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May 29, 2015

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 01-01-2015 THROUGH 03/31/2015 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

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

Enclosed is the Quarterly Progress Report required by Paragraph 20 and Attachment I of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the second quarterly progress report for Demonstration Year Ten, which covers the period from January 1, 2015 through March 31, 2015.

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

Sincerely,

[redacted]

Mari Cantwell
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TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Ten (07/01/14-10/31/15)
Second Quarter Reporting Period: 10/01/2014-12/31/2014

INTRODUCTION:

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

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

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

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

- Create coordinated systems of care for Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans
- Identify the model or models of health care delivery for the California Children Services (CCS) population that would result in achieving desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness
- Phase in coverage in individual counties through LIHP for the Medicaid Coverage Expansion (MCE) population—adults aged 19-64 with incomes at or

below 133 percent of the FPL who are eligible under the new Affordable Care Act State option

- Phase in coverage in individual counties through LIHP for the Health Care Coverage Initiative (HCCI) population—adults between 133 percent to 200 percent of the FPL who are not otherwise eligible for Medicaid
- Expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers
- Implement a series of infrastructure improvements through a new funding sub-pool called the Delivery System Reform Incentive Pool (DSRIP) that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care
    - Note: Reporting to CMS for DSRIP is done on a semi-annual and annual aggregate reporting basis and will not be contained in quarterly progress reports.

On January 10, 2012, the State submitted an amendment to the Demonstration, approved March 31, 2012, to provide Community Based Adult Services (CBAS)—outpatient, facility-based program that delivers skilled-nursing care, social services, therapies, personal care, family/caregiver training and support, means, and transportation—to eligible Medi-Cal beneficiaries enrolled in a managed care organization. Beneficiaries who previously received Adult Day Health Care Services (ADHC), and will not qualify for CBAS services, will receive a more limited Enhanced Case Management (ECM) benefit. The initial period for this amendment was through August 31, 2014. The Department submitted a Waiver amendment, after extensive stakeholder input regarding the continuation of CBAS. CMS approved short term extensions during the finalization of that amendment, and approved the amendment with a December 1, 2014 effective date.

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

- Increase authorized funding for the Safety Net Care Uncompensated Care Pool in DY 7 by the amount of authorized but unspent funding for HCCI and the Designated State Health Programs in DY 6.
- Reallocate authorized funding for the HCCI to the Safety Net Care Uncompensated Pool for DY 7.
- Establish an HIV Transition Program within the DSRIP for “Category 5” HIV transition projects to develop programs of activity that support efforts to provide continuity of quality and coverage transition for LIHP enrollees with HIV.

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

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

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

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

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

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

In September 2014 DHCS submitted an amendment to expand full-scope coverage to pregnant women 109%-138% of the federal poverty limit. In addition, in November 2014 DHCS submitted an amendment to offer our substance use disorder services through an organized delivery system that offers a full continuum of care. Both of these amendments are pending CMS approval.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

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

Enrollment information:

The “mandatory SPD population” consists of Medi-Cal-only beneficiaries with certain aid codes who reside in all counties operating under the Two-Plan Model (Two-Plan) and Geographic Managed Care (GMC) models of managed care. The “existing SPD population” consists of beneficiaries with certain aid codes who reside in all counties operating under the County-Organized Health System (COHS) model of managed care, plus Dual Eligibles and other voluntary SPD populations with certain aid codes in all counties operating under the Two-Plan and GMC models of managed care. The “SPDs in Rural Non-COHS Counties” consists of beneficiaries with certain aid codes who reside in all Non-COHS counties operating under the Regional, Imperial and San Benito models of managed care. The “SPDs in Rural COHS Counties” consists of beneficiaries with certain aid codes who reside in all COHS counties that were included in the 2013 rural expansion of managed care. The Rural counties are presented separately due to aid code differences between COHS and non-COHS models.

