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

TOBY DOUGLAS
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May 29, 2014

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 01-01-2014 THROUGH 03/31/2014 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

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

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 third quarterly progress report for Demonstration Year Nine, which covers the period from January 1, 2014 through March 31, 2014.

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

Sincerely

[redacted]

Toby Douglas
Director

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TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Nine (07/01/13-06/30/14)
Third Quarter Reporting Period: 01/01/2011-03/31/2014

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.

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
January 2014 – March 2014

County	Total Member Months
Alameda	90,211
Contra Costa	49,077
Fresno	69,770
Kern	55,775
Kings	7,620
Los Angeles	603,446
Madera	7,354
Riverside	96,487
San Bernardino	113,478
San Francisco	53,200
San Joaquin	51,305
Santa Clara	69,073
Stanislaus	35,389
Tulare	32,869
Sacramento	115,179
San Diego	122,410
Totals	**1,572,643**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
January 2014 – March 2014

County	Total Member Months
Alameda	41,999
Contra Costa	15,980
Fresno	21,509
Kern	13,717
Kings	1,993

County	Total Member Months
Los Angeles	206,883
Madera	1,980
Marin	18,444
Mendocino	17,217
Merced	46,053
Monterey	44,351
Napa	13,590
Orange	330,057
Riverside	33,179
Sacramento	38,343
San Bernardino	34,595
San Diego	41,274
San Francisco	24,030
San Joaquin	14,243
San Luis Obispo	24,827
San Mateo	68,764
Santa Barbara	44,027
Santa Clara	31,244
Santa Cruz	29,024
Solano	56,284
Sonoma	50,596
Stanislaus	6,078
Tulare	9,626
Ventura	78,279
Yolo	24,996
Totals	**1,383,182**

Enrollment (January 2014 – March 2014)

During the quarter, mandatory SPDs had an average choice rate of 53.42%, an auto-assignment default rate of 26.76%, a passive enrollment rate of 0.04%, a prior-plan default rate of 0.63%, and a transfer rate of 18.77%. In March, overall SPD enrollment in Two-Plan and GMC counties was 521,173 (point-in-time), a 2.26% increase over December's enrollment of 509,676. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY9-Q3 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

On February 6, 2014, the Medi-Cal Managed Care Division (MMCD) released the Quarter 3, 2013, edition of the MMCD Performance Dashboard for the Medi-Cal Managed Care program. The dashboard will help DHCS and its stakeholders to identify trends and better observe and understand MCP activities on all levels: statewide, by managed care model (i.e., COHS, GMC, and Two-Plan), and within an individual MCP. It includes metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, MCP finances, care coordination, and continuity of care. It also stratifies reported data by beneficiary populations including Medi-Cal-only SPDs, dual eligibles, and children transitioned from the Healthy Families Program into Medi-Cal Managed Care.

In May 2014, MMCD will post the Quarter 4 2013 edition, and will conduct a webinar with stakeholders to discuss the dashboard.

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

Operational/Policy Issues:

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

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee
On February 21, 2014, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no topics specific to the SPD Implementation discussed. Full documentation from the meeting is available at: http://www.dhcs.ca.gov/Pages/February212014SACmeeting.aspx.

Office of the Ombudsman (January 2014 – March 2014)
MMCD's Office of the Ombudsman experienced a decrease in customer calls between the periods October–December 2013 (DY9-Q2) and January–March 2014 (DY9-Q3). During DY9-Q3, the Ombudsman received 12,041 total calls, of which 9,233 concerned mandatory enrollment and 1,231 were from SPDs. During DY9-Q2, the Ombudsman received 17,382 total calls, of which 5,037 concerned mandatory enrollment and 1,241 were from SPDs. This represents a 30.73% decrease in total calls, an 83.3% increase in calls regarding mandatory enrollment, and a 0.81% decrease in calls regarding mandatory enrollment from SPDs.

For DY9-Q3, 0.04% of SPD and 0.01% of non-SPD calls concerned access issues. This is a small decrease in SPD and no change in non-SPD calls from DY9-Q2, during which 0.19% of SPD calls and 0.01% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) increased for most measures. Total SHRs increased from 492 in DY9-Q2 to 584 in DY9-Q3. The percentage of SHRs from SPDs dropped from 63% to 49%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs also increased from 106 in DY9-Q2 to 149 in DY9-03. The percentage of those requests from SPDs decreased from 56% to 40%. 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 "DY9 Q3 Ombudsman Report" and "DY9 Q3 State Hearing Report."

