DHCS
TOBY DOUGLAS
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

October 30, 2013

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ANNUAL PROGRESS REPORT FOR THE PERIOD 07-01-2012 THROUGH 06/30/2013 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Ms. Gerrits, Mr. Nelb, and Ms. Nagle:

Enclosed is the Annual Progress Report required by Paragraph 25 of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the annual progress report for Demonstration Year Eight, which covers the period from July 1, 2012 through June 30, 2013.

If you or your staff have any questions or need additional information regarding this report, please contact Anastasia Dodson, Associate Director, at (916) 440-7866.

Sincerely,

[redacted]

Toby Douglas
Director

Enclosure

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TITLE:

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

Section 1115 Annual Report

Reporting Period:
Demonstration Year: Eight (07/01/12-06/30/13)

INTRODUCTION:

The Department of Health Care Services (DHCS) submits this Annual Report for Demonstration Year (DY) 8 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, 2012 through June 30, 2013.

I. General Reporting Requirements

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

1. Healthy Families Program Transition Amendment - On December 31, 2012, The Centers for Medicare and Medicaid Services (CMS) approved an amendment to the Demonstration to:

    - Transition a population of approximately 850,000 children from the existing separate Children's Health Insurance Program (CHIP) (known as the Healthy Families Program (HFP)) into a Medicaid (known as Medi-Cal) expansion demonstration population in several phases. The timing of the transition for individual children will depend on whether the child is enrolled in a HFP managed care plan and whether that plan also participates in the Medi-Cal program as well as state readiness for each transition phase. The demonstration amendments are effective from December 31, 2012 through December 31, 2013.

2. HCCI Rollover Amendment - On June 28, 2013, CMS approved an amendment to the Demonstration that:

    - Allowed the DHCS to increase funding to the Safety Net Care Pool Uncompensated Care Pool for DY 7 by the amount of authorized but unspent funding for the Health Care Coverage Initiative (HCCI).

3. Rural Managed Care Expansion Amendment - On May 2, 2013, DHCS submitted an amendment to the 1115 Demonstration Waiver to CMS to allow DHCS to:

- Expand Medi-Cal managed care to beneficiaries currently receiving Medi-Cal services on a Fee-For-Service (FFS) basis in 28 rural California counties.
- The 28 Medi-Cal managed care rural expansion counties are 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.

4. Coordinated Care Initiative Amendment - On June 18, 2013, DHCS submitted a waiver amendment to CMS to

    - Allow DHCS to carry out the State of California's Coordinated Care Initiative (CCI) in eight select counties to integrate Medicare and Medicaid benefits for dual-eligibles (Duals), mandatorily enroll 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 January 1, 2014.

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

1. Healthy Families Program Transition Amendment –

    - Beginning August of 2012, California notified the public of the Healthy Families Program (HFP) transition to Medi-Cal by posting related documents on the DHCS website including notices to beneficiaries, Strategic and Implementation Plans to CMS and the Legislature, conducting stakeholder meetings, webinars, work group meetings, and Listening Sessions, and making available call centers and electronic mailboxes to answer questions and concerns.

2. HCCI Rollover Amendment –

    - Nothing to Report

3. 2013 Managed Care Rural 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).

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.

4. Coordinated Care Initiative 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 Demonstration resulting from the development of the Memorandum of Understanding with CMS.

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

Low Income Health Program - The final reporting instructions and template for LIHP program progress reports were distributed to the local LIHPs on May 17, 2013, with a due date of June 26, 2013, for the first annual report.

Medical Managed Care - In the Fourth Quarter Reporting Period (04/01/2013-06/30/2013), DHCS reported that it had announced the selection of plans for the 28-

rural county expansion. The announcements were Intent to Award. Contractor reviews will occur in DY9 with the receipt of Implementation Deliverables. There were no contracts issued or signed for the 28-rural county expansion during DY8.

California Children's Services - No financial or operational reviews were conducted for the California Children's Services (CCS) population mentioned in Special Terms and Conditions (STC) 21 during this Demonstration Year (DY).

- **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 8 were submitted to CMS electronically on the following dates:

  - Quarter 1 (7/1/12-9/30/12) – Submitted February 14, 2013
  - Quarter 2 (10/1/12-12/31/12) – Submitted March 14, 2013
  - Quarter 3 (1/1/13-3/31/13) – Submitted June 12, 2013
  - Quarter 4 (4/1/13-6/30/13) – Submitted August 30, 2013

- **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**

  LIHP Transition Plan-

  In DY8, there were many LIHP Transition Activities. on August 1, 2012, DHCS provided an Initial Transition Plan. It outlined the main steps that DHCS and stakeholders needed to take to transition the LIHP enrollees to coverage options available under the Affordable Care Act. On November 1, 2012, DHCS held a Communication and Outreach meeting with various stakeholders and subject matter experts. Discussions centered on transition notifications to enrollees, and communications to providers, community based organizations, and other stakeholders. As a follow-up to the Communication & Outreach in-person meeting, DHCS convened a Communication & Outreach Webinar to review

modifications to the Communication & Outreach plan based upon DHCS amendments and stakeholder comments.

In addition, DHCS continued to refine other transition plan components. DHCS convened a Continuity of Care in-person meeting on June 28, 2013 with various stakeholders and subject matter experts. Discussions focused on continuity of ongoing services covered by Medi-Cal, benefits, and communication methods relating to continuity of care and difficult to reach populations. Furthermore, four groups of enrollees that may need special attention during the transition were identified and discussed, including: 1) enrollees receiving mental health services; 2) former Ryan White clients; 3) homeless individuals; and 4) enrollees with open treatment authorizations during the transition. DHCS consolidated the transition activities into a revised Transition Plan that focused on Eligibility, Enrollment, Continuity of Care, and Communications and Outreach. DHCS continued to work to refine the Transition Plan after the end of this reporting period.

Behavioral Health Services Plan -

The Department of Health Care Services' (DHCS) electronically submitted the required Behavioral Health *Service Plan* on September 30th, 2013. This document, which was due October 1st, completed the paragraph 25.d of The 1115 Bridge to Reform Demonstration Special Terms and Conditions (STCs) deliverable which required the completion of a Behavioral Health *Service Plan*. The *Service Plan* described California's recommendations for serving the Medi-Cal expansion population as well as demonstrated the State's readiness to meet the mental health and substance use disorder needs of this population.

In its 9/30/13 communication to Mr. Nelb, Ms. Garner, and Ms. Nagle, DHCS indicated it greatly appreciated the continued guidance and flexibility CMS has provided during this process and looks forward to continued collaboration on this important and historic effort.

- **Item 28 & 29 of the Special Terms and Conditions- Evaluation design and implementation**

Low Income Health Program

DHCS and the University of California, Los Angeles (UCLA) Center for Health Policy Research entered into an inter-agency agreement, which was executed December 24, 2012, to conduct the LIHP program evaluation. As a component of the program evaluation, UCLA released a policy brief, entitled, "*Successful*

Strategies for Increasing Enrollment in California's Low Income Health Program (LIHP)", *"Smooth Transitions into Medi-Cal: Ensuring Continuity of Coverage for Low Income Health Program Enrollees"*, and *"Promoting Enrollment of Low Income Health Program Participants in Covered California".*

Seniors and Persons with Disabilities

1. Evaluation Design:

DHCS is currently developing a final evaluation proposal to be submitted to CMS pertaining to the SPD demonstration program. The time period for the evaluation will be 12 months with the start date being June 1, 2012. DHCS identified policy questions in five areas: eligibility and enrollment processes, coverage, access to care, quality of care and value based care (costs associated with the services provided to enrollees in the SPD program as compared to FFS costs). A minimum of three sources of data will be used for the evaluation: (1) Management Information Systems/Decision Support Section (MIS/DSS) claims data; (2) encounter data; and (3) a comprehensive survey study, conducted by UC Berkeley and funded by the California Health Care Foundation, focusing on satisfaction and enrollees experience. DHCS is currently finalizing the methodology to be used to evaluate each of the aforementioned five focus areas.

2. Evaluation implementation:

DHCS will begin analyzing data for purposes of the SPD evaluation during the first half of 2014.

California Children's Services -

An interagency agreement with University of California Los Angeles (UCLA) Health Policy Research to provide a program evaluation of the Demonstration Project, as required by the CMS 1115 Waiver Standard Terms and Conditions (STCs) as well as Senate Bill 208, was drafted in early June 2013. This interagency agreement addresses the Scope of Work (SOW) for the CCS Evaluation. The CCS Evaluation will examine patient, family and physician satisfaction and the financial impacts of the pilot programs as well as provide technical assistance at the request of DHCS. The existing Interagency Agreement is currently under revision to include performance standards unique to the pilot demonstration contract.

UCLA will focus the evaluation on answering questions such as:

- ✓ Does the CCS population enrolled in the pilot have access to timely, appropriate, high quality, coordinated medical and supportive services?
- ✓ Has the CCS pilot resulted in increased patient and family satisfaction with the delivery of services through the CCS Program?
- ✓ Has the CCS pilot resulted in increased provider satisfaction with delivery of and reimbursement for services?

- ✓ Has the state improved its ability to measure and assess cost-effective strategies employed by the CCS pilot to deliver high-quality, well-coordinated medical and supportive services?
- ✓ Has the CCS pilot resulted in increased use of community-based services and a decrease in inpatient and emergency room use?
- ✓ Has the annual rate of growth in expenditures for the CCS population been reduced?

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

  The DHCS Strategy for Quality Improvement in Health Care (Quality Strategy) was developed in 2012 using an internal review process and incorporating statewide stakeholder input. DHCS will update the Quality Strategy on an annual basis to reflect new initiatives and innovations in quality improvement both statewide and nationally. The 2013 Quality Strategy is due for release in November 2013, and includes additional quality improvement activities and initiatives initiated over the past year.

- **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**

  Supplement 3 regarding DSHPs has been approved by CMS. There is nothing new to report. There is an update on the Workforce Development Programs in the response below.

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

  On March 1, 2013, DHCS submitted a request to amend the demonstration to provide supplemental payments to Indian Health Service (IHS) and tribal facilities to recognize the burden of uncompensated care costs and to support the overall IHS and tribal health care delivery system. CMS approved this amendment on April 5, 2013.

  DHCS is working with the Department of Finance and the Universities of California, California State Universities, and California Community Colleges on proposed SNCP Workforce Development Programs. The Department is working to refine data,

develop program justifications, and to develop a claiming methodology for CMS approval .

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

  DHCS developed and submitted Attachment G, Supplement 1 - Health Care Cost Claiming protocol to CMS for their review and received CMS's approval August 13, 2012. In addition, DHCS submitted Attachment G – Supplement 2 Low Income Health Program Cost Claiming Protocol for Health Care Services provided under the Low Income Health Program-Claims Based on Capitation to CMS. The following local LIHPs have contract amendments under review with CMS and once approved DHCS will implement:

  - Alameda
  - Kern
  - Los Angeles
  - Riverside
  - San Bernardino
  - San Francisco
  - San Mateo
  - Santa Clara

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

  DHCS is currently developing a process to collect and ensure the requirements are met for the LIHP MOEs.

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

  During DY8, DHCS, in conjunction with the California Association of Public Hospitals and Health Systems (CAPH), developed and submitted the draft Attachment J LIHP Administrative Cost Claiming Protocol to CMS for their review on June 24, 2013.

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

  On June 28, 2013, CMS approved an amendment to the Demonstration to allow for claiming authorized but unspent HCCI funding in the other three categories of the Safety Net Uncompensated Care Pool. CMS approved a $97 million reallocation for DY 8, and a $26 million reallocation for DY 9, resulting in a total reallocation of $123 million.

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

  Medi-Cal Managed Care Division –

  During DY 8, the Medi-Cal Managed Care Division (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 one of this study included a comparison of the encounter data stored in the State's data warehouse with the data stored in each MCO's management information system. This comparison was used to determine encounter record completeness and data element accuracy. The results of this study will be published in MCO-specific reports and a statewide aggregate report in DY 9.