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
January 2015 – March 2015

County	Total Member Months
Alameda	92,591
Contra Costa	51,644
Fresno	70,550
Kern	56,545
Kings	7,799
Los Angeles	573,089
Madera	7,599
Riverside	93,693
San Bernardino	109,340
San Francisco	52,874
San Joaquin	51,561
Santa Clara	67,956
Stanislaus	37,586
Tulare	33,251
Sacramento	116,015
San Diego	117,756
Total	**1,539,849**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
January 2015 – March 2015

County	Total Member Months
Alameda	47,988
Contra Costa	20,211
Fresno	25,822
Kern	16,815
Kings	2,576
Los Angeles	841,828
Madera	2,610
Marin	19,008
Mendocino	17,517
Merced	47,589
Monterey	47,655
Napa	13,971
Orange	349,572
Riverside	129,019
Sacramento	45,535
San Bernardino	127,497
San Diego	188,871
San Francisco	29,732
San Joaquin	18,093
San Luis Obispo	25,079
San Mateo	70,080
Santa Barbara	45,242
Santa Clara	71,244
Santa Cruz	30,715
Solano	58,031
Sonoma	52,373
Stanislaus	8,826
Tulare	12,520
Ventura	82,409
Yolo	25,779
Total	**2,474,207**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
January 2015 – March 2015

County	Total Member Months
Alpine	86
Amador	1,265
Butte	21,875
Calaveras	2,105
Colusa	804
El Dorado	5,636
Glenn	1,887
Imperial	12,746
Inyo	749
Mariposa	784
Mono	259
Nevada	3,617
Placer	9,377
Plumas	1,201
San Benito	252
Sierra	163
Sutter	6,335
Tehama	5,788
Tuolumne	2,962
Yuba	6,969
Total	**84,860**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
January 2015 – March 2015

County	Total Member Months
Del Norte	8,049
Humboldt	26,977
Lake	18,916
Lassen	4,100
Modoc	2,062
Shasta	41,208
Siskiyou	10,948
Trinity	3,104
Total	**115,364**

Enrollment (January 2015 – March 2015)
During the quarter, mandatory SPDs had an average choice rate 54.07%, an auto-assignment default rate of 21.84%, a passive enrollment rate of 0.01%, a prior-plan default rate of 0.66%, and a transfer rate of 23.41%. In March, overall SPD enrollment in Two-Plan and GMC counties was 528,349 (point-in-time), a 1.64% decrease from December's enrollment of 537,185. For monthly aggregate and Medi-Cal managed care health plan (MCP)-level data, please see the attachment "DY10-Q3 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

Medi-Cal Managed Care Performance Dashboard (January 2015 – March 2015)
During the reporting period, DHCS continued to update the Medi-Cal Managed Care Performance Dashboard which assists the Department, Managed Care Plan (MCPs) and other stakeholders to identify trends and better observe and understand the program on multiple levels—statewide, by managed care plan model (i.e., COHS, GMC, Two-Plan, Regional, San Benito and Imperial) and by individual MCP. On March 5, 2015, DHCS released the fifth iteration of the dashboard via public webinar. It includes, but is not limited to, metrics that quantify and track quality of care, enrollee satisfaction, utilization and continuity of care. The dashboard also stratifies reported data by beneficiary populations including Medi-Cal-only SPDs, dual eligibles, children transitioned from the Healthy Families Program and the ACA optional expansion population.

The sixth edition of the dashboard will be released in June 2015 and DHCS will conduct a webinar to present the dashboard to MCPs and other stakeholders. The dashboard was originally developed with funding from the California Health Care Foundation (CHCF).

Operational/Policy Issues:

Network Adequacy
Between January 2015 and March 2015, the Department of Managed Health Care (DMHC) completed a provider network review of all Two Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provided DHCS with an updated list of providers that SPDs may contact to receive care. DHCS and DMHC conducted a joint review of each MCP's provider network and identified no systemic access to care issues. DMHC and DHCS held a joint webinar to answer any questions about the joint review process in February 2015. The two departments continue to work with the MCPs to ensure that all areas of network adequacy are addressed.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee
On February 11, 2015, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no specific discussions relating to SPDs. Full documentation from the meeting is available at:
http://www.dhcs.ca.gov/Pages/February11MeetingMaterials.aspx

Office of the Ombudsman (January 2015 – March 2015)
The Office of the Ombudsman experienced an overall decrease in customer calls between the periods October-December 2014 (DY10-Q2) and January-March 2015 (DY10-Q3). During DY10-Q2, the Ombudsman received 40,537 total calls, of which 12,832 concerned mandatory enrollment and 1,845 were from SPDs. During DY10-Q2, the Ombudsman received 43,113 total calls, of which 13,440 concerned mandatory enrollment and 2,147 were from SPDs. This represents a 5.97% decrease in total calls, a 4.52% decrease in calls regarding mandatory enrollment, and a 14.07% decrease in calls regarding mandatory enrollment from SPDs.