Medical Exemption Requests (January 2014 – March 2014)

There was a slight increase in Medical Exemption Requests (MERs)/Emergency Disenrollment Exemption Request (EDERs) during this period; however, DHCS's reassignment of nurses from its other divisions and the automation of the MER process kept the number of outstanding MERs to a minimum and EDERs continued to be processed on a daily basis.

Health Risk Assessment Data (July 2013 – September 2013)

According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs newly enrolled 29,711 SPDs between July 2013 and September 2013[1]. Of those, MCPs stratified 13,356 (44.95%) as high-risk SPDs and 15,794 (53.16%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 63.22%. Out of the 63.22% contacted, 14.82% completed a health risk assessment survey. For the low-risk SPDs, MCPs contacted 68.87%. Out of the 68.87% that were contacted, 30.84% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 4,057 SPDs to be in the other risk category, which is 13.65% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2013 Risk Data."

Continuity of Care Data (October 2013 – December 2013)

According to the data reported by MCPs that are operating under the Two-Plan and GMC models, SPDs submitted 1,237 continuity-of-care requests between October and December 2013. Of these, MCPs approved 1,083 requests (87.55% of all requests); held 2 requests (0.16%) in process; and denied 152 requests (12.29%). Of the requests denied, 34.87% of the requests arose from disagreement between the provider and MCP over a payment rate. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2013 Continuity of Care."

[1]Does not include complete CalViva & Health Net data. CalViva's administrator, Health Net, is working to re-implement the SPD Risk Assessments and will implement reporting processes that will allow it to provide a complete report.

Plan-Reported Grievances (October 2013 – December 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,452 grievances between October and December 2013. Of these grievances, 0.34% were related to physical accessibility, 7.85% were related to access to primary care, 4.34% were related to access to specialists, 2.41% were related to out-of-network services, and 85.06% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2013 SPD Grievance."

MERs Data (October 2013 – December 2013)
During 2013, from October through December, 5,406 SPDs submitted 5,460 MERs, an average of 1.01 MERs per SPD who submitted a MER. MMCD approved 3,998 MERs, denied 1,439, and found 23 to be incomplete. The top five MER diagnoses were Complex (586), Cancer (369), Transplant (179), Neurological (157), and Dialysis (97). Summary data is available in the attachment "Q4 2013 MERs Data."

Health Plan Network Changes (October 2013 – December 2013)
According to data reported by MCPs operating under the Two-Plan and GMC models, MCPs added 794 primary care physicians (PCPs) and removed 464 PCPs across all networks, resulting in a total PCP count of 22,616. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2013 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (January 2014 – March 2014)
Based on a review of all data collected to date DHCS composed a list of recommended questions to include in a comprehensive evaluation report on the impact of the transition of SPDs into MCPs on the beneficiaries involved in the transition. The evaluation intends to explore the following domains: eligibility and enrollment processes; network adequacy and coverage; access to care and continuity of care; and quality of care (using objective measures, such as HEDIS measures and beneficiaries' perceptions of their care). In addition, DHCS hired consultants to design a cost-value component, which measures the costs and value of services consumed by SPDs before and after their transition to managed care. A draft of the evaluation design is currently under review by DHCS management.

Encounter Data (January 2014 – March 2014)
DHCS initiated the Encounter Data Improvement Project (EDIP) in late 2012, with the goal of improving the validity and completeness of DHCS's encounter data and establishing the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP, currently under development, is DHCS's plan for measuring encounter

data, tracking it from submission to its final destination in DHCS's data warehouse, and reporting data quality to internal and external stakeholders.

During the reporting period, the Encounter Data Quality Unit (EDQU), established under the EDIP, continued its efforts to implement and maintain the EDQMRP. EDQU continued to develop metrics that will objectively measure the quality of future encounter data in the dimensions of completeness, timeliness, reasonableness, and accuracy. EDQU also initiated the development of scoring tool that will determine an Encounter Data Quality Grade for each Medi-Cal MCP based on these metrics. EDQU continued to work with other areas of DHCS to establish business requirements for an improved system developed to receive encounter data from Medi-Cal MCPs. The overall transition to this new system started during the reporting period and will be ongoing throughout 2014. Concurrently, EDQU worked with DHCS's contracted fiscal intermediary to fix malfunctioning encounter data edits in the existing system. Although many of these efforts did not specifically target SPDs, improving the quality of DHCS's encounter data will enable DHCS to better monitor the services and care provided to this population.

<u>Outcome Measures and Avoidable Hospitalizations (January 2014 – March 2014)</u>
DHCS employs the following strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures
HEDIS reporting year 2013 was the first year in which DHCS reported a subset of HEDIS measures for SPDs compared to non-SPDs. DHCS considers these results preliminary because not all SPDs had transitioned into MCPs by January 1, 2013. This summer, DHCS will release the SPD vs. non-SPD rates for the selected HEDIS measures for measurement year 2013.