  In addition, DHCS initiated the Encounter Data Improvement Project (EDIP) to improve the timeliness, reasonableness, accuracy and completeness of encounter data. As part of EDIP, DHCS established a new unit within MMCD to implement and maintain 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.

  California Children's Services –

  Per the STC 55, the State will be responsible for conducting a validation study to determine the completeness and accuracy of the encounter data 18 months after the effective date of the contract. During DY 8, the Health Plan San Mateo (HPSM) contract was "fully executed" and became operational on April 1, 2013. No validation study was conducted because the HPSM has only been operational for three months.

- **Item 56 of the Special Terms and Conditions – Submission of Encounter Data**

  Medi-Cal Managed Care Division –

  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**

  Medi-Cal Managed Care Division –

MMCD requires plans to submit quarterly reports that include network adequacy data and notice of significant changes. Data summaries are included with 1115 Waiver Quarterly Reports to CMS. MMCD contract managers actively work with the plans to resolve any concerns identified. No significant changes to report for DY8.

California Children's Services –

During this Demonstration Year (DY), the Health Plan San Mateo (HPSM) contract was "fully executed" and became operational on April 1, 2013. On March 22, 2013, the Department of Health Care Services sent a letter to the Federal Centers for Medicare and Medicaid Services (CMS) addressing HPSM's network adequacy, along with San Mateo County network certification executive summary. The Department 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 required by CMS. The executive summary covers the following: Current and Projected Enrollment Perspective, Outreach and Enrollment, Network Evaluation, Primary Care Physician Network, Specialist Physicians, Geographic Accessibility, and Continuity of Care to Providers.

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

Placer County implemented its LIHP in August 2012. Monterey and Tulare implemented their LIHPs in March 2013.

During the course of DY 8, 18 of the 19 local LIHPs received CMS county specific claiming protocol approvals. Monterey County submitted their protocol in DY 8 and anticipates approval.

DHCS submitted a LIHP contract amendment for Tulare County to CMS on June 28, 2013, to increase add-on health care services for their LIHP.

Currently 16 of the 19 local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide for the eligibility and claiming processes for state inmate populations determined eligible for LIHP by DHCS.

UCLA organized “Progress towards Building the Bridge to Reform: Lessons Learned from the LIHP Convening” on May 9, 2013 in which DHCS participated in a panel discussion of UCLA evaluation data.

DHCS continues to work with the State Office of AIDS (OA) to develop program requirements and policies to transition eligible Ryan White clients to LIHP. Surveys were conducted with the local LIHPs regarding their operational procedures. Data collected in the surveys included LIHP formulary antiretroviral drugs, prior authorization policies, back billing policies, and processes for urgent/emergent prescription fills. In addition, DHCS received Centers for Medicare & Medicaid Services’ (CMS) approval of the proposal for Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition projects October 31, 2012. DHCS received CMS approval of STC amendment to include Supplements 1 of both Attachment P, and Attachment Q, November 19, 2012. DHCS received CMS approval for the 10 participating Designated Public Hospitals (DPH’s) DSRIP Category 5 HIV Transition Projects plan modifications during January 2013.

During October and into November 2012, DHCS developed and finalized comprehensive review tools to be used in evaluating the proposed DSRIP Plan modifications to be submitted by the Designated Public Hospitals (DPHs) participating in Category 5 projects. One tool was for the DHCS' full review of the Plan modification, and the other was for the use by the subcommittee of the LIHP/OA Stakeholder Advisory Committee (SAC) in their review of the stakeholder process each participating DPH used in developing their Plan modifications.

The second annual LIHP Conference titled "Evolution" was held August 7, 2012. Approximately 150 people attended the all-day event held in Sacramento, and included county representation from the local LIHPs, as well as advocates and stakeholders.

PROJECT STATUS

Due to time constraints, Santa Barbara and Stanislaus Counties will not be implementing a LIHP.

California Department of Social Services (CDSS) and DHCS developed an interagency agreement for state fair hearings provided to LIHP enrollees. The draft scope of work and budgets are under review by DHCS and CDSS.

DHCS submitted the draft Attachment J Administrative Cost Claiming Protocol to CMS on June 24, 2013.

The following program policy letters (PPLs) are in development:

- LIHP Local Grievance Appeal Process and State Fair Hearings Process
- LIHP Inmate Eligibility Program (revision of PPL 12-001)

DHCS approved an enrollment cap for Santa Cruz County LIHP (Medi-Cruz Advantage) effective October 17, 2012 to June 30, 2013. The County requested continuation of the enrollment cap and DHCS approved the continuation until December 31, 2013.

DHCS accepted the upper income limit increase for LIHPs in the following counties:

- Santa Clara County from 75 percent to 133 percent of the FPL effective February 1, 2013.
- Kern County from 100 percent to 133 percent of the FPL effective March 1, 2013.
- San Francisco County from 25 percent to 133 percent of the FPL effective June 28, 2013.

DHCS began discussions with Monterey, Placer, and San Joaquin Counties on a possible upper income limit increase for their LIHPs.

DHCS continues to work with the California Department of Public Health (CDPH)/OA, to develop program requirements and policies to transition eligible Ryan White clients to

LIHP. In addition, the following activities regarding the DSRIP Category 5 HIV Transition Projects occurred during DY8:

- DSRIP plan modifications from the Designated Public Hospitals (DPHs) in Alameda and Ventura Counties were submitted to CMS for review.
    - The Alameda DPH plan modification included corrections to the allocation table.
    - The Ventura DPH plan modification included corrections to the allocation table and addition of the Category 5b performance improvement targets.
- Administrative review completed of Category 5 portion of semi-annual reports from the 10 DPHs participating in DSRIP Category 5.
- Clinical review of DSRIP Category 5b projects began with collaboration with OA.

DHCS has established a Transition Workgroup to develop the process and policies for implementing the LIHP transition phase of the Medicaid expansion under the Affordable Care Act (ACA). The team is working through many critical issues such as:

- The interaction of LIHP redeterminations and LIHP new enrollments with the transition.
- The outreach process for those LIHP enrollees who are eligible for health care coverage products through Covered California.
- The primary care provider linkage process for managed Medi-Cal plan enrollment.

The DHCS Transition Workgroup is also working with a Transition Stakeholder Workgroup to solicit input on various aspects of the transition, such as LIHP enrollee notices, communications and outreach strategies, continuity of care issues, and refinement of the LIHP Transition Plan submitted to CMS October 12, 2012.

DHCS held weekly teleconferences with the DHCS Transition Workgroup, UCLA and University of California – Berkeley Center for Labor Research and Education, to coordinate and strategize on UC contractual work activities for the transition of LIHP enrollees into managed Medi-Cal January 1, 2014.

DHCS continues to provide guidance and solicit feedback from stakeholders and advocates on program policy concerns, and 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.

DHCS hosted weekly teleconference calls with the California Department of Corrections and Rehabilitation (CDCR) for discussion on LIHP inmate issues. DHCS has made payments to CDCR for health care services provided to LIHP inmates in the amount of $15,950,313.91.

DHCS collaborated with the California Department of Social Services (CDSS) to develop the process and interagency agreement for CDSS to conduct state fair hearings, as the final step in the LIHP appeals and grievances process.

DHCS and UCLA collaborated on developing and testing the LIHP program progress report. These quarterly reports provide data for DHCS to monitor program compliance and effectiveness in program areas such as provider networks and health care services utilization and access. In addition, UCLA and DHCS developed an interagency agreement for the remaining years of the LIHP evaluation and LIHP transition activities. The draft scope of work and budgets are under review by DHCS and UCLA.

QUANTITATIVE FINDINGS

The following table illustrates Certified Public Expenditures (CPE), Federal Financial Participation (FFP), and Total Funds paid. To date no Intergovernmental Transfers (IGT) have been paid under the LIHP.

Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
Counties & CDCR					
(DY8Qtr1) CDCR	$ 168,112.00	$ -	$ 336,224.00	DY7	$ 168,112.00
(DY8Q1) Health Care	$ 157,619.00	$ -	$ 315,238,432.00	DY7	$ 157,619,216.00
(DY8Q1) Administrative	$ 6,987,384.00	$ -	$ 13,974,768.00	DY6	$ 6,987,384.00
(DY8Q2) CDCR	$ 17,225,556.00	$ -	$ 34,451,112.00	DY7	$ 17,225,556.00
(DY8Q2) Health Care	$ 186,134,077.00	$ -	$ 372,264,154.00	DY6	$ 35,538,396.00
				DY7	$ 120,912,618.00
				DY8	$ 29,683,064.00
(DY8Q2) Administrative	$ 6,264,116.00	$ -	$ 2,528,232.00	DY6	$ 6,264,116.00
(DY8Q3) CDCR	$ 10,800,162.00	$ -	$ 21,600,324.00	DY7	$ 9,187,935.00
				DY8	$ 1,612,227.00
(DY8Q3) Health Care	$ 169,132,157.00	$ -	$ 338,264,314.00	DY7	$ 32,874,672.00
				DY8	$ 136,257,485.00
(DY8Q3) Administrative	$ 5,923,118.00	$ -	$ 11,846,236.00	DY6	$ 5,777,196.00
				DY7	$ 145,022.00
(DY8Q4) CDCR	$ 6,211,235.00	$ -	$ 12,422,471.00	DY7	$ 1,181,316.00
				DY8	$ 5,029,919.00
(DY8Q4) Health Care	$ 322,216,344.00	$ -	$ 644,432,688.00	DY7	$ 105,710,843.00
				DY8	$ 216,505,501.00
(DY8Q4) Administrative	$ 25,142,857.00	$ -	$ 50,285,714.00	PY1	$ 15,807,937.00
				PY2	$ 2,802,379.00
				PY3	$ 1,724.00
				DY7	$ 6,530,816.00
Total	**$ 756,362,737.00**		**$ 1,817,644,669.00**		**$ 913,823,434.00**

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA

Due to the claim lags, utilization data for DY 7 was not available for the DY 7 annual report, but it is now available to be included in the DY 8 annual report. The utilization data for DY 8 is not yet available but will be provided in a subsequent report. For the DY 7 utilization data provided below there were 15 local LIHPs implemented. Placer, Monterey, Sacramento, and Tulare counties did not implement a LIHP until DY 8.

