
Quarterly Financial Statements (Rpt #6)	11/17/2014	11/14/2014	✓	
Report of All Denials of Services Requested by Providers (Rpt #5)	11/17/2014			

Evaluations:

During this quarter, DHCS analyzed the results from the Family Satisfaction Phone Survey (survey) that was administered to the HPSM CCS DP families. This survey will help the Department improve services provided to CCS clients and determine how the demonstration program pilot is working for CCS clients enrolled within the CCS Program. The Family Survey was used to establish a “baseline” of information to compare against in outlying years.

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.

The Department continued working to obtain CMS approval for the revised Attachment G, Supplement 2, "Cost Claiming Protocol for Health Care Services Provided under the LIHP – Claims Based on Capitation" for CMS approval.

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

The Department 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 that are used to monitor and measure the effectiveness of the local LIHPs and aid in the evaluation project. UCLA released the Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program policy brief in October 2014.

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). On October 8, 2014, CMS approved the exclusion of the HCCI component from the PCP increased payment claiming process for specified evaluation and management and vaccine administrative services. Additionally, on October 10, 2014, CMS provided guidance that the enhanced Federal Medical Assistance Percentage (FMAP) will only be for the difference between the Medicare rate and the payment rate applicable to such services under the State plan as of July 1, 2009. Any differential that may exist between what LIHP paid in 2013 and what Medi-Cal paid for the same service on July 1, 2009, can only be reimbursed at the standard FMAP. DHCS continued to work on the implementation of the PCP increased payment claiming process by developing a revised invoice and communicating with the local LIHPs. Additionally, the Department began working

to provide State online registry data to local LIHPs.

The Department worked with each local LIHP to determine compliance with the Maintenance of Effort (MOE) contract requirement that total non-federal expenditures in each Demonstration Year meet or exceed the annual MOE amount through December 31, 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 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.

The Department 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 annual report for DY9.
- DHCS reviewed the DPHs' semi-annual and annual reports.

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

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).

Consumer Issues:

The Department 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, DHCS meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

- Weekly DHCS and California Department of Corrections and Rehabilitation for discussion on populations determined eligible for Medi-Cal and LIHP by the Department.

DHCS continued 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. The Department updated appropriate communication processes with local LIHP and other stakeholders during program close-out activities. DHCS continued 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**
Health Care (Qtr.2)	-$470,077.12		-$940,154.24	DY6	-$470,077.12
	$10,524,196.84		$21,048,393.68	DY7	$10,524,196.84
	$3,784,800.67		$7,569,601.34	DY8	$3,784,800.67
	$22,519,948.89		$45,039,897.78	DY9	$22,519,948.89
	$10,524,196.84	$10,524,196.84	$0.00	DY7	$21,048,393.68
Total	**$46,883,066.12**	**$10,524,196.84**	**$57,407,262.96**		**$57,407,262.96**

Quality Assurance/Monitoring Activities:

DHCS continued the contract compliance process with LIHPs. The Department requested and reviewed LIHPs' submissions to ensure compliance with their LIHP contracts, including the annual quality improvement reports for FYs 2011/12, 2012/13, and 2013/14. DHCS communicated with LIHPs to follow up and complete contract compliance reporting as necessary.

Enclosures/Attachments:

- DY10 Q2 LIHP Evaluation Design Progress 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 the length of the overall BTR Waiver, 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

[3] CBAS access/capacity must be provided in every county except those that did not previously have ADHC centers, as identified in STC 91.l.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.

(available in two counties), along with the final COHS county (Ventura) also transitioning 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:

CBAS Enrollment and County Capacity (STC 99.a):

The CBAS Enrollment data (per STC. 99) for both Managed Care Organizations (MCO) and FFS beneficiaries per county for DY10, Quarter 2 is shown at the end of this section in Table 2, *Preliminary CBAS Unduplicated Participant Data for MCO and FFS Enrollment,* at the end of this report section. Table 1 provides the county capacity available per county, which is also incorporated into Table 2.

CBAS Enrollment data is based on self-reporting by the MCOs (Table 2), which is reported quarterly, along with claims data for those CBAS individuals remaining in FFS. Some MCOs report enrollment data based on their covered geographical areas, which includes multiple counties. The Enrollment data reflects this grouping of some counties in the quarterly reporting.

Enrollment data continues to reflect that CBAS participation remains under 29,000 statewide. FFS Claims data, which has a lag factor, is used for the FFS enrollment data.

CBAS Assessments Determined Eligible and Ineligibility:

DY 10	MCOs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
Quarter 1 (7/1-9/31/ 2014)	2,299	2,251 (98%)	48 (2%)	260	256 (98.5%)	4 (1.5%)
Quarter 2 (10/1-12/31/2014)	**2,860**	**2,812 *** (98%)	**48** (2%)	**62 ***	**60** (96.8)	**2** (3.2)
5% Negative change between last Quarter	NA	NA	NA	NA	NA	NA

* Note: Eligible FFS and MCO changed significantly due to ALL CBAS counties being covered by Managed Care as of December 1, 2014

During Quarter 2, there was over 220 eligibility inquiry requests submitted DHCS, of which over 170 were referred to managed care for CBAS benefits. Approximately 12 of the FFS face-to-face assessments were completed from requests submitted in the prior Quarter (September). There were 62 individuals that remained in FFS and had face-to-face assessments during Quarter 2, as noted above.

CBAS provider-reported data (per CDA) (STC 99.b)

Below are the most recent participant statistics available from recent claims data and provider reported data:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total Calif. Counties	58
Number of CBAS Centers	245
* Non-Profit Centers	62
* For-Profit Centers	183
ADA @ 245 Centers	19,584
* ADA per Centers	80

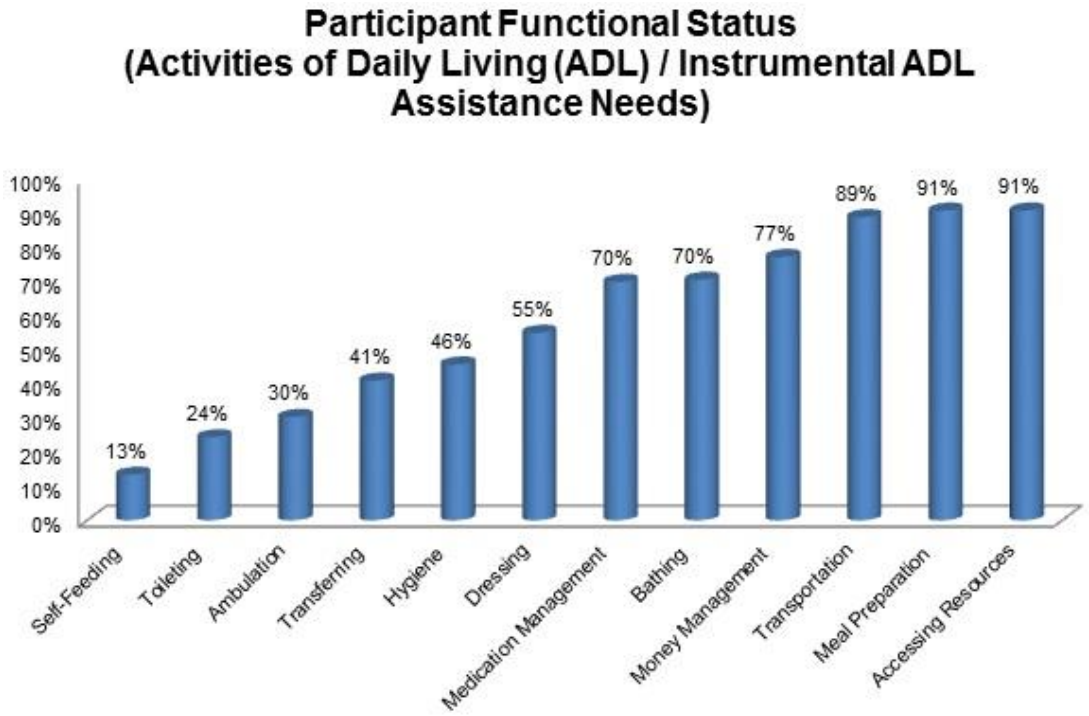
CDA – MSSR data 12/2014

Demographic Makeup	
Female	**61%**
Male	39%
Age 18-64	22%
Age 65-74	18%
Age 75-84	**38%**
Age 85+	22%

DHCS estimate percentages of Medi-Cal Paid Claims data (service period from 1/1/13 - 6/30/13, paid through 6/24/13, run date 8/3/13).