For DY10-Q3, 0.11% of SPD and 0.04% of non-SPD calls concerned access issues. This is a small increase in SPD and non-SPD calls from DY10-Q2, during which 0.10% of SPD and 0.02% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) increased for overall measures, including SPD measures. Total SHRs increased from 594 DY10-Q2 to 865 in DY10-Q3. The percentage of SHRs from SPDs increased from 38% to 42%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs increased from 178 in DY10-Q2 to 216 in DY10-Q3. The percentage of those requests from SPDs increased slightly from 33% to 35%. There were no SHRs related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachments "DY10 Q3 Ombudsman Report" and "DY10 Q3 State Hearing Report."

Medical Exemption Requests (MERs) Process (January 2015 – March 2015)

Nothing to report.

Health Risk Assessment Data (July 2014 – September 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 23,659 SPDs between July 2014 and September 2014. Of those, MCPs stratified 8,044 (34%) as high-risk SPDs and 14,160 (59.85%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 36.82% by phone and 56.80% by mail. Of the total high-risk SPDS, 35.99% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 25.28% by phone and 56.05% by mail. Of the total low-risk SPDS, 23.80% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs

determined 2,790 SPDs to be in the other risk category, which is 11.79% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 Risk Data."

Continuity of Care Data (October 2014 – December 2014)
According to the data, reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,396 continuity-of-care requests between October and December 2014. Of these, MCPs approved 1,029 requests (73.71% of all requests); held 13 requests (0.93%) in process; and denied 354 requests (25.36%). Of the requests denied, 69.77% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2014 Continuity of Care."

Plan-Reported Grievances (October 2014 – December 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 3,019 grievances between October and December 2014. Of these grievances, 0.66% were related to physical accessibility, 8.41% were related to access to primary care, 2.45% were related to access to specialists, 2.05% were related to out-of-network services, and 86.42% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2014 SPD Grievance."

Medical Exemption Requests (MERs) Data (October 2014 – December 2014)
During 2014, from October through December, 4,643 SPDs submitted 5,596 MERs, an average of 1.21 MERs per SPD who submitted a MER. DHCS approved 3,444 MERs, denied 2,119, and found 33 to be incomplete. The top five MER diagnoses were Complex (927), Cancer (237), Neurological (157), Transplant (142), and Dialysis (50). Summary data is available in the attachment "Q4 2014 MERs Data."

Health Plan Network Changes (October 2014 – December 2014)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 1,728 primary care physicians (PCPs) and removed 733 PCPs across all networks, resulting in a total PCP count of 28,351. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2014 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (January 2015 – March 2015)

Nothing to report.

Encounter Data (January 2015 – March 2015)

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

During the reporting period, the Department continued its efforts to implement the EDQMRP. DHCS continued to develop metrics that will objectively measure the quality of future encounter data in the dimensions of completeness, accuracy, reasonability and timeliness. The Department also continued to develop an encounter data monitoring database that will determine an Encounter Data Quality Grade for each Medi-Cal MCP based on these metrics. This monitoring database will also serve to track encounter data submissions and report valuable data quality information to Medi-Cal MCPs, DHCS data users and other stakeholders.

In addition, the Department worked with Medi-Cal MCPs as they transitioned to DHCS' new encounter data processing system, PACES, which will enhance DHCS' ability to implement the EDQMRP. By the end of the reporting period, 18 of 23 Medi-Cal MCPs successfully transitioned to the new system. Although these efforts did not specifically target SPDs, improving the quality of encounter data will enable DHCS to better monitor the services and care provided to this population.