LIHP Year 7 (July 1, 2011 - June 30, 2012) Utilization Data

Physical Health Services

Physical Health Services	Inpatient Hospital				Outpatient Hospital				Clinic				Physician Services				Year-to-Date Totals 7/1/11 - 6/30/12			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	Inpatient Hospital	Outpatient Hospital	Clinic Visits	Physician Services
Alameda	384	393	469	517	15,649	16,855	18,043	21,430	19,948	21,128	25,793	29,704	14	20	33	73	1,763	71,977	96,573	140
CMSP			1,408	3,098			25,268	57,725			21,996	41,334			19,662	44,899	4,506	82,993	63,330	64,561
Contra Costa	660	599	526	514	20,923	21,295	22,443	22,479	370	367	379	332	483	523	541	556	2,299	87,140	1,448	2,103
Kern	255	219	291	320	7,813	6,762	5,911	7,086	23	34	25	33	3,855	3,954	3,628	3,720	1,085	27,572	115	15,157
Los Angeles	1,618	1,659	2,034	2,246	88,084	85,171	100,527	106,352	30,004	32,923	42,359	43,711	0	0	0	0	7,557	380,134	148,997	0
Orange	2,479	2,391	2,556	2,555	15,408	15,208	16,790	17,751	5,445	5,645	6,245	6,286	45,515	45,762	51,247	51,280	9,981	65,157	23,621	193,804
Riverside			850	1,155			12,826	12,650			4,730	9,118			793	1,157	2,005	25,476	13,848	1,950
San Bernardino			1,376	1,638			5,892	13,018			274	1,280			951	2,928	3,014	18,910	1,554	3,879
San Diego	1,631	1,761	2,072	2,269	8,665	10,218	12,420	13,576	6	15	31	45	24,836	32,595	41,059	44,441	7,733	44,879	97	142,931
San Francisco	427	418	464	438	12,081	11,874	12,171	11,615	16,484	16,445	16,731	15,896	0	0	0	0	1,747	47,741	65,556	0
San Joaquin				4				3				0				5	4	3	0	5
San Mateo	169	163	186	220	3,639	2,234	1,810	2,324	19	17	9	20	2,456	2,320	3,225	3,134	738	10,007	65	11,135
Santa Clara	122	127	190	224	6,723	9,201	11,502	13,968	236	296	444	592	5,875	6,596	8,720	9,219	663	41,394	1,568	30,410
Santa Cruz			151	181			307	752			2,029	3,032			704	1,231	332	1,059	5,061	1,935
Ventura	224	215	246	223	12,771	14,513	16,930	17,457	2,964	3,537	4,089	4,523	44	88	78	116	908	61,671	15,113	326
Total	**7,969**	**7,945**	**12,819**	**15,602**	**191,756**	**193,331**	**262,840**	**318,186**	**75,499**	**80,407**	**125,134**	**155,906**	**83,078**	**91,858**	**130,642**	**162,760**	**44,335**	**966,113**	**436,946**	**468,338**

LIHP not implemented during this quarter

LIHP Year 7 (July 1, 2011 - June 30, 2012) Utilization Data

Mental Health Services

Mental Health Services	Inpatient Hospital				Outpatient Hospital				Outpatient Clinic				Physician Services				Year-to-Date Totals 7/1/11 - 6/30/12			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	Inpatient Hospital	Outpatient Hospital	Outpatient Clinic	Physician Services
Alameda	522	631	728	922	158	191	320	492	5,295	6,098	8,110	10,474	0	0	0	0	2,803	1,161	29,977	0
CMSP			651	886			1	1			1,773	1,968			513	964	1,537	2	3,741	1,477
Contra Costa	1,112	1,228	1,363	1,239	2,643	2,898	3,401	3,585	210	219	181	218	0	0	0	0	4,942	12,527	828	0
Kern	35	53	39	29	184	112	116	133	391	466	476	517	0	0	0	0	156	545	1,850	0
Los Angeles	243	241	369	901	0	0	0	0	23,021	29,521	39,135	57,444	0	0	0	0	1,754	0	149,121	0
Orange	881	516	762	597	117	123	126	124	3,408	3,756	4,361	4,580	0	0	0	0	2,756	490	16,105	0
Riverside			1,574	969			0	0			5,896	5,126			0	0	2,543	0	11,022	0
San Bernardino			500	2,123			662	1,189			4,940	7,980			707	2,688	2,623	1,851	12,920	3,395
San Diego	396	430	670	751	0	0	0	0	284	2,033	3,349	3,764	0	0	0	0	2,247	0	9,430	0
San Francisco	121	55	150	122	0	0	0	0	899	865	922	972					448	0	3,658	0
San Joaquin				0				0				45				0	0	0	45	0
San Mateo	33	13	3	24	0	7	2	12	655	666	756	618	1,699	1,692	1,912	1,925	73	21	2,695	7,228
Santa Clara	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Santa Cruz			177	182			0	0			244	2,184			8	13	359	0	2,428	21
Ventura	0	0	0	0	0	0	0	0	1,146	1,236	1,480	1,860	0	0	0	0	0	0	5,722	0
Total	**3,343**	**3,167**	**6,986**	**8,745**	**3,102**	**3,331**	**4,628**	**5,536**	**35,309**	**44,860**	**71,623**	**97,750**	**1,699**	**1,692**	**3,140**	**5,590**	**22,241**	**16,597**	**249,542**	**12,121**

LIHP not implemented during this quarter

LIHP Year 7 (July 1, 2011 - June 30, 2012) Utilization Data

Substance Use Services

Substance Use Services	Inpatient Hospital				Outpatient Hospital				Outpatient Clinic				Physician Services				Year-to-Date Totals 7/1/11 - 6/30/12			
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	Inpatient Hospital	Outpatient Hospital	Outpatient Clinic	Physician Services
Alameda																				
CMSP			0	0			0	93			1	3			642	744	0	93	4	1,386
Contra Costa																				
Kern	0	0	0	0	18	3	13	36	13	9	9	10	0	0	0	0	0	70	41	0
Los Angeles																				
Orange																				
Riverside																				
San Bernardino																				
San Diego																				
San Francisco	0	0	0	0	0	0	0	0	532	539	528	562	0	0	0	0	0	0	2,161	0
San Joaquin																				
San Mateo	0	0	0	0	4,387	6,713	6,963	5,968	27,365	59,466	95,111	92,808	0	0	0	0	0	24,031	274,750	0
Santa Clara	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Santa Cruz			0	0			0	0			29	39			0	0	0	0	68	0
Ventura																				
Total	**0**	**0**	**0**	**0**	**4,405**	**6,716**	**6,976**	**6,097**	**27,910**	**60,014**	**95,678**	**93,422**	**0**	**0**	**642**	**744**	**0**	**24,194**	**277,024**	**1,386**

LIHP not implemented during this quarter

LIHP Year 7 (July 1, 2011 - June 30, 2012) Utilization Data

Emergency Services

Emergency Services	Out of Network Emergency				Out of Network Post-Stabilization				In Network Emergency				Year-to-Date Totals 7/1/11 - 6/30/12		
	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	1st Quarter (7/1-9/30)	2nd Quarter (10/1-12/31)	3rd Quarter (1/1-3/31)	4th Quarter (4/1-6/30)	Out of Network Emergency	Post-Stabilization	In Network Emergency
Alameda	33	88	288	531	243	723	2,641	4,297	4,607	4,844	5,672	6,125	940	7,904	21,248
CMSP			1,520	1,892			9,945	11,640			23,787	26,437	3,412	21,585	50,224
Contra Costa	0	0	0	0	0	0	0	0	3,501	3,372	3,703	3,839	0	0	14,415
Kern	2	5	9	22	7	25	32	24	509	430	377	440	38	88	1,756
Los Angeles	1,456	4,024	7,373	11,783	101	318	622	951	9,225	10,792	12,741	13,961	24,636	1,992	46,719
Orange	0	0	0	0	0	1	1	0	7,390	7,390	7,390	7,392	0	2	29,562
Riverside			1,422	2,245			571	1,881			2,581	2,662	3,667	2,452	5,243
San Bernardino			541	1,093			484	535			3,181	5,050	1,634	1,019	8,231
San Diego	1	0	4	9	0	0	0	0	4,064	4,845	6,161	7,014	14	0	22,084
San Francisco	3	2	8	12	2	3	3	4	1,453	1,589	1,714	1,792	25	12	6,548
San Joaquin				0				0				26	0	0	26
San Mateo	183	193	297	395	0	0	0	0	1,910	1,744	1,718	1,730	1,068	0	7,102
Santa Clara	2	5	4	29	0	3	3	4	517	597	811	1,144	40	10	3,069
Santa Cruz			3	8			3	3			330	435	11	6	765
Ventura	0	4	2	9	0	1	5	4	505	545	672	659	15	10	2,381
Total	**1,680**	**4,321**	**11,471**	**18,028**	**353**	**1,074**	**14,310**	**19,343**	**33,681**	**36,148**	**70,838**	**78,706**	**35,500**	**35,080**	**219,373**

LIHP not implemented during this quarter

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 (June 2012 through May 2013)

Managed care enrollment in Two-Plan and GMC counties rose from 3,292,441 beneficiaries in June 2012 to 3,849,787 in May 2013, representing a 16.93 percent increase. Total SPD enrollment in Two-Plan and GMC counties was 473,412 beneficiaries in June 2012 and rose to 480,077 beneficiaries in May 2013, representing a 0.8 percent increase. While the SPD population grew slightly, the percentage of the total population decreased. In June 2012, SPDs represented 14.38 percent of the population while in May 2013, SPDs represented 12.4 percent of the population.

There were 30,755 instances of SPDs disenrolling from Medi-Cal managed care plans during this period. The stated reasons for 87.14 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 2012 through June 2013)

There was a total of 8,187 extended continuity of care requests submitted to health plans between July 2012 and June 2013. Eighty four percent or 6,917 of these requests were approved, 46 were in process at the time of reporting, and 1,224 (less than 15%) were denied. For those denied, 100 were due to no link between SPD and provider; 8 were due to quality of care issues; 308 were because the provider would not accept the reimbursement rate; 346 were because to the provider refused to work with managed care and 462 were due to other reasons.

MEDICAL EXEMPTION REQUESTS (MERs) (July 2012 through March 2013)

For July 2012 through March 2013, 4,856 unique SPDs submitted 6,904 MERs indicating an average of 1.42 MERs being submitted per unique SPD that submitted MERs. The top diagnosis code was Complex with 2,743 MERs (39.77%) between July 2012 and March 2013.

Of the MERs received, 3,104 (44.96%) were approved, 2,135 (24.12%) were incomplete and 1,665 (30.92%) were denied. MERs data for the second quarter of 2013 is unavailable due to the transition from a manual to automatic electronic system. The new system will improve the accuracy and reliability of the data.

RISK DATA (April 2012 through the end of March 2013)

61,957 SPDs were identified as High Risk by health plans and 112,741 SPDs were identified as Low Risk through a risk stratification process. Approximately 64 percent (112,034 SPDs) of the 175,120 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 will further assist the plans in assessing the needs of the beneficiary and assuring they are seen by the appropriate providers. 50,182 SPDs completed the risk assessment survey (29% of SPDs that were determined as High or Low Risk). As a result of the risk assessment survey, 11 percent of SPDs (19,045 of respondents) were determined to belong in a different risk category than what was determined through the stratification process.

OMBUDSMAN DATA (July 2012 through the end of June 2013)

There were 5,428 calls regarding mandatory SPD enrollment into managed care (11.07% of total calls to the MMCD Office of the Ombudsman). There were 49 SPD calls (0.35% of total SPD calls) compared to 20 calls from other members (0.06% of total other member calls) regarding access issues.

PLAN GRIEVANCES (July 2012 through the end of June 2013)

Approximately 19 percent out of 6,613 total SPD grievances, or 1,324 were related to access issues.

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA:

Enrollment of SPDs grew from approximately 200,000 in the second quarter of 2011 to 500,000 in the second quarter of 2012. For this time period, of the SPD population, approximately 43 percent had outpatient visits, 4 percent had inpatient visits, 62 percent had pharmacy claims, 5 percent had hospital admissions, and 13 percent had emergency room visits.

On average, each SPD that utilized the services had 5.15 outpatient visits, 2.42 inpatient visits, 11.16 pharmacy claims, 1.68 hospital admissions, and 1.66 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:

Nothing to report.

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 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 as identified in the Waiver; and 4) demonstrate ongoing compliance with above requirements.

ENROLLMENT INFORMATION FOR CBAS

The annual CBAS Enrollment data is broken down quarterly by month (below) for both Managed Care organizations (MCO) and Fee-for-Service (FFS) beneficiaries (below) in each county of participation. Beginning July 2012, CBAS participants began transitioning to Managed Care plans in 30 of California's 58 counties. CBAS participants in the remaining counties continue to receive CBAS as a Medi-Cal FFS benefit. Based on prior and current quarters, it is estimated that there were 23,000 CBAS participants in managed care plans and 1,800 in FFS at this end of this Annual reporting period.