Participant Profile			
Diagnoses *	**%**	**Conditions/Needs**	**%**
Psych Diagnosis	48%	Fall Risk	81%
Dementia	30%	Special Diet	75%
Mental Retardation or DD	7%	Use Cane/Walker/Wheelchair	62%
Other	15%	Incontinent	43%
		Behavioral Symptoms	39%

CDA Participant Characteristics, FY 2013-14



Source: CDA Participant Characteristics Report (CDA CBAS 293), Fiscal Year 2013-14

Enhanced Case Management (ECM) – *Ended August 31, 2014*

Per the Waiver Amendment, ECM services sunset on August 31, 2014. Eligible participants' ECM and care coordination had been established beginning in April 2012, and the need for further interaction diminished. To notify all possible beneficiaries that ECM would be ending, a notice was sent to over 900 managed care and FFS beneficiaries. 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. Managed care participants continue to receive the care coordination services through their existing provider plan network.

The ECM Participant Quarterly Data (Table below) shows the number of FFS ECM-eligible individuals since ECM began in April 2012, through August 2014. These individuals had been served at a local ADHC Center (between July 1, 2011, to March 31, 2012) before CBAS began on April 1, 2012; and were not-eligible for CBAS as they did not meet the program requirement for medical necessity. ECM-eligible members that enrolled in managed care health plans received ECM through their plan's case management services. ECM-FFS members received ECM with DHCS nurses contacting participants regarding their care needs, coordinating services and community referrals. Many participants requested no further contact regarding ECM services as their needs had been met.

This final report on ECM depicts the ECM-FFS Participant Data since ECM began in April 2012 (Original Count) to end date of ECM on August 31, 2014:

ECM Participant 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

* *FINAL ECM -- Closing August 31, 2014*

DHCS ECM Data 08/20/2014

Outreach/Innovative Activities:

With the approval of the CBAS Amendment from CMS on November 28, 2014, DHCS and CDA held a final Webinar to summarize final outcomes for the CBAS program. This final Webinar was held on December 2, 2014, at 2:00pm, and was open to all interested stakeholders, managed care plans, and providers. The Webinar highlighted updates to the STCs and SOPs that were negotiated with CMS through the Amendment process. To view the webinar, please click here.

A new Stakeholder process will begin in February 2015 that focuses on the CBAS amendment to the Home and Community-Based Setting Statewide Transition plan.

Operational/Policy Development/Issues:

With CMS' approval of the CBAS 1115 BTR Demonstration (11-W-00193/9) Amendment on November 28, 2014, DHCS and CDA provided a Webinar for all CBAS Providers and MCOs to better understand any changes and to confirm that CBAS was continuing as a Medi-Cal Managed Care benefit. The Webinar took place on December 2, 2014, and highlighted all new requirements.

Consumer Issues:

CBAS beneficiary / Provider Call Center complaints (FFS / MCO) (STC 99.e.iv)

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 and CDA maintain CBAS webpages for the use of all stakeholders. Emails are directed to CBAS@dhcs.ca.gov from providers and beneficiaries for answering a variety of questions.

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA. Complaint data received by the MCOs from beneficiaries and providers are also summarized below:

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%
DY10 - Qrt 2 (Oct 1 - Dec 30)	5	10	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%
DY10 - Qrt 2 (Oct 1 - Dec 30)	18	2	20	0.07%
			Plan data - Phone Center Complaints	

CBAS Grievances / Appeals (FFS / MCO) (STC 99.e.iii)

CBAS grievances are held through the MCOs and in Quarter 2, there were a total of 5 grievances filed and resolved.

The State Fair Hearings / Appeals 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 2, there were 2 cases filed/heard (from the approximate 29,000 participants), throughout the State. Hearings have typically been related to misunderstandings with Managed Care enrollment.

APPEALS / FAIR HEARINGS 2014	Initial Review	Rehearing Request	Total
October	0	0	0
November	3	0	3
December	1	0	1
QUARTERLY TOTAL	4	0	4

DHCS-CDSS ALJ Data Records 12/2014

Quality Assurance/Monitoring Activity:

DHCS continues to monitor CBAS Center locations, accessibility and capacity for monitoring access as required under the BTR Waiver. The table below indicates the consistency of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The Licensed Capacity, below, shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 57% statewide. There is availability in almost all counties where CBAS is available to allow for access 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	DY10-Q2 Oct-Dec 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	355	**355**	0%	73%
Butte	60	60	60	60	**60**	0%	31%
Contra Costa	190	190	190	190	**190**	0%	62%
Fresno	590	547	572	572	**572**	0%	69%
Humboldt	229	229	229	229	**229**	0%	29%
Imperial	250	315	330	330	**330**	0%	66%
Kern	200	200	200	200	**200**	0%	32%
Los Angeles *	17,735	17,506	18,184	18,284	**18,284**	0%	57%
Marin	75	75	75	75	**75**	0%	22%
Merced	109	109	109	109	**109**	0%	52%
Monterey	290	-	110	110	**110**	0%	40%
Napa	100	100	100	100	**100**	0%	53%
Orange	1,897	1,747	1,910	1,960	**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	2,132	1,992	1,873	1,873	**1,873**	0%	60%
San Francisco	803	803	866	866	**866**	0%	49%
San Mateo	120	120	135	135	**135**	0%	66%
Santa Barbara	55	55	55	55	**55**	0%	4%
Santa Clara	820	750	840	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	806	806	806	851	**851**	0%	65%
Yolo	224	224	224	224	**224**	0%	74%
SUM =	29,009	27,967	29,007	29,192	**29,192**	0%	57%

CDDA Licenced Capacity as of 12/31/2014

Los Angeles - 1 center closed, 2 centers opened

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

There is no drop in provider capacity of 5% or more during this Quarter; 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 and an analysis that addresses such variance.

With participant enrollment numbers in counties with CBAS centers, there is ample licensed capacity with the current capacity levels utilizing just under 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.

Access Monitoring (STC 99.e.)

DHCS and CDA continue to monitor CBAS centers access, average utilization rate, and available capacity. Currently CBAS capacity is adequate to serve Medi-Cal beneficiaries in counties with CBAS centers. With such excessive capacity in counties with multiple CBAS providers, closure of individual CBAS Centers (or consolidation of CBAS providers) continues to minimally impact the program or beneficiaries served.

Unbundled Services (95.b.iii.)

For DY 10, Quarter 2, CDA, the Department that certifies and provides oversight of CBAS Centers, reported one CBAS Center closure that occurred in the Los Angeles County area (Christian ADHC) in October 2014. Participants moved to another local Center of received Unbundled Services; five participants received no additional services (able to receive necessary care with IHSS and family resources). Additionally two Centers opened in LA County in November 2014.

	DY10_Q2 UNBUNDLED SERVICES							
Services Started:	Within 1 Week	Within 2 Week	Within 3 Week	Within 1 Month	Within 2 Months	Within 3 Months	Within 5 Months	**TOTAL**
CBAS-Transfers	2	1						**3**
Unbundled Srvs.	11		6					**17**
No *New* Services	5							**5**
DHCS/CDA Complied Data 2/2015							**TOTAL**	**25**

Another Center closed on September 30 (A Day Away ADHC, also in LA County) which fell into DY10, Q1. Prior to the center closure, 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, details of that closure were not reported previously.

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.

There was not a negative change from quarter to quarter of more than 5%, provide probable cause as well as an analysis that addresses such variances

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.