Outcome Measures and All Cause Readmissions (January 2015 – March 2015)

Healthcare Effectiveness Data Information Set (HEDIS) Measures

As HEDIS rates are reported annually, there will be no new data to report until July 2015. DHCS has posted the 2015 and 2016 External Accountability Set on DHCS's Managed Care Quality and Monitoring Division's Quality Improvement & Performance Measurement Reports website: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/ExtAcctSetforMeasurementYears2014_2015.pdf. MCPs will report the following indicators for SPDs versus other members: all cause readmissions to the hospital, ambulatory visits (outpatient and emergency department), monitoring for patients on persistent medications, and children and adolescents' access to primary care practitioners. For measures DHCS holds plans to a minimum performance level (MPL), DHCS has determined and Health Services Advisory Group (HSAG) shared this MPL with MCPs through an FTP site. HSAG is DHCS's contracted External Quality Review Organization (EQRO).

Consumer Assessment of Healthcare Providers and Systems

Nothing to Report.

Statewide Collaborative All Cause Readmissions

The Statewide Collaborative Quality Improvement Project (QIP) began in July 2011 and focuses on reducing readmissions due to all causes within 30 days of an inpatient discharge among MCP members. DHCS held a quarterly technical assistance call with

HSAG and the MCPs in February and has another call scheduled for May. The Statewide Collaborative will conclude on June 30, 2015. The re-measurement 1 Report will be submitted by HSAG at that time.

Utilization Data (January 2014 – March 2014)
During the period January through March 2014, MCPs in Two-Plan and GMC counties enrolled 544,892 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 14.26% (77,706) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.68 times.
- Each SPD who visited an ER generated an average of 2.55 ER claims.

Pharmacy Services:

- 66.56% (362,658) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 13.64 claims.

Outpatient Services:

- 49.00% (266,984) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.45 visits.
- Each SPD who accessed outpatient services generated an average of 10.42 claims.

Inpatient Services:

- 4.95% (26,979) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 2.82 visits.
- Each SPD who accessed inpatient services generated an average of 3.63 claims.

Hospital Admissions:

- 5.84% (31,822) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 1.93 visits.

Top Ten Services Accessed by SPDs

12,258,737 total claims

	Jan 2014 – Mar 2014
1	Prescribed Drugs
2	Physicians
3	Lab and X-Ray
4	Other Clinics
5	Other Services
6	Outpatient Hospital
7	Personal Care Services
8	Targeted Case Management
9	Hospital: Inpatient Other
10	Rural Health Clinics

For the top ten diagnosis categories, MCPs submitted data for a total of 3,008,002 encounters. Mental Illness was in the top rank with 34.93% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 15.70%. In the third position, "Diseases of the nervous system and sense organs" was 8.59%. The remaining seven categories ranged from 8.46% to 3.01% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment "DY9 Q3 Utilization Data."

Enclosures/Attachments:

- "DY10 Q3 Defaults Transfers 2Plan GMC"
- "DY10 Q3 Ombudsman Report"
- "DY10 Q3 State Hearing Report.
- "Q3 2014 Risk Data"
- "Q4 2014 Continuity of Care"
- "Q4 2014 SPD Grievance"
- "Q4 2014 MERs Data"
- "Q4 2014 Network Adequacy"
- "DY9 Q3 Utilization Data"
- "Managed Care AG Meeting Minutes March 12 2015"

CALIFORNIA CHILDREN SERVICES (CCS)

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

The CCS program is administered as a partnership between local CCS county programs and the Department of Health Care Services (DHCS). Approximately 75 percent of CCS-eligible children are also Medi-Cal eligible.

The pilot projects under the Bridge to Reform Demonstration Waiver are focusing on improving care provided to children in the CCS program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction and greater cost effectiveness, by integrating care for the whole child under one accountable entity. Existing state and federal funding will be used for the pilot projects, which are expected to serve 15,000 to 20,000 CCS eligible children. The positive results of these projects could lead to improved care for all 185,000 children enrolled in CCS.

The projects are a major component of the Bridge to Reform's goal to strengthen the state's health care delivery system for children with special health care needs. The pilot projects will be evaluated to measure outcomes for children served. DHCS will use the results of the evaluation to recommend next steps, including possible expansion.