CBAS Participant Enrollment Data - Fee-For-Service (FFS) and Managed Care Organization (MCO)

	July - September 2012						October - Decemer 2012						January - March 2013						April - June 2013*					
	July		August		September		October		November		December		January		February		March		April		May		June	
county	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO	FFS	MCO
Alameda	472	0	460	0	456	0	77	368	29	437	15	493	11	486	11	506	11	480	**10**	**483**	**9**	**491**	**5**	**489**
Butte	48		48		45		43		44		44		48		43		45		**45**		**43**		**42**	
Contra Costa	178	0	172	0	162	0	21	168	9	172	10	174	9	172	8	171	7	174	**8**	**172**	**9**	**172**	**8**	**169**
Fresno	688	0	682	0	663	0	50	569	12	566	11	611	10	666	9	659	7	605	**7**	**538**	**7**	**519**	**6**	**462**
Humboldt	127		124		121		125		123		122		125		121		120		**118**		**119**		**118**	
Imperial	338		362		358		369		360		351		370		365		366		**354**		**358**		**356**	
Kern	150	0	157	0	152	0	25	122	3	126	3	130		135		130		135		**84**		**139**		**122**
Kings		0		0		0		0		0		0		1		0		0		**0**		**0**		**0**
Los Angeles	18,617	0	18,648	0	18,127	0	5,747	13,315	1,448	14,036	995	14,186	884	14,538	1,035	14,087	1,001	13,641	**996**	**13,109**	**959**	**12,859**	**887**	**10,074**
Madera		0		0		0		12		14		11		14		11		12		**14**		**13**		**12**
Marin		19		19		18		18		18		16		17		16		18		**18**		**16**		**12**
Mendocino		0		0		0		0		0		0		0		0		0		**0**		**0**		**0**
Merced	1	86	1	88	1	89	1	85		91		87		85		83		83		**85**		**82**		**50**
Monterey		114		115		106		110		98		2		2		2		2		**2**		**2**		**1**
Napa		44		46		48		51		52		47		28		45		45		**49**		**50**		**0**
Orange	182	1,485	139	1,529	126	1,560	21	1,604	6	1,576	3	1,569	4	1,586	8	1,595	7	1,622	**9**	**1,642**	**11**	**1,595**	**10**	**1,239**
Riverside	477	0	484	0	477	0	109	370	69	384	42	399	28	383	26	370	22	369	**19**	**362**	**17**	**361**	**14**	**340**
Sacramento	587	0	576	0	564	0	110	510	55	482	36	541	32	479	31	426	32	316	**29**	**305**	**27**	**303**	**22**	**373**
Bernardino	305	0	303	0	298	0	59	314	29	331	20	345	23	630	14	353	12	360	**10**	**360**	**10**	**359**	**12**	**324**
San Diego	2,058	0	2,030	0	1,900	0	382	1,655	179	1,705	113	1,719	93	1,756	63	1,747	42	1,778	**39**	**1,759**	**34**	**1,772**	**27**	**1,558**
San Francisco	942	0	953	0	959	0	194	701	69	762	49	741	50	804	57	792	54	443	**54**	**346**	**54**	**336**	**48**	**292**
San Joaquin		0		0		0		0		0		0		0		0		0		**0**		**0**		**0**
Obispo		11		11		14		16		16		15		15		17		15		**17**		**16**		**17**
San Mateo	14	131		115		120		125		126		117		115		117		119		**113**		**57**		**29**
Santa Barbara		41		38		38		111		104		98		98		95		95		**93**		**91**		**77**
Santa Clara	643	0	631	0	590	0	102	437	12	446	2	490	1	545	1	560	4	445	**1**	**436**	**1**	**352**		**279**
Santa Cruz	69	93		100	1	99	2	102		106		106		102		102		101		**101**		**100**		**81**
Shasta	41		42		40		42		43		47		46		42		43		**41**		**41**		**42**	
Solano		55		59		60		56		54		36		52		60		59		**57**		**16**		**0**
Sonoma		26		24		11		11		11		11		11		11		11		**11**		**13**		**12**
Stanislaus	56	0	57	0	54	0	17	39	11	32	10	40	8	40	7	29	5	25	**5**	**36**		**0**		**0**
Tulare		0		0		0		13		9		16		18		19		11		**12**		**13**		**14**
Ventura	751	0	766	0	769	0	42	794	10	761	7	796	6	829	9	834	12	846	**10**	**835**	**7**	**836**	**5**	**762**
Yolo	134	148	92	173	97	170	24	169	5	167	3	156	5	136	4	164	4	166		**171**	**5**	**168**		**99**
Column Total:	26,878	2,253	26,727	2,317	25,960	2,333	7,562	21,845	2,516	22,682	1,883	22,952	1,753	23,743	1,854	23,001	1,794	21,976	**1,755**	**21,210**	**1,711**	**20,731**	**1,602**	**16,887**
Month Total:	**29,131**		**29,044**		**28,293**		**29,407**		**25,198**		**24,835**		**25,496**		**24,855**		**23,770**		**22,965**		**22,442**		**18,489**	

* Above data is point-in-time, with the current Quarter being PRELIMINARY, as claims for most recent month's enrollment continue to be submitted by CBAS Centers via Managed Care Plans and fee-for-service.

Data Date: 8/26/2013

Enrollment Information for ECM

The annual number of ECM participant data is shown on the ECM Table below, indicating ECM-eligible individuals that had been found not eligible for CBAS. A drop in the FFS participants is in correlation with the majority of beneficiaries that enrolled in managed care plans beginning in October, November, and December 2012. ECM-eligible class members enrolled with managed care health plans receive ECM through their plans case management services.

Another significant drop in ECM participants followed Fair Hearing decisions being released during this past year. The Fair Hearing found many beneficiaries that had been determined not eligible for CBAS by the State, were found eligible for CBAS benefits during the Fair Hearing process. However, many of those recipients did receive CBAS by means of Aid-Paid-Pending the Hearing outcome, so did not participate in ECM even when they had been found ineligible.

This ECM Table 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 2013.

Enhanced Case Management (ECM) for Fee-For-Service Participants			
Month	**ECM Eligible Individuals**	New (monthly) ECM Members*	Removed (monthly) ECM Members**
July 2012	1539	139	37
August 2012	1558	58	39
September 2012	1540	41	59
October 2012	1339	12	213
November 2012	1068	17	288
December 2012	972	32	128
January 2013	940	25	57
February 2013	714	13	56
March 2013	719	24	32
April 2013	**720**	16	40
May 2013	**699**	10	28
June 2013	**704**	26	32

All managed care plan members receive ECM as part of their plan benefits

* Class Members eligible for ECM services from previous monthly data.

** Class Members exiting ECM or gaining CBAS eligibility from previous month.

ACCOMPLISHMENTS

CBAS achieved several accomplishments during this past year. Face-to-face eligibility determinations being completed prior to authorizing any new services or a change in service, has been a major accomplishment this past year. All fee-for-service eligibility determinations moved to the same process as the Managed Care plans were performing in March 2013, building program consistency throughout the State. CBAS Centers submit Eligibility Inquiry Requests to the Managed Care plans or the Medi-Cal Field office to have the eligibility determination performed, prior to any new services being performed by the CBAS Center. Once eligibility is determined, the CBAS Center is authorized to develop the Individualized Plan of Care (IPC) with their Multidisciplinary Team of professional, or increase the number of days that the participant can benefit from receiving. The IPC is submitted with the Treatment Authorization Request (TAR) which asks for the number of days of attendance for the desired services. Once the TAR is authorized services may begin. This entire process is to culminate within 30 days, after getting the information from the Center.

This policy of requiring the face-to-face eligibility determination prior to any new services being approved, has been extremely beneficial in helping facilitate a higher level of medical necessity of the beneficiary and ensuring this program a medical model for adult day health care services. This has been seen as an accomplishment for the entire program, offering clearer guidance for Centers and for participants, building consistency for the Managed Care plans and fee-for-service participants.

CBAS Transition to Managed Care

Another accomplishment is described with the transition to Managed Care, with approximately 22,000 beneficiaries moving to a managed care plan to access their CBAS benefits. DHCS put forth extensive meetings, conference calls, and webinars to inform physician groups, and beneficiaries of the process and benefits of managed care. This transition to Managed Care, took place October 1, 2012, with CBAS benefits transferring to major counties which are served by managed care plans. Four counties (Shasta, Humboldt, Butte, and Imperial) are considered rural counties with CBAS centers and will transition to managed care plans in the next year. These four counties are the only counties that remain in FFS-only Medi-Cal status for CBAS.

The two-phase transition consisted of Phase 1 (occurred on July 1, 2012), with approximately 10 percent of CBAS recipients participating into a County Organized Health System (COHS) managed care county, with CBAS as a benefit; then, Phase 2 (occurred on October 1, 2012) as approximately 90 percent of the CBAS eligible population transitioned to the Geographic Managed Care (GMC) plan or the Two-Plan Model counties. During the next year (2013-14), the 28 remaining rural counties will transition to managed care with CBAS as a benefit. Currently, four CBAS centers provide services in three of the Rural counties (Shasta, Humboldt, and Imperial), and remain in FFS Medi-Cal.

CBAS Fair Hearings

Any beneficiary found to be not eligible for CBAS has the right to appeal the decision by requesting a State Fair Hearing. When DHCS began conducting face-to-face assessments in December 2011 on all existing ADHC beneficiaries determining their eligibility under the new CBAS assessment process, over 2,000 beneficiaries requested a State Fair Hearing after being found not eligible.

Over 2,000 cases moved through the system, working closely with the necessary State departments to get the cases resolved as quickly as possible. DHCS and California Department of Aging (CDA) worked closely with CBAS providers as beneficiaries were notified that they were eligible to receive services, or when they were not eligible. It was a work effort that was achieved by the various departments working together with the goal of the participant and the program in mind.

DHCS worked with the California Department of Social Services' (CDSS') Administrative Law Judges to expedite hearing decisions as quickly as possible beginning September 17, 2012, and ending December 2012. During that "expedited" time period, approximately 200 hearings were scheduled and heard weekly throughout the State. Many CBAS beneficiaries who filed for a fair hearing withdrew from the process primarily due to realizing there was no medical necessity for their care, or they had a change in condition, which changed their eligibility status. The table below shows the outcome summary of fair hearings completed this past year:

Total Fair Hearings Processed to date		
Eligible Cases	1237	52%
In Process Cases	17	1%
Ineligible Cases	257	11%
Withdrawn Cases	865	36%
TOTAL	**2376**	100%

During January through June 2013, only 40 Fair Hearings were filed and these cases have been performed through the normal CDSS Fair Hearing process. Fair Hearings to date are listed by County in the Table below.

CBAS Fair Hearing Data					As reported on July 31, 2013
County	Ineligible	Eligible	In Process	Withdrawn	TOTAL
Alameda	25	203		49	277
Butte		2			2
Contra Costa	9	34		12	55
Fresno	7	58		20	85
Humboldt		3			3
Imperial	2	5		1	8
Kern	2	8		8	18
Los Angeles	104	259	13	349	725
Madera		2		1	3
Merced		1		1	2
Monterey		5		7	12
Orange	4	16		15	35
Placer		1		1	2
Riverside				1	1
Sacramento	8	54		28	90
San Bernardino		3		6	9
San Diego	53	215	2	139	409
San Francisco	14	147		102	263
San Luis Obispo		1			1
San Mateo	4	19		8	31
Santa Barbara		2			2
Santa Clara	12	131	1	94	238
Santa Cruz	3	5		1	9
Shasta		1			1
Sonoma				1	1
Tulare		1		1	2
Ventura	7	29	1	13	50
Yolo	3	29		5	37
No County		3		2	5
TOTAL =	**257**	**1237**	**17**	**865**	**2376**

QUANTITATIVE FINDINGS:

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

DHCS has obtained findings on beneficiaries and providers by with assistance from California Department of Aging (CDA) complaint and email response lines. The number of complaints for this past year was minimal from both beneficiaries and providers. Complaints collected from CDA are summarized below, for the last year:

Demonstration Year 8	Beneficiary Complaints	Provider Complaints	Total Complaints	Percent Complaints
Quarter 1 (July-Sept 2012)	10	35	45	0.16%
Quarter 2 (Oct - Dec 2012)	33	61	94	0.33%
Quarter 3 (Jan - Mar 2013)	5	14	19	0.07%
Quarter 4 (Apr -June 2013)	**5**	**25**	**30**	**0.10%**
Annual Total =	53	135	188	

Data from CDA Complaint Data (Telephone & Email)

The major number of complaints came from the managed care transition in October through December, as there were numerous claiming issues that arose. These issues were resolved, and the pattern has subsided. CBAS has settled into a Managed Care benefit, and far less complaints and concerns are being collected.

