TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Eight   (07/01/12-06/30/13)
Fourth Quarter Reporting Period: 04/01/2013-06/30/2013

INTRODUCTION:

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

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

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

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

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

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

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

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

On June 28, 2012, CMS approved an amendment to the Demonstration to:
- Increase authorized funding for the Safety Net Care Uncompensated Care Pool in DY 7 by the amount of authorized but unspent funding for HCCI and the Designated State Health Programs in DY 6.
- Reallocate authorized funding for the HCCI to the Safety Net Care Uncompensated Pool for DY 7.
- Establish an HIV Transition Program within the DSRIP for "Category 5" HIV transition projects to develop programs of activity that support efforts to provide continuity of quality and coverage transition for LIHP enrollees with HIV.

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

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

Enrollment information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
Apr 2013 – Jun 2013

County	Total Member Months
Alameda	89,126
Contra Costa	47,138
Fresno	68,409
Kern	54,689
Kings	7,446
Los Angeles	583,781
Madera	7,251
Riverside	92,401
San Bernardino	109,039
San Francisco	52,142
San Joaquin	50,027
Santa Clara	66,765
Stanislaus	30,914
Tulare	31,742
Sacramento	111,857
San Diego	117,248
Totals	**1,519,975**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
Apr 2013 – Jun 2013

County	Total Member Months
Alameda	36,958
Contra Costa	13,732
Fresno	19,310
Kern	11,819
Kings	1,665
Los Angeles	177,295
Madera	1,684
Marin	18,321
Mendocino	17,120
Merced	45,261
Monterey	43,586
Napa	13,106
Orange	320,643
Riverside	28,468
Sacramento	32,658
San Bernardino	30,073
San Diego	34,813
San Francisco	21,114
San Joaquin	11,711
San Luis Obispo	24,542
San Mateo	65,834
Santa Barbara	43,423
Santa Clara	28,671
Santa Cruz	28,764
Solano	54,694
Sonoma	49,004
Stanislaus	4,596
Tulare	8,438
Ventura	76,692
Yolo	23,772
Totals	**1,287,767**

Enrollment (April 2013 – June 2013)
During the quarter, mandatory SPDs had an average choice rate of 53.37%, an auto-assignment default rate of 30.93%, a prior-plan-default rate of 1.09%, and a transfer

rate of 14.17%. In June, overall SPD enrollment in Two-Plan and GMC counties was 506,600 (point-in-time), a 0.16% increase over March's enrollment of 505,792. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY8-Q4 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

With funding from the California HealthCare Foundation (CHCF), Medi-Cal Managed Care Division (MMCD) engaged work with a vendor, Navigant, to create an online dashboard for the Medi-Cal managed care program. Navigant and MMCD continued their work to create this dashboard during the quarter. Once completed, the dashboard will help DHCS and its stakeholders to better observe and Managed Care Plan (MCP) activities on all levels: statewide, by managed care model (i.e., COHS, GMC, and Two-Plan), and within an individual MCP. It will include metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, finances, care coordination, and continuity of care. It will also stratify reported data by beneficiary populations including Medi-Cal-only SPDs.

To help ensure the success of the dashboard, MMCD and CHCF worked during the quarter to form a Technical Advisory Group (TAG) that represents a diverse group of industry experts, including MCP and provider representatives, consumer groups, technical experts, and other stakeholders. The TAG met in-person on May 8, 2013 to discuss the goals of the dashboard and to provide input on which proposed measures to include on the dashboard or future iterations of it. The first internal iteration of the dashboard will be finalized by the end of July 2013.

Operational/Policy Issues:

Network Adequacy
Between April 2013 and June 2013, the Department of Managed Health Care (DMHC) completed a provider network review for all Two-Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provide DHCS with an updated list of providers SPDs may contact to receive care. DMHC conducted a thorough review of each MCP's provider networks and identified no access-to-care issues.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee
On May 30, 2013, the DHCS Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened and discussed the following items:

Coordinated Care Initiative
DHCS has finalized its memorandum of understanding with the Centers of Medicare and Medicaid Services (CMS) to implement a "Demonstration to Integrate Care for Dual Eligible Beneficiaries" (the Coordinated Care Initiative [CCI]). DHCS has received a draft contract from CMS to establish agreements between DHCS, CMS, and each of the

participating Medicare-Medicaid Plans (MMPs).[1] The National Opinion Research Center (NORC) has been engaged by CMS and DHCS to help states ensure the readiness of their demonstration sites to implement projects like California's CCI. DHCS is talking with community-based organizations about contracting with the State to establish an ombudsman program similar to DMHC's ombudsman program, which receives consumer complaints and works to resolve them. DHCS is considering establishing an interagency agreement with DMHC to expand the program so each demonstration county has its own ombudsman office for dual eligibles.

Recently, DHCS distributed information on Dual Eligible Special Needs Plans (SNPs) to solicit stakeholder comments. Existing SNPs will continue to serve dual eligibles through 2014. The goal is to have dual eligibles transition into managed care, but if they are in a SNP and want to remain, they may remain enrolled in the SNP. However, members may not disenroll from one SNP to enroll into another SNP.