Under a competitive bid contracting process utilizing a Request for Proposals (RFP) document, DHCS, with the input of the CCS stakeholder community solicited submission of proposals to test four specific health care delivery models for the CCS Program. These included an existing Medi-Cal Managed Care Organization (MCO); a Specialty Health Care Plan (SHCP); an Enhanced Primary Care Case Management Program (E-PCCM); and an Accountable Care Organization (ACO). DHCS received five proposals from the entities listed below.

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

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

Enrollment information:

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

Month	HPSM Enrollment Numbers	Difference
Prior Quarter December 2014	1,421	
January 2015	1,364	-57
February 2015	1,303	-61
March 2015	1,302	-1

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

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

<u>Health Plan San Mateo Demonstration Project (HPSM)</u>

Department Communications with HPSM
DHCS and HPSM conduct bi-weekly scheduled conference calls to discuss various issues, inclusive of those related to financial, information technology, and deliverable reporting.

Capitated Reimbursement Rates
The Department revised rates for 2013/14 and 2014/15. HPSM's adjusted capitated rates include physician fee increase required by Section 1202 of the Affordable Care Act, and changes as required by Senate Bill 78 and Assembly Bill 1422.

Contract amendment
A contract amendment was submitted to HPSM for review on 2/3/2015. Changes included: capitated rate revisions, carve-out of specific coagulation factors, redefined

definition of other health coverage, and correction of contract term.

DHCS worked to implement a 9D aid code which will allow CCS State-Only children to enroll in CCS DPs. The purpose is to be able to automate enrollment of CCS State-Only children into a CCS DP. [1] The 9D aid code for "CCS State-Only beneficiaries" is expected to be active Spring 2015.

Rady Children's Hospital of San Diego Demonstration Project

The Department has been working with Rady Children's Hospital of San Diego (RCHSD) towards implementing their CCS DP. Communications include review of contract documents (scope of work, reporting requirements, etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, and other operational matters.

Cost Utilization Data
On March 18, 2015, DHCS released cost utilization data to RCHSD for analysis.[2]

Capitated Rates
DHCS continued to work on rate development. Development of rates was delayed due to discussions regarding covered conditions, covered pharmaceuticals, and risk corridors.

Department Communications with RCHSD
The Department and RCHSD continued to participate in weekly conference calls. Topics discussed include:

- PHARMACEUTICALS / PBM
  RCHSD continued to pursue partnerships with several Pharmaceutical Benefits Management (PBM) firms; however, this was a challenge due to PBMs' reluctance to contract for services with an initial small population size. The DP will initially cover only hemophilia associated pharmaceuticals, such as blood factors, until they are able to secure a PBM.

- MEMBER HANDBOOK / EVIDENCE OF COVERAGE (MH/EOC)
  RCHSD submitted three (3) drafts of the Member Handbook (MH) and Evidence of Coverage (EOC) during this quarter. Pending minor edits, it is anticipated the

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

[2] On November 6, 2014, the Department developed and sent RCHSD another Data Library Confidentiality Agreement (DUA) to be reviewed and signed; which would allow the Department to release cost utilization data for three fiscal years (FY) FY 2011 to 2012 through FY 2013 to 2014 for the conditions Sickle Cell, Cystic Fibrosis, Hemophilia, and the additions of Acute Lymphoblastic Leukemia (A.L.L.) and Diabetes Type I and II [ages 1-10 yrs. of age (Diabetes)]. The Department returned to RCHSD a fully executed DUA on December 11, 2014.

MH/EOC will be finalized in May 2015.

- FINANCIAL REPORTS
  On February 12, 2015, RCHSD submitted financial reports for DHCS to review.

- PROVIDER MANUAL
  RCHSD continued to develop the provider manual to satisfy a Readiness Review component. RCHSD submitted the provider manual to DHCS during the last week of January 2015 and the Department provided comments to RCHSD in February 2015. As of March 30, 2015, DHCS is waiting for the next revision to the Provider Manual.

- SITE REVIEW DEPARTMENT STANDARDS
  RCHSD will collaborate with Healthy San Diego Site Review Committee to satisfy the site review Readiness Review requirement.

- MEMBER ELIGIBILITY FILE
  San Diego County, RCHSD Information Technology (RCHSD IT), and the Department discussed the "flow and process" of member eligibility files during this quarter. DHCS verified RCHSD IT could accept a "test" eligibility file and ensured the infrastructure worked appropriately.