CBAS Center Utilization (newly opened / closed Centers)

For DY 10, Quarter 2, CDA had 245 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. Another closure occurred in Los Angeles in October, along with two Centers opening in November. Preliminary data on Center Utilization which includes this Quarter is as follows:

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
October 2014	244	1	0	-1	243
November 2014	243	0	2	+2	245
December 2014	245	0	0	0	245

CDA Data as of 12/31/2014

There was not a negative change of more than 5% from the prior quarter, so no analysis is needed to addresses such variances.

Review County Enrollment for CBAS vs. Capacity per County

TABLE 2:

Preliminary CBAS Unduplicated Participant - FFS and MCO Enrollment Data with County Capacity of CBAS

	DY9 Q3 Jan - Mar 2014			DY9 Q4 Apr - June 2014			DY10 Q1 Jul - Sept 2014			DY10 Q2 Oct - Dec 2014		
County	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used
Alameda	8	465	79%	8	464	79%	8	431	73%	5	490	82%
Butte	39	0	38%	35	0	34%	32	0	31%	1	42	42%
Contra Costa	10	119	40%	9	194	63%	6	194	62%	4	201	64%
Fresno	7	659	69%	9	590	62%	5	661	69%	11	625	66%
Humbolt	110	0	28%	109	0	28%	113	0	29%	0	105	27%
Imperial	380	0	68%	369	0	66%	367	0	66%	10	351	65%
Kern		89	26%	0	119	35%	0	110	32%	0	92	27%
Los Angeles*	1,020	15,177	54%	1,000	14,898	52%	941	16,707	57%	744	17,270	58%
Merced	0	101	55%	0	105	57%	0	96	52%	0	89	48%
Monterey	0	66	35%	0	77	41%	0	75	40%	0	83	45%
Orange	5	2,515	81%	8	2,217	69%	6	2,313	70%	1	2,248	68%
Riverside	18	389	38%	14	388	37%	13	383	37%	14	377	36%
Sacramento	30	549	65%	20	532	62%	20	544	63%	31	561	66%
San Bernardino	14	411	78%	14	418	80%	16	456	87%	16	498	95%
San Diego*	36	1,403	42%	33	1,448	47%	29	1,873	60%	32	1,530	49%
San Francisco	53	659	49%	55	688	51%	61	664	49%	63	686	51%
San Mateo	0	136	67%	0	147	64%	0	151	66%	0	148	65%
Santa Barbara	0	3	3%	0	9	10%	0	4	4%	0	2	2%
Santa Clara	0	559	43%	0	588	41%	1	544	39%	5	576	41%
Santa Cruz	0	100	66%	0	101	66%	0	107	70%	0	112	73%
Shasta	40	0	28%	40	0	28%	44	0	31%	1	42	30%
Ventura	10	911	67%	7	893	66%	1	940	65%	9	907	64%
Yolo	2	220	59%	1	215	57%	1	280	74%	1	274	72%
Marin, Napa, Solano**	0	224	45%	0	235	47%	0	177	35%	51	94	29%
Total	**1,782**	**24,791**	**54%**	**1,731**	**24,326**	**53%**	**1,664**	**26,727**	**57%**	**999**	**27,403**	**57%**
Combined Totals	**26,573**			**26,057**			**28,391**			**28,402**		

*Care1st has revised their methodology resulting in higher, more accurate particiant counts

DHCS / CDA Enrollment Data 2/2015

** 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

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**
(Qtr 2)	$ 44,250,000		$ 44,250,000	DY 10 (Jul-Sept)	$ 44,250,000
Total:	**$ 44,250,000**		**$ 44,250,000**		**$ 88,500,000**
DSRIP					
(Qtr 1)	$ 0	$ 0			$ 0
(Qtr 2)	$328,893,774	$328,893,774			$ 657,787,548
Total:	**$ 328,893,774**	**$ 328,893,774**			**$ 657,787,548**
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
(Qtr 2)	$ (8,369,990)		$ (6,020,068)	DY 6 (Sept-Oct)	$ (14,390,058)
(Qtr 2)	$79,804,676		$79,804,676	DY 10 (Jul-Dec)	$ 159,609,352
Total:	**$ 136,058,796**		**$ 137,523,518**		**$ 273,582,314**

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. In September 2014, DHCS submitted a proposed claiming methodology for the inclusion of certain workforce programs as permitted under the STCs, that proposal is still in discussions with CMS.

This quarter, Designated State Health Programs claimed **$ 71,434,686** 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 **$ 44,250,000** in federal fund payments for SNCP eligible services.

Appendix D - Proposed Budget Neutrality
California 1115 Waiver Renewal - Medi-Cal 2020

BUDGET NEUTRALITY				MEDI-CAL 2020 WAIVER					
			FY 14-15	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20	
WOW	MEGS	Trend Rate	Baseline	DY11	DY12	DY13	DY14	DY15	5 Year Total
PMPM									
TPM/GMC									
	Family	5.30%	$185.92	$195.78	$206.15	$217.08	$228.59	$240.70	
	SPDs	7.40%	$864.94	$928.95	$997.69	$1,071.52	$1,150.81	$1,235.97	
	Duals	3.28%	$117.97	$121.84	$125.84	$129.97	$134.23	$138.63	
	New Adult	4.10%	$507.16	$527.95	$549.60	$572.13	$595.59	$620.01	
COHS									
	Family	5.30%	$210.42	$221.57	$233.32	$245.68	$258.70	$272.42	
	SPDs	7.40%	$1,618.22	$1,737.97	$1,866.58	$2,004.71	$2,153.05	$2,312.38	
	Duals	2.47%	$439.25	$450.10	$461.22	$472.61	$484.29	$496.25	
	New Adult	4.10%	$687.49	$715.68	$745.02	$775.57	$807.37	$840.47	
CCI TPM/GMC									
	Family	5.30%	$187.81	$197.76	$208.24	$219.28	$230.90	$243.14	
	SPDs	7.40%	$1,051.02	$1,128.79	$1,212.32	$1,302.03	$1,398.38	$1,501.87	
	Duals	3.40%	$749.35	$774.83	$801.17	$828.41	$856.58	$885.70	
	Cal MediConnect	3.40%	$749.35	$774.83	$801.17	$828.41	$856.58	$885.70	
CCI COHS									
	Family	5.30%	$213.75	$225.08	$237.01	$249.57	$262.80	$276.72	
	SPDs	7.40%	$2,032.81	$2,183.24	$2,344.80	$2,518.32	$2,704.67	$2,904.82	
	Duals	1.61%	$652.77	$663.28	$673.95	$684.80	$695.83	$707.03	
	Cal MediConnect	1.61%	$652.77	$663.28	$673.95	$684.80	$695.83	$707.03	
CBAS		3.16%	$1,130.95	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30	
Member Months									
TPM/GMC									
	Family	1.00%	17,360,483	17,534,088	17,709,429	17,886,523	18,065,388	18,246,042	
	SPDs	1.00%	1,972,742	1,992,469	2,012,394	2,032,518	2,052,843	2,073,372	
	Duals	1.00%	627,963	634,243	640,585	646,991	653,461	659,995	
	New Adult	1.00%	15,618,295	15,774,478	15,932,223	16,091,545	16,252,460	16,414,985	
COHS									
	Family	1.00%	7,528,663	7,603,949	7,679,989	7,756,789	7,834,357	7,912,700	
	SPDs	1.00%	949,443	958,937	968,526	978,212	987,994	997,874	
	Duals	1.00%	2,499,823	2,524,821	2,550,069	2,575,570	2,601,326	2,627,339	
	New Adult	1.00%	4,407,998	4,452,078	4,496,599	4,541,565	4,586,980	4,632,850	
CCI TPM/GMC									
	Family	1.00%	33,001,616	33,331,632	33,664,948	34,001,598	34,341,614	34,685,030	
	SPDs	1.00%	5,277,609	5,330,385	5,383,689	5,437,526	5,491,901	5,546,820	
	Duals	1.00%	3,085,998	3,116,858	3,148,027	3,179,507	3,211,302	3,243,415	
	Cal MediConnect	1.00%	2,543,271	2,568,704	2,594,391	2,620,335	2,646,538	2,673,003	
CCI COHS									