CMS and the State agreed to a 3-month delay for passive enrollment to begin, and then begin passive enrollment by each enrollee's birthdate. Los Angeles County has 270,000 total eligible members, and CMS established a cap of 200,000 of those eligibles who may be enrolled. DHCS will issue a draft enrollment policy for Los Angeles County in the near future. DHCS will post drafts of the notices of enrollment and will take comments on them.

Medi-Cal Managed Care Expansion to Rural Counties
DHCS announced the selection of Anthem Blue Cross and California Health and Wellness Plan as the selected MCPs in the 18 contiguous rural counties. At the decision of the Director, the seven northern counties were excluded from the Request for Application (RFA). DHCS awarded Partnership Health Plan as the MCP for the seven northern counties under the County Organized Health System (COHS) model. Lake, San Benito, and Imperial Counties were not included within the RFA. Lake County was awarded to Partnership Health Plan as part of the COHS model. DHCS is currently in discussions with CMS on the appropriate approach for San Benito and Imperial Counties. Implementation for the eight COHS Model counties is targeted for September 1, 2013, and implementation for the 18 Regional Model counties will begin November 1, 2013.

Managed Care Monitoring
Slides for the presentation provided at the meeting are available online at:
http://www.dhcs.ca.gov/Documents/MMCDSACMay2013Dashboard.pdf.

Policy Updates
DHCS submitted an enrollment verification plan to CMS to describe how the State will verify data it receives during the duals demonstration's eligibility process. DHCS has received comments from CMS and will incorporate them into the verification plan. Subsequently, DHCS will share the plan with its stakeholders. The Department of Social Services (DSS) has developed a joint enrollment application and shared it with

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[1] Complete information on the demonstration is available at: http://www.calduals.org/.

CMS. Once it is finalized, DSS will also share this enrollment application with its stakeholders. DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL I 13-03) that provides counties with guidance on the Affordable Care Act (ACA), including the single, streamlined application status and changes to the requirements regarding modified adjusted gross income (MAGI).[2] A letter is being prepared that will provide overall policy guidance to counties and a link to website updates. DHCS is working on trailer bill language on implementation of ACA.

Full documentation from the meeting can be found at:
http://www.dhcs.ca.gov/Pages/May30,2013SACMeeting.aspx.

Office of the Ombudsman (April 2013 – June 2013)
MMCD's Office of the Ombudsman experienced a slight decrease in customer calls between the periods January–March 2013 (DY8-Q3) and April–June 2013 (DY8-Q4). During DY8-Q3, the Ombudsman received 14,911 total calls, of which 5,176 concerned mandatory enrollment, and 1,662 were from SPDs. In DY8-Q4, the Ombudsman received 15,090 total calls, of which 4,998 concerned mandatory enrollment, and 1,523 were from SPDs. This represents a 1% increase in total calls, a 3% decrease in calls regarding mandatory enrollment, and an 8% decrease in calls regarding mandatory enrollment from SPDs.

For DY8-Q4, 0.05% of SPD and 0.03% of non-SPDs calls concerned access issues. This is a small decrease from DY8-Q3, during which 0.19% of SPD calls and 0.03% of non-SPD calls were related to access issues.

The number of State Hearing Requests decreased for all measures. The high volume in the previous quarter might have been associated with a special notice that DHCS sent to certain individuals who filed MERs, offering them the right to file a State Hearing. Total State Hearing Requests decreased from 1,075 during DY8-Q3 to 675 in DY8-Q4. The percentage of requests that were from SPDs also decreased from 77% to 67%. The number of requests regarding the denial of eligibles' requests for exemption from mandatory enrollment into managed care also decreased from 589 during DY8-Q3 to 224 in DY8-Q4. The percentage of those requests from SPDs decreased from 84% to 61%. The Ombudsman received no State Hearing Requests related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachment "DY8 Q4 Ombudsman Data."

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[2] MEDILs are available at: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/2013MEDILs.aspx.

Medical Exemption Requests (April 2013 – June 2013)
DHCS continued to focus a significant amount of time during this quarter on processing Medical Exemption Requests (MERs) and Emergency Disenrollment Requests (EDERs) for SPDs and other beneficiaries affected by the two errors related to the processing of MERs. Despite efforts to address the high volume of MERs by reprioritizing staff responsibilities and focusing on streamlining and automation, the number of outstanding MERs continued to increase. MMCD has requested assistance from other DHCS divisions to assist in the review of MERs by assigning designated nurses to review MERs. Discussions are ongoing and MER training of the nurses is scheduled.

DHCS also continued to work on a project to create an electronic system for clinical staff to process MERs. This electronic system will decrease the time the clinical staff requires to process MERs, decrease the potential for errors, and streamline the reporting process. Ongoing testing of the electronic system was conducted in June. The electronic system is scheduled to launch in July 2013 with staff training occurring during the same month.