- RCHSD READINESS REVIEW DELIVERABLES
  On July 2, 2014, RCHSD began submitting to DHCS for review their policies and procedures (P&Ps) as indicated in the Readiness Review document.[3] As of March 30, 2015, 63 out of 67 deliverables have been approved by the Department.

- EVALUATION METRICS
  On January 15, 2015, RCHSD submitted another draft of disease specific clinical evaluation criteria to DHCS that RCHSD would be conducting during the DP. On February 26, 2015, DHCS provided a revision to the draft evaluation/metrics to RCHSD for review. This revision included two clinical measures per covered diagnosis.[4]

- CONTRACT ITEMS
  During this quarter, contract terms discussed included: clarification of provisions in Exhibit E such as data certification, appeals process, financial working papers, plan versus provider, and clinical evaluation.

90-Day, 60-Day, and 30-Day Notices
DHCS is drafting 90, 60, and 30-Day notices to patients, providers, and the GMC plans. These notices will be used to communicate the disenrollment of eligible CCS DP clients from five Geographic Managed Care (GMC) plans into RCHSD CCS DP. Content

[3] SCD gave RCHSD a Readiness Review document indicating required deliverables (P&Ps) in Summer/Fall 2013.
[4] On November 24, 2014, RCHSD submitted initial outcomes, measures, and interventions to identify baseline data.

within the notices consist of the following:

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

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

Pilot Schedule

It is anticipated RCHSD CCS DP will be operational in fall 2015. It should be noted that the projected implementation time table is contingent on a number of factors including development and acceptance of capitated rates by RCHSD, the ability of the contractor to demonstrate readiness to begin operations, and approvals by CMS.

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

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

Milestones

Rady Children's Hospital, San Diego (RCHSD)
The Department and RCHSD have agreed hemophilia blood factors VIII, XI, and inhibitors will be covered by the pilot for an interim period until RCHSD is able to secure a PBM.

Complaints, Grievances, and Appeals

On February 10, 2015, HPSM submitted a "CCS Quarterly Grievance Report" for the fourth quarter, July - September 2014. The CCS Quarterly Grievances Report showed during the quarter that five grievances were received.

The Grievances Report further disseminates the types of grievances that are tracked and followed: Accessibility, Benefits/Coverage, Referral, Quality of Care/Service, and Other.

- Four grievances were designated as Quality of Care/Service and were coded as "Plan denial of treatment"; all were resolved in favor of the CCS Member.
- One grievance was labeled as "Other" and was resolved in favor of the CCS Member.

Consumer Issues:

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

On January 23, 2015, the RSAB held its second meeting. The focus was on the "Formation of Technical Workgroups". The following topics and documentation was presented at the January 23rd RSAB meeting:

- Vision for the CCS Program, Survey Results, and Technical Workgroup Topics
- CCS Program Components that are "Working Well"
- CCS Program Components that "Can Be Improved"
- Reflections about the Goals Identified for the CCS Program and CCS Population

Attached is the meeting materials link:
http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterials.aspx

On March 20, 2015, the RSAB had its third meeting. The focus was on the "CCS Models of Care". The following topics and documentation was presented at the March 20th RSAB meeting:

- Care Model Proposals
- Medical Therapy Program
- Current Models
- Overview of Existing Models
- Updates from Technical Workgroups

Attached is the meeting materials link:
http://www.dhcs.ca.gov/services/ccs/Pages/MarchMeetingMaterials.aspx

Technical workgroup (TWG) conference calls were held during this quarter and meeting material links follow:

- County / State Roles and Responsibilities TWG – March 25, 2015
http://www.dhcs.ca.gov/services/ccs/Pages/CountyStateRoles.aspx

- Data TWG – February 20, 2015; March 17, 2015
  http://www.dhcs.ca.gov/services/ccs/Pages/DataTechnicalWorkgroup.aspx

- Eligibility / Health Conditions TWG – March 12, 2015
http://www.dhcs.ca.gov/services/ccs/Pages/EligibilityandHealthCondition.aspx

- Health Homes / Care Coordination / Transitions TWG – March 26, 2015
http://www.dhcs.ca.gov/services/ccs/Pages/HealthHomeCare.aspx

- Provider Access and Provider Network TWG – March 18, 2015
http://www.dhcs.ca.gov/services/ccs/Pages/ProviderAccess.aspx

Financial/Budget Neutrality Development/Issues:

Health Plan of San Mateo (HPSM)

Financial Review
DHCS completed a fourth financial review on HPSM's DP quarterly reports; specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with 85%< being the target. Please refer to Attachment, Department of Health Care Services – Systems of Care Division, Health Plan of San Mateo: Plan Analysis.