	Family	1.00%	4,810,033	4,858,133	4,906,715	4,955,782	5,005,340	5,055,393	
	SPDs	1.00%	640,368	646,772	653,239	659,772	666,370	673,033	
	Duals	1.00%	636,797	643,165	649,597	656,093	662,654	669,280	
	Cal MediConnect	1.00%	331,130	334,441	337,786	341,164	344,575	348,021	
CBAS		6.87%	369,651	395,046	422,185	451,190	482,186	515,312	
WOW Expenditures									
TPM/GMC									
	Family			$3,432,793,218	$3,650,878,571	$3,882,818,886	$4,129,494,370	$4,391,841,148	**$19,487,826,192**
	SPDs			$1,850,901,914	$2,007,747,343	$2,177,883,853	$2,362,437,730	$2,562,630,703	**$10,961,601,543**
	Duals			$77,276,948	$80,609,748	$84,086,285	$87,712,759	$91,495,634	**$421,181,374**
	New Adult			$8,328,150,208	$8,756,300,410	$9,206,461,814	$9,679,766,016	$10,177,402,787	**$46,148,081,234**
COHS									
	Family			$1,684,835,746	$1,791,873,361	$1,905,711,076	$2,026,780,900	$2,155,542,291	**$9,564,743,374**
	SPDs			$1,666,603,436	$1,807,831,411	$1,961,027,045	$2,127,204,476	$2,307,463,784	**$9,870,130,152**
	Duals			$1,136,431,961	$1,176,146,849	$1,217,249,652	$1,259,788,876	$1,303,814,718	**$6,093,432,056**
	New Adult			$3,186,258,723	$3,350,064,284	$3,522,291,089	$3,703,372,074	$3,893,762,432	**$17,655,748,603**
CCI TPM/GMC									
	Family			$6,591,658,755	$7,010,426,835	$7,455,799,252	$7,929,466,179	$8,433,225,165	**$37,420,576,185**
	SPDs			$6,016,893,987	$6,526,765,583	$7,079,843,699	$7,679,789,654	$8,330,575,029	**$35,633,867,952**
	Duals			$2,415,029,649	$2,522,112,064	$2,633,942,513	$2,750,731,524	$2,872,698,960	**$13,194,514,711**
	Cal MediConnect			$1,990,304,230	$2,078,554,319	$2,170,717,418	$2,266,967,028	$2,367,484,346	**$10,874,027,340**
CCI COHS									
	Family			$1,093,458,706	$1,162,926,137	$1,236,806,835	$1,315,381,173	$1,398,947,339	**$6,207,520,189**
	SPDs			$1,412,058,902	$1,531,716,773	$1,661,514,452	$1,802,311,187	$1,955,039,037	**$8,362,640,350**
	Duals			$426,595,434	$437,798,257	$449,295,277	$461,094,220	$473,203,015	**$2,247,986,203**
	Cal MediConnect			$221,826,651	$227,652,041	$233,630,411	$239,765,779	$246,062,269	**$1,168,937,152**
CBAS				$460,895,170	$508,123,522	$560,191,407	$617,594,735	$680,880,236	**$2,827,685,070**
Total Population Expenditures				**$ 41,991,973,636**	**$ 44,627,527,507**	**$ 47,439,270,963**	**$ 50,439,658,680**	**$ 53,642,068,892**	**$238,140,499,678**
DSH				$ 2,352,648,102	$ 2,002,648,102	$ 1,852,648,102	$ 1,792,648,102	$ 2,052,648,102	**$10,053,240,510**
IP UPL PH		6.43%	$3,504,932,961	$ 3,730,300,150	$ 3,970,158,450	$ 4,225,439,638	$ 4,497,135,407	$ 4,786,301,214	**$21,209,334,860**
Total Without Waiver Ceiling (Total Computable)				***$ 48,074,921,888***	***$ 50,600,334,059***	***$ 53,517,358,703***	***$ 56,729,442,190***	***$ 60,481,018,208***	***$269,403,075,048.54***
WW									
PMPM									
TPM/GMC									
	Family	4.25%	$130.30	$140.18	$150.48	$161.21	$172.40	$184.07	
	SPDs	4.50%	$657.05	$695.80	$736.29	$778.60	$822.82	$869.02	
	Duals	4.50%	$165.48	$172.92	$180.71	$188.84	$197.34	$206.22	
	New Adult	4.10%	$507.16	$527.95	$549.60	$572.13	$595.59	$620.01	
COHS									
	Family	4.25%	$149.47	$160.16	$171.31	$182.93	$195.04	$207.67	

	SPDs	4.50%	$935.18	$986.45	$1,040.02	$1,096.00	$1,154.50	$1,215.63	
	Duals	4.50%	$480.97	$502.62	$525.23	$548.87	$573.57	$599.38	
	New Adult	4.10%	$687.49	$715.68	$745.02	$775.57	$807.37	$840.47	
CCI TPM/GMC									
	Family	4.50%	$141.09	$147.44	$154.07	$161.01	$168.25	$175.82	
	SPDs	4.50%	$903.49	$944.14	$986.63	$1,031.03	$1,077.43	$1,125.91	
	Duals	4.50%	$743.18	$776.62	$811.57	$848.09	$886.26	$926.14	
	Cal MediConnect	4.50%	$743.18	$776.62	$811.57	$848.09	$886.26	$926.14	
CCI COHS									
	Family	4.50%	$160.66	$167.89	$175.44	$183.34	$191.59	$200.21	
	SPDs	4.50%	$1,225.74	$1,280.89	$1,338.53	$1,398.77	$1,461.71	$1,527.49	
	Duals	4.50%	$649.77	$679.01	$709.56	$741.49	$774.86	$809.73	
	Cal MediConnect	4.50%	$649.77	$679.01	$709.56	$741.49	$774.86	$809.73	
CBAS		3.16%	$1,130.95	$1,166.69	$1,203.56	$1,241.59	$1,280.82	$1,321.30	

Member Months								
TPM/GMC								
	Family	1.00%	17,360,483	17,534,088	17,709,429	17,886,523	18,065,388	18,246,042
	SPDs	1.00%	1,972,742	1,992,469	2,012,394	2,032,518	2,052,843	2,073,372
	Duals	1.00%	627,963	634,243	640,585	646,991	653,461	659,995
	New Adult	1.00%	15,618,295	15,774,478	15,932,223	16,091,545	16,252,460	16,414,985
COHS								
	Family	1.00%	7,528,663	7,603,949	7,679,989	7,756,789	7,834,357	7,912,700
	SPDs	1.00%	949,443	958,937	968,526	978,212	987,994	997,874
	Duals	1.00%	2,499,823	2,524,821	2,550,069	2,575,570	2,601,326	2,627,339
	New Adult	1.00%	4,407,998	4,452,078	4,496,599	4,541,565	4,586,980	4,632,850
CCI TPM/GMC								
	Family	1.00%	33,001,616	33,331,632	33,664,948	34,001,598	34,341,614	34,685,030
	SPDs	1.00%	5,277,609	5,330,385	5,383,689	5,437,526	5,491,901	5,546,820
	Duals	1.00%	3,085,998	3,116,858	3,148,027	3,179,507	3,211,302	3,243,415
	Cal MediConnect	1.00%	2,543,271	2,568,704	2,594,391	2,620,335	2,646,538	2,673,003
CCI COHS								
	Family	1.00%	4,810,033	4,858,133	4,906,715	4,955,782	5,005,340	5,055,393
	SPDs	1.00%	640,368	646,772	653,239	659,772	666,370	673,033
	Duals	1.00%	636,797	643,165	649,597	656,093	662,654	669,280
	Cal MediConnect	1.00%	331,130	334,441	337,786	341,164	344,575	348,021
CBAS		6.87%	369,651	395,046	422,185	451,190	482,186	515,312