Quality Assurance/Monitoring Activity

The CDA monitors the certified CBAS centers at least every other year, and notifies DHCS of all outcomes. CDA reviews all findings, reviews and reports outcomes requesting corrective action plans be developed as needed. DHCS works closely with the CDA to ensure all monitoring activity is within the scope of the Waiver and Settlement Agreement.

DHCS and CDA also work to ensure that there is ample CBAS enrollment capacity for the approximate 24,000 participants statewide. As seen by the CBAS center's licensed capacity (Table below), there is ample availability for enrollment. DHCS continues to monitor location and accessibility and consider requests as part of its ongoing monitoring of access to CBAS as required under this Waiver.

A summary of CBAS center capacity along with enrollment follows (see CBAS Center Monthly Enrollment with Center Capacity Used per County), as well as by county and licensed CBAS Center with percentage of quarterly change (per STC 91(k) and STC91(l)(i)(b)) noted in the Table below:

County	CBAS Centers Licensed Capacity					
	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	**Apr-June 2013**	**Percent Change: Oct/Dec to Jan/Mar**
Alameda	415	415	355	355	355	0.0%
Butte	60	60	60	60	60	0.0%
Contra Costa	190	190	190	190	190	0.0%
Fresno	590	590	530	530	547	3.2%
Humboldt	229	229	229	229	229	0.0%
Imperial	250	250	250	315	315	0.0%
Kern	200	200	200	200	200	0.0%
Los Angeles	17,735	17,590	17,430	17,505	17,506	0.0%
Marin	75	75	75	75	75	0.0%
Merced	109	109	109	109	109	0.0%
Monterey **	290	290	290	0	0	0.0%
Napa	100	100	100	100	100	0.0%
Orange	1,897	1,897	1,747	1,747	1,747	0.0%
Riverside	640	640	640	640	640	0.0%
Sacramento	529	529	529	529	529	0.0%
San Bernardino	320	320	320	320	320	0.0%
San Diego	2,132	2,052	1,957	1,992	1,992	0.0%
San Francisco	803	803	803	803	866	7.8%
San Mateo	120	120	120	120	120	0.0%
Santa Barbara	55	55	55	55	55	0.0%
Santa Clara	820	820	820	820	750	**-8.5%**
Santa Cruz	90	90	90	90	90	0.0%
Shasta	85	85	85	85	85	0.0%
Solano	120	120	120	120	120	0.0%
Sonoma	45	0	0	0	0	0.0%
Stanislaus	80	80	80	80	0	**-100.0%**
Ventura	806	806	806	806	806	0.0%
Yolo	224	224	224	224	224	0.0%
SUM =	29,009	28,739	28,214	28,099	**28,030**	**-0.2%**

CDA Utilization and Capacity data

As the above table suggests, CBAS Centers continue with ample capacity for utilization of approximately 60 percent, depending on county. Per STC 91(j)(i), if a county experiences a negative change of more than 5 percent in provider licensed capacity, a corrective action plan is to be in place. During this year, counties continued to have ample CBAS capacity to serve beneficiaries without resorting to unbundled services when other Centers are available within a county area; unless there was only one Center in the county area, such as Stanislaus and previously in Monterey and Sonoma, unbundled services are needed. In counties where there are multiple CBAS providers, the closure of an individual Center has little impact on CBAS participants, since many counties have excess capacity. CDA and DHCS work closely to ensure all participants are released with services or referrals.

CBAS participants affected by a Center closure can receive unbundled services. The list below indicates the available senior centers (socialization, group activities), home health

agencies (in home skilled nursing, physical and occupational therapy), and In-Home Supportive Services (IHSS) (in-home chore and personal care services) provider resources, which are the likely unbundled services for CBAS participants:

Available Home and Community-Based Services

County	Senior Centers	Home Health Agencies	IHSS Providers
Alameda	30	54	17,196
Butte	7	7	3,009
Contra Costa	22	30	7,026
Fresno	19	21	12,105
Humboldt	7	2	1,444
Imperial	5	5	4,615
Kern	24	19	3,833
Los Angeles	104	883	147,820
Marin	8	9	1,511
Merced	10	1	2,391
Monterey	11	11	3,574
Napa	5	3	961
Orange	45	101	17,397
Riverside	32	69	17,130
Sacramento	23	39	18,540
San Bernardino	46	127	19,234
San Diego	64	75	21,159
San Francisco	41	17	20,041
San Mateo	20	24	3,763
Santa Barbara	14	11	2,583
Santa Clara	26	48	16,351
Santa Cruz	11	2	2,276
Shasta	5	10	2,656
Solano	7	7	2,988
Sonoma	8	11	5,061
Stanislaus	5	10	4,950
Ventura	14	66	3,556
Yolo	7	1	1,772
Total =	**620**	**1,663**	**364,942**

Notably, the large volume of IHSS providers is a key characteristic of California's home and community-based services to substitute institutional care for seniors and persons with disabilities. The latter can engage/employ their providers of choice and self-direct their own care in the home. CBAS beneficiaries are all eligible for IHSS, and over 85 percent of CBAS participants receive IHSS in addition to their CBAS.

During this year, DHCS continued to monitor access to CBAS Centers, average utilization rate, and available capacity, with no other action necessary at the time. There continues to be enough CBAS capacity to serve FFS Medi-Cal beneficiaries [STC 91(k)] without resorting to unbundled services in most county areas and many community-based services are available to serve at the local level. The majority of beneficiaries are able to enroll in another local Center for ongoing services. With such excessive capacity in counties where there are multiple CBAS providers, closure of individual CBAS Centers (or consolidation of CBAS providers) has little impact on CBAS

participants at this time. The table below compares capacity with CBAS enrollment over the last year:

CBAS Center Monthly Enrollment with Center Capacity Used per County

CBAS Particpant Enrollment Data - Fee For Service (FFS) and Managed Care Organization (MCO) with Percent Capacity Used at CBAS Centers

County	July - September 2012							October - December 2012							January - March 2013							April - June 2013						
	July		August		September		CAPACITY USED	October		November		December		CAPACITY USED	January		February		March		CAPACITY USED	April		May		June		CAPACITY USED
	FFS	MCO	FFS	MCO	FFS	MCO		FFS	MCO	FFS	MCO	FFS	MCO		FFS	MCO	FFS	MCO	FFS	MCO		FFS	MCO	FFS	MCO	FFS	MCO	
Alameda	472		460		456		66%	77	368	29	437	15	493	79%	11	486	11	506	11	480	83%	10	483	9	491	5	489	82%
Butte	48		48		45		46%	43		44		44		43%	48		43		45		45%	45		43		42		43%
Contra Costa	178		172		162		53%	21	168	9	172	10	174	57%	9	172	8	171	7	174	56%	8	172	9	172	8	169	56%
Fresno	688		682		663		68%	50	581	12	580	11	622	69%	10	680	9	670	7	617	74%	7	552	7	532	6	474	57%
Humboldt	127		124		121		32%	125		123		122		32%	125		121		120		31%	118		119		118		31%
Imperial	338		362		358		83%	369		360		351		85%	370		365		366		69%	354		358		356		67%
Kern	150		157		152		45%	25	135	3	135	3	130	42%		154		149		146	44%		96		152		136	38%
Los Angeles	18,617		18,648		18,127		62%	5,747	13,315	1,448	14,036	995	14,186	56%	884	14,538	1,035	14,087	1,001	13,641	51%	996	13,109	959	12,859	887	10,074	44%
Marin	0	19	0	19	0	18	15%		18		18		16	14%		17		16		18	13%		18		16		12	12%
Merced	1	86	1	88	1	89	48%	1	85		91		87	48%		85		83		83	45%		85		82		50	39%
Monterey **	0	114	0	115	0	106	23%		110		98		2	14%		2		2		2	0%		2		2		1	0%
Napa	0	44	0	46	0	48	27%		51		52		47	30%		28		45		45	23%		49		50		0	19%
Orange	182	1,485	139	1,529	126	1,560	52%	21	1,604	6	1,576	3	1,569	54%	4	1,586	8	1,595	7	1,622	54%	9	1,642	11	1,595	10	1,239	51%
Riverside	477		484		477		44%	109	370	69	384	42	399	42%	28	383	26	370	22	369	37%	19	362	17	361	14	340	34%
Sacramento	587		576		564		64%	110	510	55	482	36	541	65%	32	479	31	426	32	316	49%	29	305	27	303	22	373	39%
San Bernardino	305		303		298		56%	59	314	29	331	20	345	68%	23	630	14	353	12	360	86%	10	360	10	359	12	324	66%
San Diego	2,058		2,030		1,900		57%	382	1,655	179	1,705	113	1,719	58%	93	1,756	63	1,747	42	1,778	54%	39	1,759	34	1,772	27	1,558	51%
San Francisco	942		953		959		70%	194	701	69	762	49	741	62%	50	804	57	792	54	443	54%	54	346	54	336	48	292	26%
San Mateo	14	131	0	115	0	120	62%		125		126		117	60%		115		117		119	58%		113		57		29	33%
Santa Barbara	0	52	0	49	0	52	55%		127		120		113	89%		113		112		110	88%		110		107		94	87%
Santa Clara	643		631		590		45%	102	437	12	446	2	490	36%	1	545	1	560	4	445	37%	1	436	1	352		279	28%
Santa Cruz	69	93	0	100	1	99	79%	2	102		106		106	69%		102		102		101	67%		101		100		81	62%
Shasta	41		42		40		28%	42		43		47		31%	46		42		43		30%	41		41		42		29%
Solano	0	55	0	59	0	60	29%		56		54		36	24%		52		60		59	28%		57		16		0	12%
Sonoma **	0	26	0	24	0	11	0%		11		11		11	0%		11		11		11	0%		11		13		12	0%
Stanislaus **	56		57		54		41%	17	39	11	32	10	40	37%	8	40	7	29	5	25	28%	5	36		0		0	0%
Ventura	751		766		769		56%	42	794	10	761	7	796	59%	6	829	9	834	12	846	62%	10	835	7	836	5	762	60%
Yolo	134	148	92	173	97	170	72%	24	169	5	167	3	156	46%	5	136	4	164	4	166	42%		171	5	168		99	39%
Column Total:	26,878	2,253	26,727	2,317	25,960	2,333		7,562	21,845	2,516	22,682	1,883	22,936		1,753	23,743	1,854	23,034	1,794	21,976		1,755	21,210	1,711	20,731	1,602	16,887	
Month Total:	29,131		29,044		28,293		59%	29,407		25,198		24,819		55%	25,496		24,888		23,770		52%	22,965		22,442		18,489		45%

** 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.

Data Date: 8/26/2013

CBAS Research Study Comparing ADHC in 2010-11 to CBAS in 2012-13

The table below compares annual participant health status of measurable areas for individuals enrolled in the ADHC program during 2012-11, and those enrolled in the CBAS program as of 2012-13. Since the CBAS program has only been operation since April 2012, this is preliminary research. The CBAS program requires a higher level of medical necessity to determine eligibility, so 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.