In 2012, DHCS established a MER Workgroup that includes key advocates, stakeholders, and staff members from DHCS, and the State Legislature. The purpose of the MER Workgroup is to revise the MER application form, draft new informing materials, create call-center scripts, and improve the MER process and its efficiency. To achieve these goals, DHCS continues to meet at least once each month with the MER Workgroup. Ongoing issues for discussion included publishing a MER Continuity of Care APL, revising beneficiary notifications (such as approval and denial letters), clarifying MER denial codes, and revising the MER form. The MER Workgroup is instrumental in providing important and valuable feedback.

Health Risk Assessment Data (October 2012 – December 2012)
According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs newly enrolled 31,177 SPDs between October 2012 and December 2012. Of those, MCPs stratified 10,681 (34.3%) as high-risk SPDs and 20,491 (65.7%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 77.3%, and, of those contacted, 26.4% completed a Health Risk Assessment Survey. Of the low-risk SPDs, MCPs contacted 53.1%, and, of those contacted, 25.9% completed a Health Risk Assessment Survey. After the Risk Assessment Surveys were completed, MCPs determined 3,650 SPDs to be in the other risk category, which is 11.7% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2012 Risk Data."

Continuity of Care Data (January 2013 – March 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,724 continuity of care requests between January and March 2013. Of these, MCPs approved 1,566 requests (90.8% of all requests); held 4 requests (0.2%) in process; and denied 154 requests (8.9%). Of the requests denied, over a quarter of the requests (27.9%) were because the provider and MCP could not agree to a payment rate. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2013 Continuity of Care."

Plan-Reported Grievances (January 2013 – March 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,720 grievances between January and March 2013. Of these grievances, 0.8% were related to physical accessibility, 13% were related to access to primary care, 6.4% were related to access to specialists, 1.0% were related to out-of-network services, and 78.8% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2013 SPD Grievance."

MERs Data (January 2013 – March 2013)
During the period January 2013 through March 2013, 2,230 SPDs submitted 2,668 MERs, which is on average 1.2 MERs per SPD who submitted a MER. MMCD approved 1,301, denied 350, and determined that 1,017 were incomplete. The top five MER diagnoses were Complex (1,099), Cancer (505), Neurological (294), Transplant (290), and Dialysis (237). Summary data is available in the attachment "Q1 2013 MERs Data."

Health Plan Network Changes (January 2013 – March 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs added 908 primary care physicians (PCPs) and removed 1,201 PCPs across all networks, resulting in a total PCP count of 21,058. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2013 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (April 2013 – June 2013)
DHCS engaged a consultant through funding from the Blue Shield of California Foundation (BSCF) to help the State identify an appropriate structure for the evaluation of the transition of the SPD population to managed care. The BSCF consultant will review all data collected to date pertaining to the transition and compose a list of recommended questions to include in the evaluation through interviews with external stakeholders and advocates, health plans, Legislative staff, and individuals employed by DHCS. The consultant is on schedule to issue a report in the summer of 2013.

<u>Encounter Data (April 2013 – June 2013)</u>
During the reporting period, DHCS established the Encounter Data Quality Unit (EDQU) within MMCD, which is primarily responsible for implementing and maintaining the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP, which is currently under development, is DHCS's plan for measuring encounter data, tracking it from submission to its final destination in the Department's data warehouse, and reporting on data quality internally and externally. To implement this plan, EDQU has started to develop metrics that will objectively measure the quality of MCP-submitted encounter data in the dimensions of completeness, timeliness, reasonability and accuracy. EDQU has also started to identify specific MCOs with missing encounter data and work with them to resolve the deficiencies. Although these efforts do not specifically target SPDs, improving the quality of the Department's encounter data will enable better monitoring of the services and care provided to this population.

<u>Outcome Measures and Avoidable Hospitalizations (April 2013 – June 2013)</u>
DHCS employs multiple strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations, for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures
DHCS is responsible for ensuring that HEDIS reporting complies with the requirements of the Section 1115 Medicaid Waiver. HEDIS results will be reported by categories for MCPs and counties. In November 2012, DHCS released the final HEDIS measures for 2013 and the final SPD stratification method for MCPs to use for selected measures. DHCS is finalizing the annual update to the quality and performance improvement program requirements for 2013, and anticipates its release and posting to the MMCD website in September 2013 (available at this link:
http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx).

Consumer Assessment of Healthcare Providers and Systems
During calendar year (CY) 2013, DHCS, through its External Quality Review Organization (EQRO), administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. During the period October 2012 through December 2012, DHCS and the EQRO developed three additional questions for adults and three additional questions for children that focus on the needs of the SPD population during the period of the survey. This will allow comparative analysis of beneficiary satisfaction between SPDs and the Medi-Cal Managed Care population as a whole.

In February 2013, DHCS mailed 73,260 CAHPS Surveys to adult members and parents or caretakers of child members. Survey results will include member responses in four areas:
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often.

Additionally, the results of five composite measures will reflect member experiences with:
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making.

The survey closed in May with a response rate of 35% for adults and 39% for children. The final report will be published in January 2014.