Quality Assurance/Monitoring Activities:

On February 12, 2015, HPSM submitted contractual report, "Enrollment and Utilization Table". Please refer to the table below.

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

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

Report Name	Date Due	Received	Pending Review	SCD Approved
Provider Network Reports (Rpt #7)	01/30/2015	2/13/2015		YES
Grievance Log/Report (Rpt #7)	01/30/2015	2/2/2015		
Member Services Guide / Evidence of Coverage (Rpt #2)	01/30/2015	--		Online
Formulary Report (Rpt #2)	01/30/2015	--		Online
Quality Improvement Report (Rpt #2)	01/30/2015			
Quarterly Financial Statements (Rpt #7)	02/16/2015	2/15/2015	✓	
Report of All Denials of Services Requested by Providers (Rpt #6)	02/16/2015	--		

Evaluations:

Nothing to report.

Enclosures/Attachments:

Attached enclosure "California Children Services (CCS) Member Months and Expenditures" consisting of Number of Member Months in a Quarter, Number of Unique Eligibles Based on the First Month of Eligibility in the Quarter, and Expenditures Based on Month of Payment.

LOW INCOME HEALTH PROGRAM (LIHP)

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

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

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

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

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

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

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

DHCS continued working to obtain CMS approval for the revised county specific cost claiming protocols submitted by Alameda and San Bernardino LIHPs under Attachment G Supplement 1, Section K, Total Funds Expenditures of Other Governmental Entity, to add other entities that could provide CPEs for claiming purposes. On January 7, 2015, CMS denied the requested revisions to the Alameda and San Bernardino county specific cost claiming protocols. On February 26, 2015, DHCS requested that CMS reconsider their denial of the revisions to the two county specific cost claiming protocols.

DHCS continued working to obtain CMS approval for the revised Attachment G - Supplement 2 *Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health program-Claims Based on Capitation (*Attachment G - Supplement 2). On January 7, 2015, CMS notified DHCS that Attachment G - Supplement 2 was not approved. On February 13, 2015, DHCS requested that CMS reconsider their denial of Attachment G - Supplement 2.

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

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

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

The Department worked with each local LIHP to determine compliance with the Maintenance of Effort (MOE) contract requirement that total non-federal expenditures in each Demonstration Year meet or exceed the annual MOE amount through December 31, 2013.

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

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

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

- Designated Public Hospitals (DPHs) submitted their annual report for DY9.
- DHCS reviewed the DPHs' semi-annual and annual reports.

On February 27, 2015, CMS approved the revised Low Income Health Program Administrative Costs Claiming Protocol Implementation Plan which corrected the calculation error in the percentage of reallocated activities allowable for claiming. DHCS is beginning to process these administrative claims.

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

Consumer Issues:

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

- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition to health care coverage under Medi-Cal of individuals diagnosed with HIV, who had been receiving health care services through the Ryan White programs and had transitioned to a local LIHP prior to January 1, 2014. In addition, DHCS meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

- Weekly DHCS and California Department of Corrections and Rehabilitation for discussion on populations determined eligible for Medi-Cal and LIHP by the Department.

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

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
Health Care (Qtr.3)	$420,154	$420,154		DY 7	$840,308
	$2,500,898.89		$5,001,797.78	DY 8	$2,500,898.89
	$2,376,046.77		$4,752,093.54	DY 9	$2,376,046.77
Total	**$5,297,099.66**	**$420,154**	**$9,753,891.32**		**$5,717,253.66**

Quality Assurance/Monitoring Activities:

DHCS continued the contract compliance process with LIHPs. The Department requested and reviewed LIHPs' submissions to ensure compliance with their LIHP contracts, including the annual quality improvement reports for FYs 2011/12, 2012/13, and 2013/14. DHCS communicated with LIHPs to follow up and complete contract compliance reporting as necessary.