Participant Status Per Centers' Reporting	FY 2010-11 ADHC	FY 2012-13 CBAS
Dementia	27%	31%
Mental Retardation or DD	6%	7%
Psych Dx	47%	48%
Behavioral Symptoms	36%	39%
Incontinent (bowel and/or bladder)	39%	43%
Ambulates Independently	64%	57%
Ambulates with Staff Assistance	20%	22%
Hearing/ Vision/ Sensory Deficits	68%	63%
Mealtime Assistance	11%	15%
		CDA Data 09.2013

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 Item – Applies to all the CCS Pilots**
January 16, 2013	Protocols finalized, accepted by CMS, and the Department received a letter of CMS approval of the Protocols.
Date	**Action Items – Applies to the Remaining Pilots (RCHSD, CHOC/CalOptima, LA Care, and Alameda)**
Anticipated October 31, 2013	OIL (Operational Instruction Letter) to MMIS 0242 Table for RCHSD for Procedure and Accommodation codes
Anticipated October 31, 2013	OIL to MMIS 0242 Table for CHOC/CalOptima for Procedure and Accommodation codes
On hold as of March 1, 2013 (Originally established May 2012)	OIL to MMIS 0242 Table for Alameda for Procedure and Accommodation codes
December 2012 – May 2013	Appropriate vehicle to provide the Demonstration contractors with cost utilization data that complies with DHCS HIPAA security and confidentiality requirements (Data Use Agreement - Capitation Rate Data Library Confidentiality Agreement)
June 10, 2013 – June 21, 2013	Addendum to the Data Use Agreement to provide the Demonstration contractors with cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
July 2012 – Present (September 23, 2013)	Continuation of the Contracting Process – RCHSD (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
July 2012 – Present (September 23, 2013)	Continuation of the Contracting Process – CHOC/CalOptima (includes amendment to Attachment 10 and includes Attachment 20, the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
July 2012 – Present (September 23, 2013)	Continuation of the Contracting Process – Alameda (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
July 2012 – Present (September 23, 2013)	Continuation of the Contracting Process – LA Care (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
September – November 2013	RCHSD pilot scheduled to be phased in
2014	CHOC/CalOptima pilot scheduled to be phased in

2014	Alameda pilot scheduled to be phased in
2014	LA Care pilot scheduled to be phased in
Date	**Knox-Keene Action Items**
March 4, 2013	DMHC approved the Knox-Keene Waiver Request exemption from DHCS for the RCHSD pilot
January 2013 – March 2013	DHCS management, CHOC, and CalOptima came to an agreement that CHOC would use CalOptima's existing Knox-Keene license
Date	**HPSM Pilot Action Items**
August 27, 2012; Amended March 8, 2013	OIL to MMIS 0242 Table for HPSM for Procedure and Accommodation codes
July 2012 – March 2013	Continuation of the Contracting Process – HPSM (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
January 9, 2012 – January 29, 2013	Developed the Readiness Review Deliverables matrix – HPSM pilot
February 20, 2013 – March 25, 2013	DHCS reviewed 151 Policies and Procedures (P&Ps) deliverables based on the Readiness Review Deliverables matrix – HPSM pilot
March 28, 2013	"Top 10" Readiness Review P&Ps Deliverables were approved by CMS for the HPSM Pilot
June 1, 2012 – January 18, 2013	Developed the CMS Contract Checklist, contained the required components for the contract – HPSM pilot
February 22, 2013	CMS approved the CMS Contract Checklist and verified that the HPSM pilot contract contained the required components
October 2011 – March 12, 2013	Financial – Rates (Mercer) for HPSM pilot developed
March 26, 2013	Financial – Rates (Mercer) for HPSM pilot were finalized and accepted by CMS, DHCS, and HPSM
March 27, 2013	HPSM pilot – CMS approved the HPSM pilot contract and informed DHCS that HPSM could begin operations for this Demonstration Pilot
March 20, 2013 – March 29, 2013	HPSM Contract Signatures obtained by the required parties (HPSM, SCD, Accounting, CMU)
April 1, 2013	HPSM CCS Demonstration became operational under the DHCS Waiver
Committees / Advisory Groups / Stakeholders Meetings	
July 2012 – June 2013 (Bi-Monthly)	CMS Regional and State Check-in Conference Calls

September 2012 – September 2013 (Quarterly)	CCS Executive Committee Meetings
July 23, 2012; November 19, 2012; February 22, 2013; May 30, 2013; August 5, 2013	DHCS Waiver Stakeholder Advisory Committee
August 2, 2012	Medi-Cal Managed Care Division (MMCD) Advisory Group
September 27, 2012; March 4, 2013	Knox Keene – Department Managed Health Care (DMHC)

The milestones listed below were achieved during DY 8 (July 1, 2012 through June 30, 2013).

- July 23, 2012: DHCS presented an overview and update of the CCS pilots and engaged in a discussion of issues that was followed by a question and answer segment to members of the DHCS Waiver Stakeholder Advisory Committee (SAC).

- August 2, 2012: Systems of Care Division (SCD) presented a CCS Demonstration update to the Medi-Cal Managed Care Division (MMCD) Advisory Group.

- October 5, 2012: DHCS completed and submitted another draft of the Protocols, which included responses to CMS' questions that were posed to the original draft from June 2012.

- October 12, 2012: DHCS provided a draft contract version (including exhibits) to RCHSD for their review.

- October 26, 2012: DHCS had a conference call with CMS for clarification on several Protocol questions which were then forwarded to CMS on November 14, 2012.

- November 13, 2012: DHCS provided an updated draft contract (including exhibits) to RCHSD for their review.
- December 19, 2012: An evaluation meeting occurred between UCLA and SCD management to discuss the parameters of the evaluation for the pilots.

- December 2012: Agreement was reached with the DHCS's Privacy Officer, Office of Legal Services, and upper management regarding the appropriate administrative vehicle required to provide the Demonstration contractors with cost utilization data that complies with HIPAA security and confidentiality requirements (Capitation Rate Data Library Confidentiality Agreement).

- January 16, 2013: CMS sent a letter to DHCS that the Protocols were reviewed and approved.

- January 25, 2013: DHCS provided an updated draft contract version to HPSM for their review.

- February 22, 2013: DHCS provided a draft contract to CalOptima (CHOC pilot) for their review.

- February 22, 2013: DHCS presented a briefing document of the CCS pilots to members of the DHCS Waiver SAC.

- March 4, 2013: DHCS received an approval letter from the Department of Managed Health Care (DMHC) approving an exemption to a Knox-Keene licensure for RCHSD.

- March 2013: Per an agreement between DHCS management, CHOC, and CalOptima; CHOC would use CalOptima's Knox-Keene license.

- March 5, 2013: DHCS sent HPSM Pilot "Top 10" Readiness Review P&Ps deliverables requested by CMS to review and approve.

- March 6, 2013: DHCS sent Capitation Rate Data Library Confidentiality Agreement packages to the Contractors (RCHSD, CHOC/CalOptima, Alameda, and LA Care) allowing the Department to release cost utilization data to the Demonstration contractors and complies with Department HIPAA security and confidentiality requirements.

- March 7, 2013: DHCS provided an updated draft contract (including exhibits) to CalOptima (CHOC pilot) for their review.

- March 26, 2013: The capitation rates were amended and finalized for the HPSM pilot contract.

- March 27, 2013: CMS approved the HPSM pilot contract and informed DHCS that HPSM could begin operations for the Demonstration Project.

- March 28, 2013: HPSM returned back to the Department a signed contract.

- April 1, 2013: The California Children's Services (CCS) Demonstration for Health Plan San Mateo (HPSM) became operational on April 1, 2013.

- April 9, 2013: LA Care returned to SCD a signed Capitation Rate Data Library Confidentiality Agreement that allows DHCS to release cost utilization data to the Demonstration contractor.
- April 17, 2013: MMCD received proposed language changes to their existing MMCD CalOptima Contract from SCD to amend Attachment 10 and include Attachment 20.

- May 2, 2013: DHCS received an initial draft of the Scope of Work (SOW) for the CCS Evaluation from the UCLA Health Policy Research.

- May 13, 2013: UCLA, HPSM, San Mateo County, UCSF, Stanford and SCD participated in a CCS Evaluation conference call discussing topics such as; data, proposed site-visits, etc.

- May 16, 2013: DHCS management received email communication from RCHSD regarding which International Classification of Diseases (ICD-9) codes should be used in identifying the following conditions: Cystic Fibrosis, Sickle Cell, and Hemophilia.

- May 30, 2013: DHCS sent to RCHSD an updated version of the contract, (including the SOW, exhibits, and attachments) for their review.

- May 30 2013: DHCS presented a briefing document of the CCS pilots to members of the DHCS Waiver SAC.

- May 30, 2013: RCHSD returned to SCD a signed Capitation Rate Data Library Confidentiality Agreement that allows DHCS to release cost utilization data to the Demonstration contractor.

- June 12, 2013: CalOptima returned a signed Capitation Rate Data Library Confidentiality Agreement to SCD that allows DHCS to release cost utilization data to the Demonstration contractor.

- June 21, 2013: DHCS sent an Addendum to the Capitation Rate Data Library Confidentiality Agreement packages to the Contractors (RCHSD, CHOC/CalOptima, Alameda, and LA Care) in order for the Department to release cost utilization data to the Demonstration contractors and complies with DHCS HIPAA security and confidentiality requirements.

PROJECT STATUS:

Evaluation Design and Implementation

During Demonstration Year (DY) 8, DHCS continued to meet with the CCS pilot evaluation advisory committee, which consists of key CCS stakeholders, to discuss the strategic direction of the evaluation process. Stakeholders included representatives of children's hospitals, the California Specialty Care Coalition, individual providers, local county CCS programs, families of member clients, and other state and county agencies.

On December 19, 2012 an evaluation meeting occurred between UCLA and SCD to discuss the parameters of the evaluation for the pilots. Subsequently, (May 2, 2013) UCLA Health Policy Research submitted a draft SOW for the CCS Evaluation. This IAA

addresses the SOW and budget detail items for the CCS Evaluation. More detail regarding the CCS Demonstration Pilot evaluation is located under the section heading "Evaluation".

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. DHCS's SCD also maintained separate communications with the CMS Region IX staff relative to issues such as review of the CCS Demonstration contracts, development and review of Special Terms and Conditions (STCs) protocols, readiness review deliverables documents, preparation and review of member notices, and review and approval of other CMS requirements.

Protocols

Continuing from the prior Demonstration Year 7, the Department maintained its on-going, discussions with CMS regarding the submission of an updated and revised STCs protocols document (Protocols) which CMS received for review on September 7, 2012. CMS provided vital feedback and clarification on the Protocols to the Department. On October 5, 2012, DHCS completed and submitted another draft of the Protocols, which addressed concerns raised by CMS regarding the Protocols. On October 26, 2012, DHCS had a conference call with CMS for clarification on several Protocols questions, which were then addressed and forwarded to CMS on November 14, 2012. During a CMS conference call, on December 12, 2012, CMS stated the approval letter for the Protocols had been forwarded for signature, was signed by CMS on January 16, 2013, and received by the DHCS Director.

Knox-Keene License

DHCS has also been in communication with the Department of Managed Health Care (DMHC) and submitted a request for exemption to Knox-Keene licensure under the Accountable Care Organization model in San Diego County: Rady Children's Hospital (RCHSD). Exemption to the Knox-Keene licensure would not waive conformance with Knox-Keene performance requirements. Conformance will be accomplished through contract compliance which will 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 time frames. The Department received a response back from DMHC approving the Knox-Keene License Waiver request on March 4, 2013.

Additionally, DHCS had engaged in numerous discussions and conference calls with both CHOC and CalOptima in resolving CHOC's Knox Keene issue. DHCS, CHOC, and CalOptima decided that CHOC would have CalOptima participate and use CalOptima's existing Knox-Keene license. The feasibility of CHOC acquiring a Knox-Keene license

was too expensive and could not meet the tight time-table for this Demonstration Project.

Capitation Rates

Continuing from the prior Demonstration Year (mid-October 2011), DHCS has been working on development of reimbursement rates with DHCS's actuarial contractor, Mercer. The rates for HPSM pilot were the first to be finalized. The capitation rates were accepted by HPSM on February 11, 2013, amended on March 12, 2013, and were once more amended and finalized on March 26, 2013.