WW Expenditures								
TPM/GMC								
	Family		$2,457,893,051	$2,664,835,961	$2,883,499,914	$3,114,512,932	$3,358,536,352	**$14,479,278,210**
	SPDs		$1,386,354,358	$1,481,701,485	$1,582,520,348	$1,689,116,203	$1,801,811,248	**$7,941,503,643**
	Duals		$109,676,039	$115,757,575	$122,176,333	$128,951,010	$136,101,344	**$612,662,301**
	New Adult		$8,328,150,208	$8,756,300,410	$9,206,461,814	$9,679,766,016	$10,177,402,787	**$46,148,081,234**
COHS								
	Family		$1,217,836,126	$1,315,621,254	$1,418,914,972	$1,528,012,154	$1,643,223,315	**$7,123,607,820**

	SPDs			$945,939,787	$1,007,283,220	$1,072,117,057	$1,140,635,731	$1,213,044,463	**$5,379,020,257**
	Duals			$1,269,018,444	$1,339,385,517	$1,413,654,443	$1,492,041,582	$1,574,775,288	**$7,088,875,274**
	New Adult			$3,186,258,723	$3,350,064,284	$3,522,291,089	$3,703,372,074	$3,893,762,432	**$17,655,748,603**
CCI TPM/GMC									
	Family			$4,914,399,926	$5,186,903,402	$5,474,517,195	$5,778,079,174	$6,098,473,664	**$27,452,373,361**
	SPDs			$5,032,651,443	$5,311,711,965	$5,606,246,394	$5,917,112,756	$6,245,216,658	**$28,112,939,216**
	Duals			$2,420,623,907	$2,554,847,502	$2,696,513,796	$2,846,035,486	$3,003,848,154	**$13,521,868,846**
	Cal MediConnect			$1,994,914,638	$2,105,532,655	$2,222,284,441	$2,345,510,113	$2,475,568,649	**$11,143,810,495**
CCI COHS									
	Family			$815,619,563	$860,845,668	$908,579,560	$958,960,297	$1,012,134,645	**$4,556,139,734**
	SPDs			$828,445,645	$874,382,956	$922,867,491	$974,040,493	$1,028,051,039	**$4,627,787,624**
	Duals			$436,714,411	$460,930,225	$486,488,806	$513,464,610	$541,936,223	**$2,439,534,274**
	Cal MediConnect			$227,088,449	$239,680,503	$252,970,787	$266,998,017	$281,803,057	**$1,268,540,813**
CBAS				$460,895,170	$508,123,522	$560,191,407	$617,594,735	$680,880,236	**$2,827,685,070**
Total Population WW Expenditures				**$36,032,479,886**	**$38,133,908,104**	**$40,352,295,847**	**$42,694,203,383**	**$45,166,569,554**	**$202,379,456,774**
HOSPITAL EXPENDITURES									
Public Hospital Payments		6.43%	$2,637,061,900	$2,806,624,980	$2,987,090,966	$3,179,160,916	$3,383,580,963	$3,601,145,218	**$15,957,603,043**
Mental Health Supplements		6.43%	$4,816,992	$5,126,725	$5,456,374	$5,807,218	$6,180,622	$6,578,037	**$29,148,976**
TOTAL HOSPITAL EXPENDITURES				**$2,811,751,705**	**$2,992,547,340**	**$3,184,968,134**	**$3,389,761,585**	**$3,607,723,255**	**$15,986,752,019**
WAIVER EXPENDITURES (Prior to Shared Savings)									
Global Budget for the Uninsured				$2,824,648,102	$2,474,648,102	$2,324,648,102	$2,264,648,102	$2,524,648,102	**$12,413,240,510**
Designated State Health Programs				$800,000,000	$800,000,000	$800,000,000	$800,000,000	$800,000,000	**$4,000,000,000**
Delivery System Transformation & Alignment Incentives				$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	**$8,000,000,000**
Public Safety Net System Incentives				$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	**$8,000,000,000**
Other Incentives (funded through reinvestment of shared savings)									**$0**
IHS Uncompensated Care				$1,550,000	$1,550,000	$1,550,000	$1,550,000	$1,550,000	**$7,750,000**
TOTAL WAIVER EXPENDITURES				**$5,226,198,102**	**$4,876,198,102**	**$4,726,198,102**	**$4,666,198,102**	**$4,926,198,102**	**$24,420,990,510**
Total With Waiver Expenditures (Prior to Shared Savings)				***$ 44,070,429,693***	***$ 46,002,653,546***	***$ 48,263,462,083***	***$ 50,750,163,070***	***$ 53,700,490,910***	***$242,787,199,303***
Annual Budget Neutrality Margin (TC Savings)				**$4,004,492,195**	**$4,597,680,513**	**$5,253,896,620**	**$5,979,279,119**	**$6,780,527,298**	**$26,615,875,745**
Cumulative Budget Neutrality Margin (TC Savings)				**$4,004,492,195**	**$8,602,172,709**	**$13,856,069,329**	**$19,835,348,448**	**$26,615,875,745**	**$26,615,875,745**
California Federal-State Shared Savings Calculation									
Total Federal Savings				$2,002,246,098	$2,298,840,257	$2,626,948,310	$2,989,639,560	$3,390,263,649	**$13,307,937,873**
Budget Neutrality Calculation Including Reinvestment of Shared Savings									
WAIVER EXPENDITURES (Post Shared Savings)									
Global Budget for the Uninsured				$2,824,648,102	$2,474,648,102	$2,324,648,102	$2,264,648,102	$2,524,648,102	**$12,413,240,510**
Designated State Health Programs				$800,000,000	$800,000,000	$800,000,000	$800,000,000	$800,000,000	**$4,000,000,000**
Delivery System Transformation & Alignment Incentives				$3,600,000,000	$3,600,000,000	$3,600,000,000	$3,600,000,000	$3,600,000,000	**$18,000,000,000**
Public Safety Net System Incentives				$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	$1,600,000,000	**$8,000,000,000**
Other Incentives (funded through reinvestment of shared savings)				$2,000,000,000	$2,000,000,000	$2,000,000,000	$2,000,000,000	$2,000,000,000	**$10,000,000,000**
IHS Uncompensated Care				$1,550,000	$1,550,000	$1,550,000	$1,550,000	$1,550,000	**$7,750,000**

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TOTAL WAIVER EXPENDITURES	**$7,226,198,102**	**$6,876,198,102**	**$6,726,198,102**	**$6,666,198,102**	**$6,926,198,102**	**$34,420,990,510**
Total With Waiver Expenditures (Post Shared Savings)	***$ 46,070,429,693***	***$ 48,002,653,546***	***$ 50,263,462,083***	***$ 52,750,163,070***	***$ 55,700,490,910***	***$252,787,199,303***
Annual Budget Neutrality Margin	**$2,004,492,195**	**$2,597,680,513**	**$3,253,896,620**	**$3,979,279,119**	**$4,780,527,298**	**$16,615,875,745**
Cumulative Budget Neutrality Margin	**$2,004,492,195**	**$4,602,172,709**	**$7,856,069,329**	**$11,835,348,448**	**$16,615,875,745**	**$16,615,875,745**