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

In 2012, MCPs submitted their collaborative all-cause readmissions (ACR) QIP proposals, which included their historical CY 2011 data, to MMCD, MCP QIP proposals were reviewed by MMCD and validated by HSAG.

During the first quarter of CY 2013, MCPs submitted documentation of the barrier analyses and interventions to DHCS and HSAG for review. All MCPs participated in individualized technical assistance calls to discuss their barrier analyses and planned interventions with DHCS and HSAG and receive feedback to optimize their ability to achieve improved outcomes. Six MCPs were required to revise and resubmit their barrier analyses and interventions. Follow-up technical assistance calls were held with each of these plans from May to June, 2013

HSAG conducted a HEDIS Compliance Audit[3] of the MCPs CY 2012 measurement period rates from February 2013 to April 2013, which included the collaborative ACR QIP outcome measure. All MCPs will submit their ACR QIPs' baseline data for CY 2012 in September 2013.

In June 2013, HSAG submitted an interim report that detailed the activities of the ACR Collaborative through the study design phase of the QIP.

Case Management and Coordination of Care Survey
DHCS requires its MCPs to develop and implement processes to ensure the provision of case management (CM), care coordination, and continuity-of-care (COC) services to their members. DHCS monitors the CM and COC services provided by MCPs through an annual electronic survey to identify trends in services and/or resources related to

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[3] National Committee for Quality Assurance: http://www.ncqa.org/tabid/59/Default.aspx.

case management and coordination of care among the MCPs. DHCS recently compiled and analyzed results from CY 2012 and compared the data with CY 2011 baseline data. The baseline survey data was for the year prior to SPD enrollment; it provided information about MCP's CM and COC activities and services before the start of mandatory SPD enrollment. Preliminary results of statewide data indicate the following:

- 23% increase in SPD enrollment between CY 2012 and 2011 (baseline).
- 16% increase in the number of members enrolled in Complex Case Management (CCM) each month with completed Individual Care Plans.
- 43% decrease in the number of members discharged from CCM each month.
- The top reason for failure to meet care plan goals continues to be "member compliance."

State Audits
DHCS and DMHC entered into an interagency agreement to conduct financial audits, network adequacy assessments, and medical surveys for the SPD population on behalf of DHCS. The interagency agreement was set to expire on June 30, 2013; however, DHCS and DMHC came to an agreement to extend the interagency agreement to June 30, 2014. Ongoing discussions continue regarding coordination efforts between the departments.

Utilization Data (April 2012 – June 2012)
During the period April 2012 through June 2012, DHCS enrolled 512,230 unique SPDs into MCPs in Two-Plan and GMC counties, a 12.1% increase in enrollment from the previous quarter. However, services provided to SPDs varied in increases and decreases:

- 1.58% increase in emergency room (ER) claims,
- 17.4% increase in ER visits,
- 21.3% decrease in outpatient claims, and
- 4.9% decrease in outpatient visits.
- 23.8% increase in pharmacy claims,
- 17.2% increase in hospital admissions,
- 1.8% increase in inpatient claims,
- 18.4% increase in inpatient visits.

A bar graph depicting these changes and those described below is available in the attachment "DY8 Q4 Utilization Data."

Regarding ER services for these 512,230 unique SPDs:

- 13.2% (67,756) visited the ER, a 2% increase compared to the ratio to the total population for the previous quarter (59,211).
- 14.4% (8,545) more SPDs visited the ER than during the previous quarter.
- 17.4% (17,094) more ER visits were made compared to the previous quarter.
- Each SPD visited the ER an average of 1.7 times, a 2.6% increase in average visits compared to the previous quarter.

- 1.5% (2,875) more ER claims were generated compared to the previous quarter.
- Each SPD generated an average of 2.94 ER claims, an 11.3% decrease in average claims compared to the previous quarter.

Regarding pharmacy services for these 512,230 unique SPDs:

- 67.7% (346,724) accessed pharmacy services, a 3.2% increase compared to the ratio of the total population for the previous quarter (299,442).
- 15.8% (47,282) more SPDs accessed pharmacy services than during to the previous quarter.
- Each SPD generated an average of 12.91 claims for pharmacy services, a 6.9% increase over the previous quarter (12.07 claims).

Regarding outpatient services for these 512,230 unique SPDs:

- 42.5% (217,948) accessed outpatient services, a 4% decrease compared to the ratio to the total population for the previous quarter (202,503).
- 7.6% (15,445) more SPDs accessed outpatient services, than during the previous quarter.
- 4.9% (54,262) fewer visits to outpatient medical were made than during the previous quarter (1,112,741).
- 21.3% (486,765) fewer outpatient services claims were generated compared to the previous quarter (2,280,904).
- Each SPD generated an average of 4.86 outpatient medical visits, an 11.6% decrease over the previous quarter (5.49 visits).
- Each SPD generated an average of 8.23 outpatient claims, a 26.9% decrease from the previous quarter (11.26 claims).