Capitation Rate Data Library Confidentiality Agreement & Addendum

Agreement was reached with DHCS's Privacy Officer, Office of Legal Services (OLS), and upper management regarding an appropriate administrative vehicle that would allow DHCS to provide to the Demonstration contractors with cost utilization data that complied with HIPAA security and confidentiality requirements. In March 2013, DHCS sent Capitation Rate Data Library Confidentiality Agreement (Agreement) packages to the Contractors (RCHSD, CHOC/CalOptima, Alameda, and LA Care) which would allow DHCS to release cost utilization data to the Demonstration contractors and comply with DHCS HIPAA security and confidentiality requirements. However, OLS contacted SCD and requested that an Addendum to the Agreement be sent to each of the Contractors. This Addendum addressed a few items that had been left out of the original Agreement. This Addendum was emailed to the Contractors on June 21, 2013 and each Contractor was to sign and return a two-page Addendum to DHCS. As of August 19, 2013, cost utilization data was released only to RCHSD, CHOC/CalOptima, and LA Care.

HPSM – Contract

An updated contract package (which contained the Exhibits, CMS Contract Checklist, and the Readiness Review Deliverables matrix) was sent to HPSM for their review on August 10, 2012 and DHCS received questions back from HPSM on September 16, 2012. In the meantime, whiles HPSM was reviewing that version of the contract; the Department had updated the draft contract package again and forwarded it to HPSM for their review and comment on September 10, 2012. In preparation for a conference call that took place on November 14, 2012; DHCS then sent another version of the contract package to HPSM on November 9, 2012. This conference call allowed both DHCS and HPSM to further discuss the operational issues, contract package language, and reimbursement. The draft contract package was further edited and forwarded to HPSM for review several more times in January 2013 (January 10, 15, and 25).

CMS approved the HPSM Contract on March 27, 2013 and informed DHCS that HPSM could begin operations for this Demonstration Project. The final contract package was sent to HPSM for signature on February 27, 2013 and was returned back to DHCS on March 28, 2013 from HPSM signed. The California Children's Services (CCS) Demonstration for HPSM became operational on April 1, 2013.

HPSM Readiness Review Deliverables

Continuing from the prior Demonstration Year, DHCS developed a Readiness Review Deliverables tool which included both outreach and readiness tools to operationalize the HPSM pilot. The Readiness Review Deliverables tool (Matrix) listed deliverables that the HPSM pilot needed to submit to DHCS prior to going live. These P&Ps ensured that the HPSM Demonstration Project had safeguards for access to care and family centered care practices. HPSM gave DHCS its P&Ps for the Readiness Review matrix on February 7, 2013. By March 5, 2013 the "Top 10" Readiness Review P&Ps deliverables that CMS specifically requested, were sent to CMS for their review and approval. These Readiness Review P&P deliverables included: Provider Network of CCS approved health care providers and health care facilities; Provider to Member Ratios; Specialists by type within the Contractor's network; Federally Qualified Health Centers and Indian Health Services Facilities; Geographic/Physical access and Geo Access report. These Readiness Review P&P deliverables excluded: services for Drug and Alcohol services; Care Coordination; Mental Health including Memorandum of Understanding (MOU) for Local Mental Health Plan and Local Regional Centers; Targeted Case Management; Member Identification Card, and Member Services Guide. On March 28, 2013, CMS gave their consent that the HPSM pilot had met the Readiness Review Deliverables requirements and could begin operations slated for April 1, 2013.

Outreach / Innovative Activities – HPSM

On April 22, 2013, DHCS upper management and SCD management met in-person with HPSM and County Staff. The context of this in-person meeting was to determine 1) How the California Children's Services (CCS) implementation process was coming along and 2) If there were any concerns among the beneficiaries being transferred to the pilot (a question from Federal CMS). SCD management discovered that HPSM and County Staff had developed a "Frequently Asked Questions" document for individuals who were transitioning, helped to alleviate the concerns of the beneficiaries, and provided consistent information from both the HPSM Demonstration and CCS program.

RCHSD – Contract

DHCS received questions from RCHSD on June 28, 2012, regarding the "sample" contract provided by DHCS. Responses were provided to RCHSD on July 20, 2012. RCHSD posed additional questions to the "sample" contract to DHCS on August 7, 2012. DHCS responded to those questions on August 8, 2012. Questions or concerns consisted of clarification of the SOW requirements; possible language changes to several exhibits; carve-outs; rates; inclusion of a definition list; etc. In October 2012, DHCS completed another draft of the RCHSD contract and shared the document with RCHSD to review on October 17, 2012. DHCS received another set of comments and questions to be incorporated into the RCHSD contract on October 25, 2012. Based on the comments received in October, DHCS sent a revised version of the RCHSD contract was sent, at their request, during a conference call on November 13, 2013. On

May 30, 2013, DHCS sent an updated version of the contract (SOW, Exhibits, and Attachments) to review, per RADY's request.

CHOC/CalOptima – Contract

In February 2013, DHCS completed a draft of the CHOC/CalOptima contract and shared the document with CalOptima for review February 15, 2013. CalOptima then requested ten (10) health conditions be included in the next contract version. The Department then sent a revised draft of the CHOC/CalOptima contract to CalOptima on March 7, 2013.

The DHCS's existing contract with CalOptima may be amended to include all requirements of the Demonstration Project. On April 17, 2013, MMCD received proposed language changes to their existing MMCD CalOptima Contract from SCD to amend Attachment 10 and include Attachment 20. On April 30, 2013, SCD had a conference call with MMCD with directions for rewrites of Attachments 10 and 20. SCD submitted a revised version of both attachments for review (Attachment 10 and Attachment 20) to MMCD on July 18, 2013.

QUANTITATIVE FINDINGS:

The monthly enrollment for Health Plan San Mateo (HPSM) is shown in the table below. Please note that these numbers are based on the MIS/DSS system. The MIS/DSS is a subsystem of the California Medicaid Management Information System (CA-MMIS) and serves as the California DHCS Medi-Cal Data Warehouse.

Month	HPSM Enrollment Numbers	Difference
April 2013	1,259	
May 2013	1,448	15.0%
June 2013	1,485	2.6%

QUALITATIVE FINDINGS/CASE STUDIES

CMS had asked both HPSM and SCD if any of the stakeholders had raised any concerns with HPSM after becoming operational on April 1, 2013. Neither, HPSM nor SCD has received negative feedback for this pilot; which might be due to the Frequently Asked Questions (FAQs) that HPSM developed in anticipation of some issues that might arise. The FAQ addressed some common questions which follow: What is this pilot project? Am I going to get a new card or why did I get a new card? Do I have to change my doctor or specialist? Who is my primary contact at CCS going to be? How do I get out of this pilot?

UTILIZATION DATA

DHCS and the demonstration pilots' experienced significant challenge in obtaining and providing cost utilization data stemming from the need to conform to HIPAA security requirements. Discussions were ongoing with the Department's Privacy Officer, OLS, and program staff to identify the appropriate administrative vehicle required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk. By March 6, 2013, DHCS developed and released to the four Demonstration contractors (RCHSD, CHOC/CalOptima, Alameda, and LA Care) a Capitation Rate Data Library Confidentiality Agreement to be reviewed, signed, and returned; which would allow DHCS to release cost utilization data. In June 2013, the Office of HIPAA Compliance requested a two page Addendum to the Capitation Rate Data Library Confidentiality Agreement to include items that were omitted in the original Agreement package. 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/CalOptima, and LA Care.

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. Other challenges are issues that are specific to each location such as covered populations and health conditions, general organizational structure, reporting requirements, etc. Some of these challenges listed below have been resolved during the Demonstration Year.

RCHSD - Providing claims data to RCHSD consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and confidentiality requirements; completion and agreement of capitated reimbursement rates; confirmation of health conditions; possibility of additional health conditions for the future; and member and health plan notification.

LA Care - Status of the Knox-Keene Wavier amendment approval with DMHC; providing claims data to LA Care consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; infrastructure challenges associated with three individual provider networks; coordination with other initiatives (coordinated care initiative, dual population, healthy family transition, Affordable Care Act); coordination with local CCS Program / eligibility and enrollment.

CHOC – Status of Knox-Keene licensure; providing claims data to CHOC consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; and confirmation of 10 health conditions, which may be reduced.

Alameda – Providing claims data to Alameda consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; confirmation of population (high acuity focus vs. entire population); and confirmation of administrative infrastructure.

EVALUATION

An interagency agreement with UCLA Health Policy Research to provide a program evaluation of the Demonstration Project, as required by the CMS 1115 Waiver Standard Terms and Conditions as well as Senate Bill 208, was drafted in early June 2013. This interagency agreement is to address the SOW for the evaluation. The evaluation is to examine patient, family and physician satisfaction and the financial impacts of the pilot programs as well as provide technical assistance at the request of DHCS. However, towards the beginning of July 2013, a more current version of the SOW is in the process of being drafted by UCLA.

UCLA will focus the evaluation on answering a limited number of questions that follow below:

- ✓ Does the CCS population enrolled in the four pilots have access to timely, appropriate, high quality, coordinated medical and supportive services?
- ✓ Have the CCS pilots resulted in increased patient and family satisfaction with the delivery of services through the CCS program?
- ✓ Have the CCS pilots resulted in increased provider satisfaction with delivery of and reimbursement for services?
- ✓ Has the state improved their ability to measure and assess cost-effective strategies employed by CCS pilots to deliver high-quality, well-coordinated medical and supportive services?
- ✓ Have the CCS pilots resulted in increased use of community-based services and a decrease in inpatient and emergency room use?
- ✓ Has the annual rate of growth in expenditures for the CCS population in the pilot areas been reduced?

UCLA, HPSM, San Mateo County, UCSF, Stanford and SCD participated in a conference call on May 13, 2013 discussing data, proposed site-visits, etc. More specific detail regarding these topics follows:

Data

- ✓ UCLA inquired as to what data systems are available at each pilot.
- ✓ UCLA discussed how they would gather data from pilot and control groups.
- ✓ UCLA stated they would need access to HPSM's internal claims data, HPSM's data is "locked-up on paper" and in an Excel workbook format.

- ✓ HPSM to evaluate and determine the best practices to transfer the data into an electronic format so the information can be “worked” by UCLA.
- ✓ Evaluation will be quantitative in nature using; reported data, Family/Patient/Provider Surveys. UCLA will subcontract to use Florida’s Title 5 Needs Assessment survey for sample groups.

UCLA conducted site visits in June/July 2013

- UCLA created a meeting schedule for the site-visit and an agenda to meet with the various HPSM departments (IT, legal, etc.) and review how their programs work, the integration of the CCS Demonstration, changes that have been made since the operational date of the pilot, how the implementation of the pilot is working, timelines, goals/objectives to measure progress over a time span, etc.
- UCLA will abide by the Committee for the Protection of Human Subjects (CPHS) rules and regulations (http://www.oshpd.ca.gov/Boards/CPHS/researchers.html#II)

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

Since the transition started on January 1, 2013 through June 30, 2013, California has successfully transitioned 614,495 Healthy Families Program (HFP) children to Medi-Cal in Phases 1A, 1B, 1C, and 2. California has complied with all STCs relative to the transition through June 30, 2013 including but not limited to receiving federal approval for each phase, submission of implementation plans for each phase, completion of network adequacy assessments, conducting reoccurring stakeholder engagement sessions, and communication to beneficiaries via notices, Frequently Asked Questions, and Welcome Packets.

Eligibility

California established new Medi-Cal aid codes and premium requirements for beneficiaries to enroll into the new OTLICP who would have previously qualified for HFP. A total of 130,057 newly enrolled into OTLICP from January 1 through June 30, 2013.

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

Health Care

In Phases 1A, 1B, 1C, 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 are provided 30 calendar days from the time of enrollment to choose a PCP before one is chosen for them.

Since the start of the transition in January 1 through June 30, 2013, the health plans have reported 108 continuity of care requests. 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 can 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 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). As such, Dental Care reached successfully 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, 1287 new FFS and dental plan providers were added during January – June 2013 .; 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 Mental Health Plans (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. From January – June 2013, 19,374 transitioned and OTLICP children received Medi-Cal specialty mental health services.

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 January – June 2013, 324 transition and OTLICP children received SUD treatment services.

PROJECT STATUS

During the reporting period of July 1, 2012 through June 30, 2013, the State has conducted the following activities to satisfy statutory requirements and ensure a smooth transition of HFP children to Medi-Cal.