Consumer Assessment of Healthcare Providers and Systems
During calendar year 2013, DHCS, through its external quality review organization (EQRO), administered the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys. The survey closed in May 2013 with a response rate of 35% for adults and 39% for children. DHCS will publish the final report in May 2014.

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

The Baseline Report—now under development—will include SPD versus non-SPD readmission rates for measurement year 2012, before the interventions began in 2013.

Utilization Data (January 2013 – March 2013)
During the period January through March 2013, MCPs in Two-Plan and GMC counties enrolled 522,955 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 13.83% (72,338) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.67 times.
- Each SPD who visited an ER generated an average of 2.65 ER claims.

Pharmacy Services:

- 68.74% (359,490) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 12.89 claims.

Outpatient Services:

- 46.65% (243,960) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.09 visits.
- Each SPD who accessed outpatient services generated an average of 9.73 claims.

Regarding inpatient services:

- 5.02% (26,270) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 3.05 visits.
- Each SPD who accessed inpatient services generated an average of 3.67 claims.

Regarding hospital admissions:

- 5.76% (30,122) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 2.17 visits.

Top Ten Services Accessed by SPDs

11,112,844 total claims

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

For the top ten diagnosis categories, MCPs submitted data for a total of 2,717,552 encounters. Mental Illness was in the top rank with 33.86% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 16.8%. In the third position, "Diseases of the circulatory system" was 8.51%. The remaining seven categories ranged from 8.43% to 3.04% of the encounters.

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

Enclosures/Attachments:

- "DY9 Q3 Defaults Transfers 2Plan GMC"
- "DY9 Q3 Ombudsman Report"
- "DY9 Q3 State Hearing Report.
- "Q3 2013 Risk Data"
- "Q4 2013 Continuity of Care"
- "Q4 2013 SPD Grievance"
- "Q4 2013 MERs Data"
- "Q4 2013 Network Adequacy"
- "DY9 Q3 Utilization Data"
- "MMCD AG Meeting Minutes March 13 2014 meeting"

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

Month	HPSM Enrollment Numbers	Difference
Prior Quarter December 2013	1,479	
January 2014	1,468	-11
February 2014	1,469	1
March 2014	1,468	-1

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

The Department of Health Care Services (DHCS) continues to collaborate with Demonstration entities relative to issues and challenges specific to each of the model locations. A challenge that impacts all demonstration entities are capitation rate determination. This largely results from the need to determine the specific population(s) to be included in the demonstration. This, in turn, delays the state's ability to develop capitation rates. Other challenges vary among the demonstration models but can include final determination of the target population, final determination of disease specific groups, general organizational structure, reporting requirements, etc.

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

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 Systems of Care Division (SCD) also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Department Communications with HPSM
On February 27, 2014, SCD Management and HPSM engaged in a conference telephone call to discuss issues related to financial, information technology, and reporting requirements.

Capitated Reimbursement Rates
The SCD is in the process of preparing to enroll the CCS State-Only population in San Mateo County into the CCS Demonstration Pilot. The goal is to automate enrolling the CCS State-Only children and for payment to occur through the CAPMAN payment system.

On February 10, 2014, SCD received the approved memorandum from Medi-Cal Eligibility Division (MCED) to ITSD and California Medicaid Management Information System (CA-MMIS) to request the development and implantation of a new aid code "9D" for CCS State-Only beneficiaries. The aid code will be identified as 9D, CCS State-Only, Child Enrolled in a Health Care Plan.

Encounter Data
The HPSM resubmitted its encounter data for April 2013 through December 2013 with the correct plan code associated with each claim. Originally, HPSM submitted the encounter data using the Managed Care plan code 503 instead of the HPSM CCS Demonstration Project plan code 703.

Aid Codes
January 1, 2014, a list of new aid codes became available, SCD staff is in the process of determining which aid codes should be available for HPSM's use in the enrollment of children into the CCS DP.

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

Capitated Reimbursement Rates
Continuing from mid-October 2011, DHCS has been working on development of reimbursement rates with the Department's actuarial contractor, Mercer. RADY needs to provide a final set of CCS health conditions to the Department which will be used to determine the final reimbursement rates.