Appendix E - Updated BTR Budget Neutrality

State of California
1115 Waiver
Total Computable

WITHOUT WAIVER	Trend Rates	Relevant Historical Data: Trended FY09	Trended FY10	2013 Managed Care Expansion historical data 0607-1011	CCI ammendment historical data 06/07 - 10/11	10/11 - 11/12 trend for dual eligibles	FY 10-11 DY06	FY11-12 DY07	FY12-13 DY08	13-14 DY09	14-15 DY10	5 Year Total
MEGS CMS-64 reporting form (if applicable)												
PMPM												
State Plan Groups												
Family - COHS	**5.30%**						**$171.68**	**$180.78**	**$190.36**	**$200.14**	**$210.42**	
Family - COHS	*5.30%*		*$163.04*				*$171.68*	*$180.78*	*$190.36*	*$202.66*	*$215.41*	
Expansion Family COHS	*5.30%*			*$139.87*						*$165.52*	*$176.30*	
Family - TPM/GMC	**5.30%**						**$150.40**	**$158.37**	**$166.76**	**$177.13**	**$185.92**	
Family - TPM/GMC	*5.30%*		*$142.83*				*$150.40*	*$158.37*	*$166.76*	*$177.81*	*$189.25*	
Expansion Family TPM/GMC	*5.30%*			*$131.12*						*$155.30*	*$165.55*	
SPD - COHS	**7.40%**						**$1,069.73**	**$1,148.89**	**$1,233.91**	**$1,601.50**	**$1,618.22**	
Existing SPD's - COHS	*7.40%*	*$927.40*	*$996.03*				*$1,069.73*	*$1,148.89*	*$1,233.91*	*$1,704.12*	*$1,815.28*	
Expansion SPDs - COHS	*7.40%*			*$714.09*						*$889.15*	*$959.28*	
Expansion SPDs - Humboldt PACE	*7.40%*			*$714.09*						*$889.15*	*$950.10*	
SPD - TPM/GMC	**7.40%**						$730.43	$784.48	$842.53	$801.95	$865.09	
Existing SPD's - TPM/GMC	*7.40%*	*$633.24*	*$680.10*				*$730.43*	*$784.48*	*$842.53*	*$801.93*	*$864.41*	
Special Populations-SPD's	*7.40%*	*$633.24*	*$680.10*				*$730.43*	*$784.48*	*$842.53*	*$801.93*	*$864.41*	
Expansion SPDs - TPM/GMC	*7.40%*			*$646.94*						*$805.96*	*$869.94*	
Special Populations-Spec. Needs Child.	***3.28%***						$1,390.66	$1,436.27	$1,483.38	$1,532.04	$1,582.29	
Duals - COHS										$428.67	$439.25	
Existing Duals - COHS	2.47%				*$420.01*	*-2.8%*				*$428.67*	*$439.25*	
Expansion Duals - COHS	2.47%				*$420.01*	*-2.8%*				*$428.67*	*$439.25*	
Expansion Duals - Humboldt PACE	2.47%				*$420.01*	*-2.8%*				*$428.67*	*$439.25*	
Duals - TPM/GMC										$114.23	$117.97	
Existing Duals - TPM/GMC	3.28%				*$110.17*	*-2.8%*				*$114.23*	*$117.97*	
Expansion Duals - TPM/GMC	3.28%				*$110.17*	*-2.8%*				*$114.23*	*$117.97*	
CCI - COHS												
Cal-Medi-Connect - COHS	*1.61%*				*$640.15*	*-2.8%*				*$642.42*	*$652.77*	
MLTSS Duals - COHS	*1.61%*				*$640.15*	*-2.8%*				*$642.42*	*$652.77*	
MLTSS Family - COHS	*5.30%*									*$202.99*	*$213.75*	
MLTSS SPDs - COHS	*7.40%*									$1,892.75	*$2,032.81*	
CCI - TPM/GMC												
Cal-Medi-Connect - TPM/GMC	*3.40%*				*$697.36*	*-2.8%*				*$724.71*	*$749.35*	
MLTSS Duals - TPM/GMC	*3.40%*				*$697.36*	*-2.8%*				*$724.71*	*$749.35*	
MLTSS Family - TPM/GMC	*5.30%*									*$178.35*	*$187.81*	
MLTSS SPDs - TPM/GMC	*7.40%*									*$978.60*	*$1,051.02*	
Hypothetical Populations												
MCE	5.00%						$300.00	$315.00	$330.75	$347.29		
ECM	3.16%	$10.00					$10.00	$10.00	$10.00	$10.00	$10.00	
CBAS	3.16%	$861.31					$888.53	$916.60	$945.57	$975.45	$1,130.95	
Revised Member Months (January 2012)												
State Plan Groups												
Family - COHS							7,472,894	8,835,823	9,141,046	9,382,285	7,528,663	
Family - COHS	*1.00%*						*7,472,894*	*8,835,823*	*9,141,046*	*8,745,696*	*6,567,487*	
Expansion Family COHS	*1.00%*									*636,589*	*961,176*	
Family - TPM/GMC							36,909,330	38,522,848	40,987,170	40,350,950	17,360,483	
Family - TPM/GMC	*1.00%*						*36,909,330*	*38,522,848*	*40,987,170*	*39,122,206*	*14,924,481*	
Expansion Family TPM/GMC	*1.00%*									*1,228,743*	*2,436,002*	
SPD - COHS							1,069,930	1,234,096	1,204,954	1,451,546	949,443	
Existing SPD's - COHS	*1.00%*						*1,069,930*	*1,234,096*	*1,204,954*	*1,268,765*	*730,873*	
Expansion SPDs - COHS	*1.00%*									*182,781*	*218,530*	
Expansion SPDs - Humboldt PACE	*1.00%*									*0*	*40*	

Version Date: 2-2-15
Updated for actual expenditures through Dec. 2013 (CCI MEGs excluded)

SPD - TPM/GMC					1,772,191	4,407,461	5,967,526	6,499,950	2,030,813
Existing SPD's - TPM/GMC	*1.00%*				*1,744,004*	*1,838,643*	*1,882,522*	*2,741,325*	*336,963*
Special Populations-SPD's	*1.00%*				*28,187*	*2,568,818*	*4,085,004*	*3,720,000*	*1,445,596*
Expansion SPDs - TPM/GMC	*1.00%*							*38,625*	*248,254*
Special Populations-Spec. Needs Child.		888,456	915,110		1,356,036	1,396,717	1,438,619	1,481,777	1,526,230
Duals - COHS								2,482,089	2,499,823
Existing Duals - COHS	*1.00%*							*2,275,061*	*2,242,353*
Expansion Duals - COHS	*1.00%*							*207,028*	*257,470*
Expansion Duals - Humboldt PACE	*1.00%*								
Duals - TPM/GMC								1,462,122	627,963
Existing Duals - TPM/GMC	*1.00%*							*1,460,898*	*611,838*
Expansion Duals - TPM/GMC	*1.00%*							*1,224*	*16,125*
CCI - COHS									
Cal-Medi-Connect - COHS	*1.00%*							19,969	331,130
MLTSS Duals - COHS	*1.00%*							243,477	636,797
MLTSS Family - COHS	*1.00%*							-	4,810,033
MLTSS SPDs - COHS	*1.00%*							-	640,368
CCI - TPM/GMC									
Cal-Medi-Connect - TPM/GMC	*1.00%*							36,262	2,543,271
MLTSS Duals - TPM/GMC	*1.00%*							182,770	3,085,998
MLTSS Family - TPM/GMC	*1.00%*							-	33,001,616
MLTSS SPDs - TPM/GMC	*1.00%*							-	5,277,609
Hypothetical Populations									
MCE					2,996,500	3,918,500	4,610,000	2,535,500	
ECM					0	21,000	84,000	84,000	14,000
CBAS					0	84,000	336,000	345,877	369,651
Total Member Months					**51,576,881**	**58,420,445**	**63,769,315**	**66,558,574**	**83,233,890**
Projected Without Waiver Expenditures									
State Plan Groups									
Family - COHS					$1,282,954,812	$1,597,342,020	$1,740,103,877	$1,877,776,570	$1,584,192,027	$8,082,369,305
Family - COHS					*$1,282,954,812*	*$1,597,342,020*	*$1,740,103,877*	*$1,772,409,173*	*$1,414,732,655*	
Expansion Family COHS								*$105,367,397*	*$169,459,372*	
Family - TPM/GMC					$5,551,162,904	$6,100,909,260	$6,835,219,770	$7,147,279,483	$3,227,735,200	$28,862,306,616
Family - TPM/GMC					*$5,551,162,904*	*$6,100,909,260*	*$6,835,219,770*	*$6,956,452,499*	*$2,824,463,707*	
Expansion Family TPM/GMC								*$190,826,984*	*$403,271,493*	
SPD - COHS					$1,144,538,835	$1,417,843,819	$1,486,805,636	$2,324,647,509	$1,536,408,205	$7,910,244,003
Existing SPD's - COHS					*$1,144,538,835*	*$1,417,843,819*	*$1,486,805,636*	*$2,162,127,812*	*$1,326,738,379*	
Expansion SPDs - COHS								*$162,519,697*	*$209,631,821*	
Expansion SPDs - Humboldt PACE								*$0*	*$38,004*	$38,004
SPD - TPM/GMC					$1,294,454,286	$3,457,553,831	$5,027,812,502	$5,212,660,942	$1,756,827,444	$16,749,309,005
Existing SPD's - TPM/GMC					*$1,273,865,769*	*$1,442,373,999*	*$1,586,078,996*	*$2,198,350,757*	*$291,274,187*	
Special Populations-SPD's					*$20,588,516*	*$2,015,179,832*	*$3,441,733,506*	*$2,983,179,600*	*$1,249,587,638*	
Expansion SPDs - TPM/GMC								*$31,130,585*	*$215,965,619*	
Special Populations-Spec. Needs Child.					$1,885,785,024	$2,006,067,936	$2,134,022,973	$2,270,139,494	$2,414,938,072	$10,710,953,498
Duals - COHS								$1,063,987,999	$1,098,058,124	$2,162,046,122
Existing Duals - COHS								*$975,242,039*	*$984,963,297*	
Expansion Duals - COHS								*$88,745,960*	*$113,094,826*	
Expansion Duals - Humboldt PACE								$0	$0	$0
Duals - TPM/GMC								$167,011,216	$74,081,942	$241,093,158
Existing Duals - TPM/GMC								*$166,871,456*	*$72,179,646*	
Expansion Duals - TPM/GMC								*$139,760*	*$1,902,296*	
CCI - COHS								$169,243,706	$2,961,719,237	
Cal-Medi-Connect - COHS								*$12,828,540*	*$216,150,328*	
MLTSS Duals - COHS								*$156,415,166*	*$415,679,280*	
MLTSS Family - COHS									*$1,028,140,913*	
MLTSS SPDs - COHS									*$1,301,748,715*	
CCI - TPM/GMC								$158,734,725	$15,963,054,103	
Cal-Medi-Connect - TPM/GMC								*$26,279,441*	*$1,905,801,013*	
MLTSS Duals - TPM/GMC								*$132,455,284*	*$2,312,493,680*	
MLTSS Family - TPM/GMC									*$6,197,905,799*	
MLTSS SPDs - TPM/GMC									*$5,546,853,612*	