Strategic Plan

On October 2, 2012, CHHS submitted a HFP transition to Medi-Cal Strategic Plan to members of the California Legislature and shared publicly on DHCS' website. CHHS have worked closely with DHCS, MRMIB, DMHC, and a diverse array of stakeholders to develop the Strategic Plan and to prepare for the transition of all HFP children to Medi-Cal beginning January 1, 2013. The Strategic Plan addresses legislative requirements; the operational steps, timelines, and key milestones necessary for a successful transition; methods and processes for stakeholder engagement; state, county, and local administrative components; changes to the health care and dental delivery systems; and the process for obtaining federal approval.

Implementation Plans and Network Adequacy Assessments

In collaboration with various governmental partners and stakeholders, the State submitted Implementation Plans for Phase 1 on November 1, 2012, Phase 2 on January 1, 2013, Phase 3 on May 1, 2013, and Phase 4 on June 1, 2013 to members of the California Legislature and shared publicly on DHCS' website. The Implementation plans

were accompanied by network adequacy assessments to ensure no disruption of services for transitioning children. Network adequacy assessment addendums were subsequently shared to provide an update on improved networks of providers.

Monthly Monitoring Reports

The monthly monitoring reports are developed and submitted to CMS for purposes of satisfying the Bridge to Reform 1115 Demonstration Waiver, STC117, and the statutory requirement to the California Legislature. The reports present 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, have been submitted for each month since the beginning of the transition in January through June 2013. Upon receipt of the each month's monitoring report, CMS and DHCS would convene conference calls to discuss any questions or comments CMS has on the monitoring reports.

Federal Approval

On October 30, 2012, the State submitted a Bridge to Reform Section 1115 Demonstration Wavier amendment to enable full scope Medi-Cal coverage for transitioning HFP beneficiaries without a full Medi-Cal determination until a change in the beneficiaries' circumstances or annual renewal date. The new coverage group, previously HFP is now considered the OTLICP under Medi-Cal. Upon CMS' approval of the waiver on December 31, 2012, OTLICP is able to operate under the waiver from January 1, 2013 through December 31, 2013. Once the transition of HFP children completes, OTLICP will fall under the State Plan. The State Plan Amendment (SPA) 13-005 was officially submitted on May 31, 2013 for this authority. Prior to the official submission, drafts of the SPA were shared with stakeholders on the DHCS website. The State is continuing to work closely with CMS to obtain approval for SPA 13-005.

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, DHCS 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 very operative during the transition period with both MRMIB and DHCS. The newly established relationship with DHCS has been collaborative and productive.

Stakeholder Engagement

Beginning August of 2012, the State has convened 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 DHCS' HFP transition to Medi-Cal website for public review and comment. An email address is posted on the website for questions and/or comments to be submitted to DHCS' Planning Team for response. Additionally, the various program areas convene their own stakeholder meetings with stakeholders relative to their program areas: Eligibility, Managed Care, Dental, Mental Health, and Substance Use Disorders.

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 1A, 1B, 1C, and 2 from January 1, 2013 through June 30, 2013 received all the required notices prior to their transition. The notices reminds children and families that the transitioning children will continue to receive coverage throughout their transition, changes to their health plans if any, and provides 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. DHCS has led meetings with its county partners and technical stakeholders to define and execute the operational changes needed to transition HFP children to Medi-Cal. All transitioned children's case information have been successfully transferred to Medi-Cal for Phases 1A, 1B, 1C, and 2 from January 1, 2013 through June 30, 2013.

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, DHCS had a responsibility to establish policies and procedures for eligibility determinations, premium collection, cost sharing provisions, and performance metrics for application processing. DHCS has 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

DHCS conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey is to provide direct feedback from impacted families on how the transition from HFP to Medi-Cal is going

and to alert DHCS to any concerns. Beneficiaries' experiences are evaluated in areas of medical, dental, mental health, and substance use disorder services.

QUANTITATIVE FINDINGS

Eligibility

As of June 30, 2013, the State has successfully transitioned 614,495 children from HFP to Medi-Cal in Phases 1A, 1B, 1C, and 2, and 130,057 have newly enrolled into OTLICP. Below is a summary of how many children have transitioned and remaining to transition:

Transition Status [1]	Number of Children
Identified for transition in December 2012	846,016
Successfully transitioned in Phases 1 and 2	- 614,495
*Discontinued by MRMIB prior to scheduled transition**	- 85,863
To be transitioned in Phases 3 and 4 (approximately)	***145,658***

In addition to the transitioned children and newly enrolled children, the State also processed annual renewals for transitioning beneficiaries. The total number of children who underwent annual renewal in each month is:

January 2013	February 2013	March 2013	April 2013	May 2013	June 2013	Total Children
10,040	***17,804***	***32,682***	***46,573***	***51,405***	***48,855***	***207,359***

Disenrollment's were also captured during the transition as totals are shown for each month below. There were no disenrollment's 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.

[1] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report July 15, 2013*
http://www.dhcs.ca.gov/services/Documents/HFP%20Transition%20Monitoring%20Report%207-16-13.pdf

February 2013	*March 2013*	*April 2013*	*May 2013*	*June 2013*
124	***14,964***	***11,192***	***37,697***	***20,837***

Managed Care

On average, 97% of children were assigned to a primary care provider after they transitioned into Medi-Cal. Between January 1 through June 30, 2013, health plans have reported 108 continuity of care requests, in which all have been resolved by assisting beneficiaries with selecting new or changing PCPs, providing information on prior authorizations, and clarifying behavioral health services covered.

Dental

In the first six months of HFP transition: average number of days between scheduling an appointment and the actual appointment date for dental services is 7.25 days; average number of newly enrolled providers is 214.5 per month; average number of disenrolled providers is 77.83 per month; number of warm phone call transfers started from 45 in January to 537 in June; 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 92.45% a 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:

January 2013	*February 2013*	*March 2013*	*April 2013*	*May 2013*	*June 2013*
1,337	2,117	3,187	5,234	5,421	2,078

Due to the lag in claims submission after the service date, the data above is under representative of the actual number of children served and the actual numbers of units of service provided. Nonetheless, the data illustrates that transitioned and OTLICP children are able to access Medi-Cal specialty mental health services following the transition.

Substance Use Disorder

As of June 30, 2013, there were 1,565 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:

January 2013	*February 2013*	*March 2013*	*April 2013*	*May 2013*	*Total*
19	***51***	***87***	***164***	***3***	***324***

QUALITATIVE FINDINGS/CASE STUDIES

Beneficiary Survey

DHCS conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey is to provide direct feedback from impacted families on how the transition from HFP to Medi-Cal is going and to alert DHCS to any concerns. Beneficiaries' experiences are evaluated in areas of medical, dental, mental health, and substance use disorder services. On average, 59% of beneficiaries provided the highest and 4.4% provided the lowest satisfactory rating when asked of their overall experience with the transition.

Dental Survey

For dental services, DHCS has 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 DHCS to assess the number of providers that plan to enroll in Denti-Cal or contract with Medi-Cal dental managed care plans and continued 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. DHCS 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 will continue to treat children who have 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 will be able to remain with their same provider.

UTILIZATION DATA

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Inquiries have been made to DHCS specifically regarding children with a diagnosis of autism and their ability to continue to receive Applied Behavioral Analysis (ABA) services upon their transition to Medi-Cal. Approximately a dozen specific cases, out of what has been reported to be approximately 300 cases statewide, have been 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.

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, ABA services, 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 will dictate 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 DDS’s 1915(i) state plan amendment provided through the 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. DHCS will continue to monitor these cases.

2013 MANAGED CARE EXPANSION

The Medi-Cal Managed Care Division (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. Today, approximately 5.6 million Medi-Cal beneficiaries in 30 counties receive their health care through three models of managed care: Two-Plan, County Organized Health Systems (COHS) and Geographic Managed Care (GMC). Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

DHCS has been working to expand Medi-Cal managed care services into areas that are currently FFS only. This statewide expansion is part of Governor Brown's 2012-2013 budget. The General Fund cost savings of this expansion is projected at $2.7 million in 2012-2013 and $8.8 million in 2013-2014. This expansion will provide beneficiaries throughout the state with care through an organized delivery system. Approximately 370,000 eligible beneficiaries will be impacted (plus 43,000 Healthy Families children). In preparation for this statewide expansion, in April 2012, DHCS released a Request for Interest to solicit health plans' interest in providing Medi-Cal managed care services in 28 FFS only counties. In June 2012, Assembly Bill 1467 was enacted and chaptered adding Section 14087.98 to the Welfare and Institutions Code, thus granting DHCS the authority to expand managed care into the remaining 28 FFS rural counties.

ACCOMPLISHMENTS:

February 27, 2013 DHCS released a Notice of Intent to Award – Request for Application Number 28RFA2012/2013 Medi-Cal Managed Care Regional Expansion. This release served as the official Notice of Intent to Award indicating the selection of Anthem Blue Cross (ABC) and California Health and Wellness Plan (CHWP) into Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba.

February 28, 2013 DHCS announced the selection of Partnership HealthPlan of California (PHC) for the seven counties of Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou and Trinity that were excluded from the Request for Application 28RFA2012/2013 Medi-Cal Managed Care Regional Expansion.

May 2013 selected CHWP for Imperial County and ABC for San Benito County.

PROJECT STATUS:

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May 2013 selected CHWP for Imperial County, and ABC for San Benito County.

QUANTITATIVE FINDINGS:

Nothing to report.

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA:

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

February 27, 2013 DHCS released REQUEST FOR APPLICATION NUMBER 28RFA2012/2013 -- BULLETIN 2 that announced DHCS exercised its right under the RFA to exclude county(s) listed in the RFA. The seven counties excluded were Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

April 12, 2013 DHCS released a Regional Expansion Implementation Update that indicated the start date for the Medi-Cal Managed Care Regional Expansion has been changed from June 1 to September 1 for all 28 counties.

San Benito County was originally slated to operate as a County Organized Health System model county under Central California Alliance for Health. After a thorough stakeholder process that included DHCS participation, CCAH's governing board unanimously disapproved the expansion of CCAH's operation into San Benito County

on April 24, 2013. After careful consideration of the available options, DHCS selected ABC.

DESIGNATED STATE HEALTH PROGRAMS (DSHP)

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

DY 5 final reconciliations for the following programs were completed: CCS, GHPP, MIA/LTC, and BCCTP.

PROJECT STATUS

Assembly Bill 1467 gave the Department the statutory authority 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 waiver amendment to request CMS authority to make these claims.

QUANTITATIVE FINDINGS:

As of June 2013, DHCS claimed a total amount of $317,896,954 for DSHP in DY 8. The table below lists the claim detail for each program:

State Only Medical Programs	
California Children Services (CCS)	$ 80,304,810
Genetically Handicapped Persons Program (GHPP)	$ 40,827,722
Medically Indigent Adult Long-Term Care (MIA/LTC)	$ 19,102,638
Breast & Cervical Cancer Treatment Program (BCCTP)	$ 1,472,036
AIDS Drug Assistance Program (ADAP)	$ 66,339,340
County Mental Health Services Program	$ 10,560,853
Department of Developmental Services (DDS)	$ 88,124,001
Every Woman Count (EWC)	$ -
Prostate Cancer Treatment Program (PCTP)	$ 1,295,053
State Only Medical Programs Total	$ 308,026,453
Workforce Development Programs	

Song Brown HealthCare Workforce Training	$ 3,778,000
Steven M. Thompson Physician Corp Loan Repayment Program	$ 1,092,501
Mental Health Loan Assumption	$ 5,000,000
Workforce Development Total	$ 9,870,501
Grand Total for DSHP	$ 317,896,954

Annual Report

Waiver Year 8

July 2012-June 2013

Designated State Health Programs (DSHP)

Payment Type	Total Computable Costs (CPEs)	FFP Claim		Total Claim
State of California				
DSHP	$ 635,793,905	$ 317,896,954		$ 317,896,954