Department Communications with RADY
The Department has implemented weekly conference calls with RADY to discuss and resolve various issues such as:

- In an effort to control costs, especially those associated with blood factors, RADY is proposing to contract with preferred pharmaceutical vendors (three to five).
- RADY is analyzing data to consider inclusion of additional CCS conditions into the CCS DP.
- Knox-Keene Requirements. RADY is currently reviewing the Knox-Keene protections to ensure compliance with the requirements.
- RADY historically has not operated as a health plan; as such, they are in the process of developing a Member Services Guide, a Provider Network Guide, and various policies and procedures.
- The process for disenrollment of eligible clients from five San Diego GMC plans and enrollment into the CCS demonstration.

- RADY is in the process of enhancing their provider network to include additional Federally Qualified Health Centers (FQHCs) that are currently serving the target population.
- RADY does not have GeoMap capabilities; as such, they are working on a report that will satisfy statute requirements for geographical access.

Pilot Schedule

It is anticipated Rady Children's Hospital of San Diego County (RADY) demonstration pilot will be operational in fall 2014.

There is no projected starting date for the remaining three pilot models at this time.
- Los Angeles Care Health Plan (LA Care)
- Children's Hospital of Orange County (CHOC)
- Alameda County Health Care (Alameda)

A challenge that impacted four of the five Demonstrations was 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.

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

- 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.

Consumer Issues:

Nothing to Report

Financial/Budget Neutrality:

Enrolling CCS-Only

SCD has met with ITSD, MCED and OHC multiple times during this quarter to enroll the CCS State-Only population into the HPSM CCS Demonstration Pilot. The goal is to have an automated process with invoicing occurring through CAPMAN.

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

Quality Assurance/Monitoring Activities:

On February 14, 2014, HPSM submitted contractual report, "Enrollment and Utilization Table". Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
4/1/2013 – 6/30/2013	0	1,474	116	1,358	3,951
7/1/2013 – 9/30/2013	1,358	140	130	1,368	4,093
10/1/2013 – 12/31/2013	1,368	241	119	1,490	8,382

HPSM deliverables submitted during this quarter are listed in the table below, the table also provided the status of each deliverable.

Report Name	Date Due	Received	Pending Review	SCD Approved
Report of All Denials of Services Requested by Providers (Rpt #1)	1/3/2014	YES	✓	Report incomplete, allowed extension to complete
Provider Network Reports (Rpt #1)	1/22/2014	YES		YES
Provider Network Reports (Rpt #2)	1/22/2014	YES		YES
Insurance Requirements (Rpt #1)	1/29/2014	YES		YES
Members Service Guide / Evidence of Coverage	1/29/2014	YES		YES
Formulary Report (Rpt #1)	1/29/2014	YES		YES
Provider Network Reports(Rpt #3)	1/30/2014	YES		YES
Quality Improvement Report (Rpt #1)	1/30/2014	YES	✓	Report incomplete, allowed extension to

				complete 4/15/2014 - Received updated report
Statement of Conflicts of Interest (Rpt #1)	1/30/2014	YES		YES
Quarterly Financial Statements (Rpt #3)	2/17/2014	YES		YES
Report of All Denials of Services Requested by Providers (Rpt #2)	2/17/2014	YES	✓	Allowed extension to complete

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.

Enrollment Information:

The Quarterly LIHP enrollment report, applicant report, and the grievances and appeals report will no longer be submitted to CMS as the program ended December 31, 2013.

Outreach/Innovative Activities:

Since January 1, 2014, LIHP enrollees continue to transition to Medi-Cal and to health care options under Covered California on January 1, 2014.

Operational/Policy Issues:

Effective January 1, 2014, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California per the Affordable Care Act. Effective January 1, 2014, local LIHPs no longer provided health care services to LIHP enrollees and focused on LIHP administrative and close-out activities.

DHCS continued working with CMS on a request by Alameda that would allow Alameda County Medical Center, a designated public hospital, to report Certified Public Expenditures (CPE) to Alameda LIHP for the period of November 1, 2010 – June 30, 2011 under Attachment G Supplement 1, Section K, as an Other Governmental Entity.

On March 26, 2014, DHCS held a LIHP Administrative Activities webinar for local LIHPs which provided them with instructions on how to claim their LIHP administrative activities, including their backcasting period administrative claims.

DHCS had preliminary discussions with San Bernardino LIHP on how the San Bernardino district hospitals that provided services to LIHP enrollees could provide CPEs for claiming purposes from January 1, 2012 through December 31, 2013 for these LIHP services.

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

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

The Department collaborated with UCLA to plan the revisions to UCLA's expansion website architecture to increase accessibility for the public to the LIHP utilization and demographic data by county on the UCLA web site. UCLA implemented the redesigned website January 21, 2014.