Regarding inpatient services for these 512,230 unique SPDs:

- 4.5% (23,048) accessed inpatient services, a 1.3% decrease compared to the ratio to the total population from the previous quarter (20,818).
- 10.7% (2,230) more SPDs accessed inpatient services compared to the previous quarter.
- 18.4% (8,489) more visits to inpatient services were made compared to the previous quarter (46,210).
- 1.8% (1,216) more claims for inpatient services were generated compared to the previous quarter (67,530).
- Each SPD generated an average of 2.37 medical visits, a 6.9% increase from the previous quarter (2.22 visits).
- Each SPD generated an average of 2.98 claims, an 8% decrease from the previous quarter (3.24 claims).

Regarding hospital admissions for these 512,230 unique SPDs:

- 5.3% (27,032) were admitted to a hospital, a 0.1% increase compared to the ratio to the total population from the previous quarter (24,075).

- 12.3% (2,957) more SPDs were admitted to a hospital than during the previous quarter (24,075).
- Each SPD generated an average of 1.69 claims for hospital admissions, a 4.3% increase from the previous quarter (1.62 claims).

For the top ten services accessed, MCPs submitted 10,259,867 total claims, a 15.4% increase over the previous quarter. As shown in the table below, the number of claims for services decreased in most categories, except in "Other Clinics," which increased, and two categories were new while two dropped off the list. "Prescribed Drugs" remained the most-accessed service, followed by "Lab/X-Ray" and "Physicians," respectively. "Outpatient Hospital" dropped to fifth from fourth. "Other Services" dropped to seventh from fifth. "Rural Health Clinics" dropped to tenth from sixth. "Hospital: Inpatient Other" dropped to eighth from seventh. "Other Clinics" rose from eighth to fourth. "Transportation" and "Rehab Services" dropped off the list. "Targeted Case Management" and "Personal Care Services" were new to the list in ninth and sixth positions respectively. A bar chart showing the changes between the two quarters is available in the attachment "DY8 Q4 Utilization Data."

Change in Ranking of Top Ten Services Accessed by Newly Enrolled SPDs

	Quarter 3: Jan 2012 – March 2012	Quarter 4: Apr 2012 – Jun 2012
1	Prescribed Drugs	Prescribed Drugs
2	Lab/X-Ray	Lab/X-Ray
3	Physicians	Physicians
4	Outpatient Hospital	Other Clinics
5	Other Services	Outpatient Hospital
6	Rural Health Clinics	Personal Care Services
7	Hospital: Inpatient Other	Other Services
8	Other Clinics	Hospital: Inpatient Other
9	Transportation	Targeted Case Management
10	Rehab Services	Rural Health Clinics

For the top ten diagnosis categories, MCPs submitted data for a total of 1,978,758 encounters. Mental Illness was in the top rank with 28.7% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 14%. In the third position, "Diseases of the circulatory system" was 10.1%. The remaining seven categories ranged from 9.2% to 3.9% of the encounters.

Quarterly aggregate and MCP-level data can be found in the attachment "DY8 Q4 Utilization Data."

Enclosures/Attachments:

- "DY8 Q4 Defaults Transfers 2Plan GMC"
- "DY8 Q4 Ombudsman Data"
- "Q4 2012 Risk Data"
- "Q1 2013 Continuity of Care"
- "Q1 2013 SPD Grievance"
- "Q1 2013 MERs Data"
- "Q1 2013 Network Adequacy"
- "DY8 Q4 Utilization Data"

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: 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

Enrollment information:

The monthly enrollment for Health Plan San Mateo (HPSM) is shown in the table that follows. Please note that these numbers are based on the MIS/DSS system and not from the monthly FAME file from MEDs. At this time, Systems of Care Division (SCD) has requested the monthly FAME file for enrollment confirmation purposes.

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

Outreach/Innovative Activities:

On April 22, 2013 the Department of Health Care Services (DHCS) upper management and Division management met in-person with HPSM and County Staff. The meeting consisted of the following:

- Determine how the California Children's Services (CCS) implementation process was coming along.
- Centers for Medicare & Medicaid Services (CMS) had asked on a prior call if there were any concerns among the beneficiaries being transferred to the pilot. SCD spoke with HPSM at the meeting and discovered that HPSM and County Staff had developed a "Frequently Asked Questions" document for individuals who were transitioning. This helped alleviate the concerns of the beneficiaries and provided consistent information from both the HPSM and CCS programs.

Operational/Policy Issues:

DHCS continues to collaborate with all five Demonstration entities relative to issues and challenges specific to each of the model locations. A challenge that impacts four of the five Demonstrations is access to cost utilization data required by these entities to adequately determine 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.

HPSM Demonstration Project

The CCS Demonstration for HPSM became operational on April 1, 2013.

Department Communications with CMS
The Department participates in pre-scheduled reoccurring meetings with CMS which includes CMS Region IX staff, CMS Central Office staff, and other DHCS organizations

who are participating in other components of the 1115 Bridge to Reform Waiver. The Department's SCD also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Assessment Tool
- HPSM has developed a draft Assessment Tool that they have implemented since from the start of the operation period (April 1, 2013).
- HPSM used the DHCS contract as the foundation when designing the proposed Assessment Tool.
- DHCS will provide ~15 elements that must be incorporated within HPSM's Assessment Tool.
- HPSM's foresight is to link the Assessment Tool to individual care plans. HPSM plans to complete Individual Comprehensive Assessments (ICA) within one year and on annual basis and hopes to link the ICAs to preliminary and chart reviews.