Enclosures/Attachments:
"LIHP Evaluation Design Progress Report"

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$0		$0		$0
(Qtr 2)	$44,250,000		$44,250,000	DY 10 (Jul-Sept)	$88,500,000
(Qtr 3)	$38,510,492		$38,510,492	DY 9	$77,020,984
(Qtr 3)	$73,750,002		$73,750,002	DY 10 (Oct-Dec)	$147,500,004
Total:	**$156,510,494**		**$156,510,494**		**$313,020,988**
DSRIP					
(Qtr 1)	$0	$0			$0
(Qtr 2)	$328,893,774	$328,893,774			$657,787,548
(Qtr 3)	$0	$0			$0
Total:	**$328,893,774**	**$ 328,893,774**			**$657,787,548**
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr1)	$381,935		$(477,266)	DY 6 (Oct-Jun)	$(95,331)
(Qtr1)	$15,520,725		$15,440,725	DY 9 (Jul-Jun)	$30,961,450
(Qtr1)	$48,721,450		$48,775,451	DY 10 (Jul-Sept)	$97,496,901
(Qtr 2)	$(8,369,990)		$(6,020,068)	DY 6 (Sept-Oct)	$(14,390,058)
(Qtr 2)	$79,804,676		$79,804,676	DY 10 (Jul-Dec)	$159,609,352
(Qtr 3)	$(2,171,254)		$(1,539,460)	DY 5 (Feb-Aug)	$(3,710,714)
(Qtr 3)	$(798,553)		$1,432,596	DY 6 (Sept-Jun)	$634,043
(Qtr 3)	$(6,858,168)		$(6,858,168)	DY 7 (Jul-Jun)	$(13,716,335)
(Qtr 3)	$12,088,794		$12,088,794	DY 10 (Oct-Dec)	$24,177,588
(Qtr 3)	$79,346,738		$79,346,743	DY 10 (Jan- Mar)	$158,693,480
Total:	**$ 217,666,353**		**$ 221,994,023**		**$ 439,660,376**

I. DESIGNATED STATE HEALTH PROGRAM (DSHP) UPDATE

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

approved claiming protocols.

This quarter, Designated State Health Programs claimed **$ 81,607,557** in federal fund payments for SNCP eligible services.

II. SAFETY NET CARE POOL UNCOMPENSATED CARE UPDATE

Expenditures may be made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received, furnished by the hospitals or other providers identified by the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.
This quarter, designated public hospitals received **$ 112,260,494** in federal fund payments for SNCP eligible services.

California Children's Services (CCS) Member Months and Expenditures

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

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

Report Number	Time Period	Number of Member Months in a Quarter	Number of Unique Eligibles Based on the First Month of Eligibility in a Quarter	Expenditures Based on Month of Payment
DY6, Q1	September – December 2010	551,505	138,443	$829,406,465
DY6, Q2	January – March 2011	406,113	135,693	$676,468,735
DY6, Q3	April – June 2011	404,674	134,774	$649,757,648
DY7, Q1	July – September 2011	408,149	135,612	$570,379,382
DY7, Q2	October – December 2011	403,452	135,812	$592,896,974
DY7, Q3	January – March 2012	405,879	136,489	$639,248,570
DY7, Q4	April – June 2012	409,451	137,496	$574,933,670
DY8, Q1	July – September 2012	404,973	135,775	$565,527,403
DY8, Q2	October – December 2012	409,169	137,698	$442,066,945
DY8, Q3	January – March 2013	426,875	142,507	$382,433,183
DY8, Q4	April - June 2013	457,711	152,598	$349,532,016
DY9, Q1	July – September 2013	449,582	149,612	$433,168,578
DY9, Q2	October – December 2013	457,645	153,488	$296,658,524
DY9, Q3	January – March 2014	463,509	154,851	$300,036,064
DY9, Q4	April – June 2014	471,221	157,788	$281,705,513
DY10, Q1	July – September 2014	478,266	160,331	$309,373,961
DY10, Q2	October – December 2014	483,945	162,656	$306,466,779
DY10, Q3	January – March 2015	487,153	163,267	$307,547,034