Hypothetical Populations								
MCE			$898,950,000	$1,234,327,500	$1,524,757,500	$880,547,456	$0	$4,538,582,456
ECM			$0	$210,000	$840,000	$840,000	$140,000	$2,030,000
CBAS			$0	$76,994,808	$317,711,377	$337,385,572	$418,056,532	$1,150,148,290
Other below the line adjustments								
Public Hospital IP UPL	6.43%	$2,439,501,519	$2,596,361,467	$2,763,307,510	$2,940,988,182	$3,205,705,972	$3,504,932,961	$15,011,296,092
Total Without Waiver Ceiling (Total Computable)			**$14,654,207,327**	**$18,654,556,683**	**$22,008,261,818**	**$24,815,960,644**	**$34,540,143,846**	**$114,673,130,317**
WITH WAIVER								
PMPM								
State Plan Groups								
Family - COHS			$142.22	$158.58	$146.28	$154.26	$149.47	
Family - COHS			*$142.22*	*$158.58*	*$146.28*	*$153.46*	*$145.78*	
Expansion Family COHS						*$165.28*	*$174.68*	
Family - TPl			$121.56	$125.69	$126.02	$135.24	$130.30	
Family - TPM/GMC			*$121.56*	*$125.69*	*$126.02*	*$134.61*	*$123.43*	
Expansion Family TPM/GMC						*$155.22*	*$172.42*	
SPD - COHS			$1,009.36	$971.98	$920.39	$987.98	$935.18	
Existing SPD's - COHS			*$1,009.36*	*$971.98*	*$920.39*	*$996.18*	*$921.74*	
Expansion SPDs - COHS						*$931.06*	*$979.73*	
Expansion SPDs - Humboldt PACE						*$0.00*	*$3,268.08*	
SPD - TPM/GMC			$541.03	$654.26	$616.93	$665.54	$722.39	
Existing SPD's - TPM/GMC			*$542.15*	*$651.23*	*$619.65*	*$666.15*	*$631.78*	
Special Populations-SPD's			*$472.09*	*$656.43*	*$615.67*	*$663.28*	*$714.06*	
Expansion SPDs - TPM/GMC						*$839.58*	*$893.86*	
Special Populations-Spec. Need Children			$1,390.66	$1,436.27	$1,469.02	$1,487.82	$1,506.86	
Duals - COHS						$474.44	$480.97	
Existing Duals - COHS						*$479.58*	*$486.58*	
Expansion Duals - COHS						*$417.96*	*$432.18*	
Expansion Duals - Humboldt PACE						$3,619.66	$3,782.54	
Duals - TPM/GMC						$208.75	$165.48	
Existing Duals - TPM/GMC						*$208.79*	*$167.06*	
Expansion Duals - TPM/GMC						*$163.53*	*$105.36*	
CCI - COHS								
Cal-Medi-Connect - COHS						*$621.79*	*$649.77*	
MLTSS Duals - COHS						*$621.79*	*$649.77*	
MLTSS Family - COHS						$153.74	*$160.66*	
MLTSS SPDs - COHS						$1,172.95	*$1,225.74*	
CCI - TPM/GMC								
Cal-Medi-Connect - TPM/GMC						*$711.18*	*$743.18*	
MLTSS Duals - TPM/GMC						*$711.18*	*$743.18*	
MLTSS Family - TPM/GMC						$135.01	*$141.09*	
MLTSS SPDs - TPM/GMC						*$862.93*	*$901.76*	
Hypothetical Groups								
MCE			$300.00	$315.00	$330.75	$347.29		
ECM			$10.00	$10.00	$10.00	$10.00	$10.00	
CBAS		$861.31	$888.53	$916.60	$945.57	$975.45	$1,130.95	
Revised Member Months (January 2012)								
State Plan Groups								
Family - COHS			7,472,894	8,835,823	9,141,046	9,382,285	7,528,663	
Family - COHS			*7,472,894*	*8,835,823*	*9,141,046*	*8,745,696*	*6,567,487*	
Expansion Family COHS						*636,589*	*961,176*	
Family - TPM/GMC			36,909,330	38,522,848	40,987,170	40,350,950	17,360,483	
Family - TPM/GMC			*36,909,330*	*38,522,848*	*40,987,170*	*39,122,206*	*14,924,481*	
Expansion Family TPM/GMC						*1,228,743*	*2,436,002*	
SPD - COHS			1,069,930	1,234,096	1,204,954	1,451,546	949,443	
Existing SPD's - COHS			*1,069,930*	*1,234,096*	*1,204,954*	*1,268,765*	*730,873*	
Expansion SPDs - COHS						*182,781*	*218,530*	

Version Date: 2-2-15

Updated for actual expenditures through Dec. 2013 (CCI MEGs excluded)