Rady Children's Hospital of San Diego (RADY) Demonstration Project

Department Communications with RADY
DHCS has provided two contract versions to RADY and has exchanged contract language changes with RADY. DHCS has also been engaged in numerous discussions and conference calls with RADY regarding issues associated with access to cost utilization data, clarification of the CCS population to be covered, organizational structure, staffing etc.

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

On May 16, 2013, DHCS management received email communication from RADY regarding what ICD-9 codes should be used in grouping the following conditions: Cystic Fibrosis, Sickle Cell, and Hemophilia.

Children's Hospital Orange County (CHOC) Demonstration Project

Department Communications with CHOC and Cal Optima
DHCS has provided a draft contract version to Cal Optima on February 15, 2013. Cal Optima requested ten (10) health conditions be included in the next contract version. DHCS has also engaged in numerous discussions and conference calls with CHOC and Cal Optima regarding issues associated with access to cost utilization data, confirmation of 10 health conditions, resolving the Knox-Keene issue, etc.

Department Communications with MMCD
The next CCS pilot contract anticipated to begin with CHOC through a subcontract with Cal Optima. DHCS currently has a contract with Cal Optima which will be amended to include all requirements of the Demonstration Project. This amendment is currently being developed. On April 17, 2013 MMCD received proposed language changes to their existing MMCD Cal Optima 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.

Pilot Schedule

DHCS is projecting that the four pilot models will be phased in according to the general time table provided below.
- Rady Children's Hospital of San Diego County (RADY) – 2013 (September - November)
- Los Angeles Care Health Plan (LA Care) – 2014
- Children's Hospital of Orange County (CHOC) – 2014
- Alameda County Health Care (Alameda) – 2014

It should be noted that the projected implementation time table for each of the Demonstration Projects is contingent on a number of factors including acceptance of reimbursement rates by the contracting entity, the ability of the contractor to demonstrate readiness to begin operations, and approval of the contract by CMS.

Additionally, DHCS has had numerous conference calls with each of the awardees in this quarter to discuss challenges or updates.

- RADY - Providing claims data to RADY 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.

- CHOC – 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.

- LA Care - 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.

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.

Operational Issues

Data Library Confidentiality Agreement / Rates with Awardees
The SCD was required by DHCS's Office of Legal Services (OLS) to address a few items that were left out of the original CCS Capitation Rate Data Agreement package. On June 21, 2013 an email was sent to each of the Contractors were asked to sign and return a two page Addendum to the Capitation Rate Data Library Confidentiality Agreement (Addendum). The Addendum is to be added to the original agreement. There were no changes to the original agreement or any of the exhibits. The addendum specifically addressed the following:

- Instructions for data destruction at the end of the use period
- An agreement end date
- Addendum reference and link to original exhibits A, B, and C.
- Identification of a Data Custodian, associated with the Contractor's location.
- Signature block for a DHCS representative

LA Care
- On April 9, 2013, LA Care returned to the SCD a signed Capitation Rate Data Library Confidentiality Agreement (Agreement) which allows DHCS to release cost utilization data to the Demonstration contractor and complies with DHCS's HIPAA security and confidentiality requirements.[4]
- April 18, 2013, email correspondence regarding which data elements to include and zip codes to use in the analysis (LA).

Cal Optima / CHOC
- Email correspondence on April 11th Cal Optima regarding language changes in the Agreement
- On May 20th, Cal Optima emailed their proposed changes to the Data Library Confidentiality Agreement for DHCS to review.
- On June 12, 2013, Cal Optima returned to the SCD a signed Agreement which allows DHCS to release cost utilization data to the Demonstration contractor and complies DHCS's HIPAA security and confidentiality requirements.

RADY
- On April 10, 2013 Email correspondence from RADY, clarification of the SSA agreement regarding site visits. Management response is it does not apply; we will not do a site visit to ensure compliance.
- On May 6, 2013 received an email containing RADY's draft changes to the Agreement.
- On May 22 DHCS received a detailed description of the Personal Controls that RADY employs that meets the requirements of the Department's BAA.

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[4] On March 6, 2013, the Department developed and sent to the four Demonstration contractors a Capitation Rate Data Library Confidentiality Agreement to be reviewed and signed. As of March 31, 2013, no Data Library Confidential Agreements were returned to the Department.

- On May 30, 2013, RADY returned to the SCD a signed Agreement which allows DHCS to release cost utilization data to the Demonstration contractor and complies with DHCS's HIPAA security and confidentiality requirements.

Rates with Consultant Mercer
- On April 5 – Telephone conversation with Mercer to be consultant for DHCS to advise how to pull the data for those Awardees who return a signed Data Library Confidentiality Agreement.
- On April 18, 19, and May 3, email exchange regarding data layout, caseload counts, and caseload fields.