Expansion SPDs - Humboldt PACE				*0*	*40*	
SPD - TPM/GMC	1,772,191	4,407,461	5,967,526	6,499,950	2,030,813	
Existing SPD's - TPM/GMC	*1,744,004*	*1,838,643*	*1,882,522*	*2,741,325*	*336,963*	
Special Populations-SPD's	*28,187*	*2,568,818*	*4,085,004*	*3,720,000*	*1,445,596*	
Expansion SPDs - TPM/GMC				*38,625*	*248,254*	
Special Populations-Spec. Need Children	1,356,036	1,396,717	1,438,619	1,481,777	1,526,230	
Duals - COHS				2,482,089	2,499,823	
Existing Duals - COHS				*2,275,061*	*2,242,353*	
Expansion Duals - COHS				*207,028*	*257,470*	
Expansion Duals - Humboldt PACE				*0*	*0*	
Duals - TPM/GMC				1,462,122	627,963	
Existing Duals - TPM/GMC				*1,460,898*	*611,838*	
Expansion Duals - TPM/GMC				*1,224*	*16,125*	
CCI - COHS						
Cal-Medi-Connect - COHS				*19,969*	*331,130*	
MLTSS Duals - COHS				*243,477*	*636,797*	
MLTSS Family - COHS				*0*	*4,810,033*	
MLTSS SPDs - COHS				*0*	*640,368*	
CCI - TPM/GMC						
Cal-Medi-Connect - TPM/GMC				*36,262*	*2,543,271*	
MLTSS Duals - TPM/GMC				*182,770*	*3,085,998*	
MLTSS Family - TPM/GMC				*0*	*33,001,616*	
MLTSS SPDs - TPM/GMC				*0*	*5,277,609*	
Hypothetical Groups						
MCE	2,996,500	3,918,500	4,610,000	2,535,500	0	
ECM	0	21,000	84,000	84,000	14,000	
CBAS	0	84,000	336,000	345,877	369,651	
Total Member Months	**51,576,881**	**58,420,445**	**63,769,315**	**66,558,574**	**83,233,890**	
Expenditures						
POPULATION EXPENDITURES						
State Plan Groups						
Family - COHS	$1,062,759,148	$1,401,201,904	$1,337,189,310	$1,447,322,909	$1,125,279,565	$6,373,752,836
Family - COHS	*$1,062,759,148*	*$1,401,201,904*	*$1,337,189,310*	*$1,342,110,628*	*$957,384,417*	
Expansion Family COHS				*$105,212,281*	*$167,895,148*	
Family - TPM/GMC	$4,486,594,700	$4,841,904,336	$5,165,126,194	$5,457,151,506	$2,262,074,801	$22,212,851,536
Family - TPM/GMC	*$4,486,594,700*	*$4,841,904,336*	*$5,165,126,194*	*$5,266,427,433*	*$1,842,066,930*	
Expansion Family TPM/GMC				*$190,724,073*	*$420,007,871*	
SPD - COHS	$1,079,944,050	$1,199,520,076	$1,109,029,673	$1,434,101,106	$887,902,549	$5,710,497,453
Existing SPD's - COHS	*$1,079,944,050*	*$1,199,520,076*	*$1,109,029,673*	*$1,263,921,551*	*$673,671,432*	
Expansion SPDs - COHS				*$170,179,555*	*$214,100,393*	
Expansion SPDs - Humboldt PACE				*$0*	*$130,723*	
SPD - TPM/GMC	$958,811,259	$2,883,646,027	$3,681,521,202	$4,325,956,508	$1,467,035,501	$13,316,970,499
Existing SPD's - TPM/GMC	*$945,504,511*	*$1,197,385,038*	*$1,166,505,821*	*$1,826,136,384*	*$212,887,978*	
Special Populations-SPD's	*$13,306,748*	*$1,686,260,989*	*$2,515,015,381*	*$2,467,391,012*	*$1,032,243,515*	
Expansion SPDs - TPM/GMC				*$32,429,113*	*$221,904,008*	
Special Populations-Spec. Need Children	$1,885,779,146	$2,006,061,683	$2,113,353,886	$2,204,616,960	$2,299,821,139	$10,509,632,812
Duals - COHS	$0	$0	$0	$1,177,603,586	$1,202,348,234	$2,379,951,821
Existing Duals - COHS	*$0*	*$0*	*$0*	*$1,091,074,785*	*$1,091,074,785*	
Expansion Duals - COHS				*$86,528,802*	*$111,273,449*	
Expansion Duals - Humboldt PACE				*$0*	*$0*	
Duals - TPM/GMC	$0	$0	$0	$305,220,654	$103,914,007	$409,134,661
Existing Duals - TPM/GMC	*$0*	*$0*	*$0*	*$305,020,566*	*$102,215,103*	
Expansion Duals - TPM/GMC				*$200,088*	*$1,698,904*	
CCI - COHS				$163,807,646	$2,186,619,989	$2,350,427,635
Cal-Medi-Connect - COHS				*$12,416,491*	*$215,157,941*	
MLTSS Duals - COHS				*$151,391,155*	*$413,770,819*	
MLTSS Family - COHS				*$0*	*$772,769,495*	
MLTSS SPDs - COHS				*$0*	*$784,921,735*	
CCI - TPM/GMC				$155,771,178	$13,598,899,822	$13,754,670,999
Cal-Medi-Connect - TPM/GMC				*$25,788,809*	*$1,890,108,142*	

MLTSS Duals - TPM/GMC							*$129,982,369*	*$2,293,451,994*	
MLTSS Family - TPM/GMC							*$0*	*$4,656,212,919*	
MLTSS SPDs - TPM/GMC							*$0*	*$4,759,126,767*	
Hypothetical Groups									
MCE				$898,950,000	$1,234,327,500	$1,524,757,500	$880,547,456	$0	$4,538,582,456
ECM				$0	$210,000	$840,000	$840,000	$140,000	$2,030,000
CBAS				$0	$76,994,808	$317,711,377	$337,385,572	$418,056,532	$1,150,148,290
TOTAL POPULATION EXPENDITURES				**$10,372,838,303**	**$13,643,866,334**	**$15,249,529,142**	**$17,890,325,081**	**$25,552,092,139**	**$82,708,650,999**
HOSPITAL EXPENDITURES									
Public Hospital Payments	6.43%	$2,063,555,821		$2,196,242,461	$2,315,498,426	$2,418,075,006	$2,525,195,729	$2,637,061,900	$12,092,073,523
Mental Health Supplements		$3,114,064		$3,754,220	$3,995,616	$4,252,534	$4,525,972	$4,816,992	$21,345,336
TOTAL HOSPITAL EXPENDITURES				**$2,199,996,681**	**$2,319,494,043**	**$2,422,327,541**	**$2,529,721,702**	**$2,641,878,893**	**$12,113,418,858**
WAIVER SAVINGS EXPENDITURES									
Existing Uncompensated Care				$1,172,000,000	$1,172,000,000	$1,172,000,000	$1,172,000,000	$1,172,000,000	$5,860,000,000
Proposed Uncompensated Care				$461,486,827	$822,000,000	$497,000,000	$276,000,000	$100,000,000	$2,156,486,827
Coverage Initiative (134%-200%)				$184,000,000	$214,000,000	$263,000,000	$154,000,000	$0	$815,000,000
Investment/Incentive Pool				$1,006,880,349	$1,300,000,000	$1,400,000,000	$1,400,000,000	$1,400,000,000	$6,506,880,349
HIV Transition Incentive Program				$0	$0	$110,000,000	$55,000,000	$0	$165,000,000
IHS Uncompensated Care				$0	$0	$15,461,000	$17,011,000	$1,550,000	$34,022,000
TOTAL SNCP EXPENDITURES				**$2,824,367,176**	**$3,508,000,000**	**$3,457,461,000**	**$3,074,011,000**	**$2,673,550,000**	**$15,537,389,176**
Total With Waiver Expenditures				$15,397,202,160	$19,471,360,377	$21,129,317,683	$23,494,057,783	$30,867,521,032	$110,359,459,033
Cost Share/Spenddown/Premiums reported on 64 Summary									
Total Net Waiver Expenditures				**$15,397,202,160**	**$19,471,360,377**	**$21,129,317,683**	**$23,494,057,783**	**$30,867,521,032**	**$110,359,459,033**
Adjustment for 1115A waiver savings									
Annual Budget Neutrality Margin				**-$742,994,833**	**-$816,803,694**	**$878,944,135**	**$1,321,902,862**	**$3,672,622,814**	
Cumulative Budget Neutrality Margin				**-$742,994,833**	**-$1,559,798,527**	**-$680,854,392**	**$641,048,470**	**$4,313,671,284**	