Milestones

Knox-Keene
- CHOC will be participating with Cal Optima – Knox-Keene issue resolved.
- In May 2013, DHCS management has confirmed with RADY which ICD-9 codes should be used in grouping the following conditions: Cystic Fibrosis, Sickle Cell, and Hemophilia.

Consumer Issues:

On May 30, 2013, DHCS convened an 1115 Waiver Stakeholder Advisory Committee (SAC) meeting in Sacramento. The meeting included a CCS Demonstration briefing document of the CCS pilots and is available at:
http://www.dhcs.ca.gov/Documents/DHCSProgramUpdates-SACMay302013.pdf

Meeting agenda and materials can be found at:
http://www.dhcs.ca.gov/Documents/FINAL-May30SACAgenda.pdf
http://www.dhcs.ca.gov/Pages/DHCSStakeholderAdvisoryCommittee.aspx

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

An interagency agreement with UCLA to provide program evaluation of the Demonstration Project, as required by the CMS 1115 Waiver Standard Terms and Conditions as well as Senate Bill 208, is currently being developed and is expected to be completed soon. This interagency agreement addresses the Scope of Work and budget detail items for the evaluation. The 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.

UCLA will focus the evaluation on answering some or all of the following questions:

- 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?

On May 13, 2013, a conference call between UCLA, HPSM, San Mateo County, UCSF, Stanford, and SCD took place and dealt with numerous topics such as; data, proposed site visits, etc. More detail regarding these topics are as 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 will conduct site visits in June/July 2013
- UCLA proposed for the site visit to create a meeting schedule 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)

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.

Enrollment Information:

Quarterly LIHP enrollment and applicant reports, and the grievances and appeals report will be submitted to CMS in a separate note.

Outreach/Innovative Activities:

The University of California Los Angeles Center for Health Policy Research (UCLA) released policy notes entitled "*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*". These policy notes can be accessed via:
http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1191
http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1192

DHCS began planning for the LIHP Conference, "At the Forefront: LIHP Transition Prepares California for Health Care Reform" to be held on August 14-15, 2013, at the Sacramento Convention Center.

Operational/Policy Issues:

The Centers for Medicare & Medicaid Services (CMS) approved Los Angeles County specific claiming protocol on April 16, 2013. Alameda County specific claiming protocols were approved by CMS on April 19, 2013. Sacramento County specific claiming protocols were approved by CMS on May 10, 2013. The specific claiming protocols for Tulare County and County Medical Services Program (CMSP) were approved by CMS on June 5, 2013.

DHCS-LIHP participated in a panel discussion of UCLA evaluation data at a UCLA convening, "Progress Towards Building the Bridge to Reform: Lessons Learned from the LIHP Convening on May 9, 2013."

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.

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.

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 accepted the upper income limit increase for San Francisco County from 25 percent to 133 percent of the Federal Poverty Level (FPL) effective June 28, 2013 and began discussions with Monterey County on a possible upper income limit increase for

their LIHP.

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.

DHCS submitted the draft Attachment J, administrative cost claiming protocol to CMS on June 24, 2013.

The following program policy letters (PPLs) continued to be in development during the quarter:

- LIHP Local Appeal Process and State Fair Hearings Process
- LIHP Inmate PPL revisions

DHCS originally approved an enrollment cap for the 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. This means that enrollment to this local LIHP is closed through the end of the program.

Currently 16 of 19 operational local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state and county populations determined eligible for LIHP by DHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

CMS is in the process of approving the capitated rate amendments for eight LIHPs (Alameda, Los Angeles, Kern, Riverside, San Bernardino, San Francisco, San Mateo, and Santa Clara). DHCS is working on the development of the capitated rate payment process and procedures.

DHCS continues to work with the California Department of Public Health, Office of AIDS (OA), to develop program requirements and policies to transition eligible Ryan White clients to LIHP. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- 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 from OA.

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

- The interaction of LIHP redeterminations and LIHP 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 Medi-Cal plan enrollment.

The project team 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 last year.

Consumer Issues:

DHCS continues to conduct and/or participate in the following stakeholder engagement processes:

- On June 7, Bob Baxter, Chief of DHCS's LIHP Implementation Section participated as a panel member at the Community Clinic Association of Los Angeles County (CCALAC) Policy Café, in Los Angeles. DHCS staff and representatives of the UCLA were invited to participate in the Policy Café by Louise McCarthy, Master of Public Policy, President and Chief Executive Officer of CCALAC. The subject of the panel discussion was the impact of the LIHP transition on community clinics in Los Angeles County.

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

- Weekly teleconferences with the local LIHP counties to address important questions relating to the LIHP program and transition activities.

- Quarterly teleconferences with advocacy groups to address questions and concerns regarding the LIHP program.

- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition of individuals diagnosed with HIV and receiving health care services through the Ryan White programs, to health care coverage under LIHP and Medi-Cal. In addition, the LIHP Division meets with

OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

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

- Weekly teleconferences with the Attachment J Workgroup continued throughout the quarter. The workgroup contributed to the draft Attachment J protocol, draft Attachment J Implementation Plan, draft Training Plan and additional supporting documents. DHCS anticipates these will be submitted to CMS in the following quarter.

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

Financial/Budget Neutrality:

During the quarter, the first DSRIP Category 5 HIV Transition projects incentive payments were made in the amount of $54,592,365.56. These expenditures were processed by DHCS Safety Net Financing Division, and are reported in the financial section of the Division's 1115 Waiver Quarterly Report for this quarter.

LIHP Division Payments					
Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
CDCR (Qtr 4)	$6,211,235	$0.00	$12,422,471	DY 7	$1,181,316
				DY 8	$5,029,919
Health Care (Qtr 4)	$322,216,344	$0.00	$644,432,688	DY 7	$105,710,843
				DY 8	$216,505,501
Administrative (Qtr 4)	$25,142,857	$0.00	$50,285,714	PY1	$15,807,937

LIHP Division Payments					
Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
				PY2	$2,802,379
				PY3	$1,724
				DY7	$6,530,816
Total	$353,570,436	$0.00	$707,140,873		$353,570,436

Quality Assurance/Monitoring Activities:

DHCS collaborated with UCLA in developing reporting procedures and correcting data for reports to monitor and measure the effectiveness of the local LIHPs. UCLA developed a new reporting tool designed to help resolve minor reporting issues that LIHPs were experiencing in reporting monthly enrollment data. The new tool has the capability to track data submitted and provides the ability to thoroughly review the data prior to submission to reduce data entry errors in reports.

DHCS continues to monitor the quarterly grievances and appeals reports from the local LIHPs and follows up with them on any potential program compliance problems affecting LIHP enrollees' access to program services.

Enclosures/Attachments:

UCLA quarterly progress report for DY8 Q4 regarding the implementation of the LIHP Evaluation Design.

FINANCIAL/BUDGET NEUTRALITY

Payment Type	FFP Payment FFP Payment	Other Payment (IGT)	(CPE) (CPE)	Service Period	Total Funds Payment Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$ 96,500,000		$ 96,500,000	DY 8 (Jul. –Sept.)	$ 193,000,000
(Qtr 2)	$ 96,500,000		$ 96,500,000	DY 8 (Oct. – Dec.)	$ 193,000,000
(Qtr 3)	$ 96,500,000		$ 96,500,000	DY 8 (Jan. – Mar.)	$ 193,000,000
(Qtr 4)	$ 71,919,014		$ 71,919,014	DY 8 (Apr. - Jun.)	$ 143,838,028
(Qtr 4)	$ 116,833,335		$ 116,833,335	DY 7 (June)	$ 233,666,670
Total:	**$ 478,252,349**		**$ 478,252,349**		**$ 956,504,698**
DSRIP					
(Qtr 1)					
(Qtr 2)					
(Qtr 3)					
(Qtr 4)	$2,393,289	$2,393,289		DY 7	$4,786,577
(Qtr 4)	$370,387,456	$370,387,456		DY 8 (Jul.-Dec.)	$740,774,911
Total:	**$372,780,745**	**$372,780,745**			**$745,561,488**
Designated State Health Program (DSHP)					

Payment Type	FFP Claim FFP Claim		(CPE) (CPE)	Service Period	Total Claim Total Claim
State of California					
(Qtr1)	$ 23,709,051		$ 47,418,102	DY 8 (Jul-Sept)	$ 23,709,051
(Qtr 2)	$ 92,010,154		$ 171,911,397	DY 8 (Oct-Dec)	$ 92,010,154
(Qtr 3)	$ 194,096,551		$ 382,481,377	DY 8 (Jan-Mar)	$ 194,096,551
(Qtr 4)	$ 147,408,884		$ 345,386,127	DY 8 (Apr-Jun)	$ 147,408,884
Total:	**$ 433,515,589**		**$ 899,778,901**		**$ 433,515,589**

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 $147,408,884 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 $188,752,349 in federal fund payments for SNCP eligible services.

California Children Services (CCS) Member Months and Expenditures

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

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

Report Number	Time Period	Number of Member Months in a Quarter	Number of Unique Eligibles Based on the First Month of Eligibility in a Quarter	Expenditures Based on Month of Payment
DY6, Q1	September – December 2010	551,505	138,443	$829,406,465
DY6, Q2	January – March 2011	406,113	135,693	$676,468,735
DY6, Q3	April – June 2011	404,674	134,774	$649,757,648
DY7, Q1	July – September 2011	408,149	135,612	$570,379,382
DY7, Q2	October – December 2011	403,452	135,812	$592,896,974
DY7, Q3	January – March 2012	405,879	136,489	$639,248,570
DY7, Q4	April – June 2012	409,451	137,496	$574,933,670
DY8, Q1	July – September 2012	404,973	135,775	$565,527,403
DY8, Q2	October – December 2012	409,169	137,698	$442,066,945
DY8, Q3	January – March 2013	426,875	142,507	$382,433,183
DY8, Q4	April - June 2013	457,711	152,598	$349,532,016