DHCS collaborated with UCLA in drafting and reviewing reports and publications for the evaluation of the LIHP component of the California Bridge to Reform Demonstration and

the Final HCCI Evaluation reports. The report on the prior demonstration ten-county HCCI program that enrolled more than 230,000 low income uninsured adults was released on January 29, 2014.

DHCS staff and UCLA worked to develop an interagency agreement for the evaluation of the remaining years of LIHP and for LIHP transition activities. The final interagency agreement covering the term of September 1, 2012 – June 30, 2015 was executed on March 5, 2014. DHCS staff continued to work internally to establish the payment process for the claims under this interagency agreement.

On January 21, 2014, DHCS submitted an edit to Attachment G, Supplement 1 to CMS to make necessary revisions regarding the cost claiming process for mental health services provided by non DPH-based LIHPs other than mental health services provided at a hospital operated by a non DPH-based LIHP, including services provided in a subcontract. This specific edit is required pursuant to Attachment G, Supplement 1, Section F, of the Special Terms and Conditions. DHCS staff continued to work with CMS to obtain approval of this edit.

Department staff continued to work with CMS to revise the approved Attachment J protocol and approval letter to correct the close-out period date from 2013 to 2014.

DHCS continued to follow up with CMS to obtain a decision on the request submitted December 27, 2013, regarding the exclusion of HCCI for the Primary Care Provider (PCP) increased payment per the CMS ruling 42 CFR Part 438, 441, and 447 which entitles the LIHP providers to receive the difference of the increased amount for the calendar year 2013. Section 1902(a)(13)(C) of the Act "requires the states pay a minimum payment amount for certain primary care services delivered by designated primary care physicians. Primary care services are defined in the new section 1902 (jj) of the Act and include certain specified procedure codes for evaluation and management (E&M) services and certain vaccine administration codes. Under this provision, states must reimburse at least as much as the Medicare physician fee schedule (MFPS) rate in CYs 2013 and 2014 or, if greater, the payment rate that will apply using the CY 2009 Medicare CF".

The Department continued LIHP transition to Medi-Cal activities. Specific tasks and activities including but are not limited to:

- Coordination with DHCS, local LIHPs, and county social services agencies to resolve transition issues impacting former LIHP enrollees.
- DHCS monitored transition data to determine status of the LIHP transition and any remaining issues.
- DHCS collaborated with Covered California regarding the transition of HCCI enrollees.
- DHCS conducted teleconferences with the local LIHPs and county social services agencies to discuss issues and current status of the transition.
- DHCS provided guidance on the transition process and data to assist in the

transition of LIHP enrollees.

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

DHCS staff continued working on the LIHP Capitation Rate Contract Amendment and Attachment G, Supplement 2, Cost Claiming Protocol for Health Care Services Provided under the LIHP-Claims Based on Capitation. DHCS staff has requested guidance from CMS on how amendments to previously expired contracts should be handled for LIHP.

The Department revised the language for the LIHP State Hearings and Appeals Process interagency agreement with the California Department of Social Services (CDSS) and is waiting for CDSS' review and execution.

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

The Department reviewed the DPHs' second semi-annual reports and annual reports for DY8 DPHs submitted their first semi-annual reports for DY9 on March 31, 2014.

DHCS continued to process and execute Data Use Agreements (DUA) to extend the Business Associate Addendum (BAA) in the LIHP contract to allow the continued exchange of protected enrollee information after the original LIHP contracts expired on December 31, 2013.

The Department continued the process to initiate the reimbursement, from all 19 LIHPs, for costs DHCS incurred related to reporting and storage of LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

As of March 31, 2014, all 19 local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state populations determined eligible for LIHP by DHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

DHCS developed and continues conducting surveys to collect information from local LIHPs on the status of transitioning MCE enrollees into Medi-Cal. In addition, the Department continues to communicate and collaborate with LIHPs and the local social services agencies to remedy LIHP-related transition issues.

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:

- Monthly 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, who had been receiving health care services through the Ryan White programs and had transitioned to a local LIHP prior to January 1, 2014, to health care coverage under 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.

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

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
CDCR (Qtr. 3)	$981,624	$0.00	$1,963,248	DY 7	$981,624
	$4,529,615	$0.00	$9,059,230	DY 8	$4,529,615
	$687,230	$0.00	$1,374,460	DY9	$687,230
Health Care (Qtr. 3)	-$489,228	$0.00	-$978,456	DY 6	-$489,228
	$851,975	$0.00	$1,703,950	DY 8	$851,975
	$128,175,825	$0.00	$256,351,650	DY9	$128,175,825
	$900,000	$900,000	$0.00	DY7	$1,800,000
	$35,671,379	$35,671,379	$0.00	DY8	$71,342,758
Total	**$171,308,420**	**$36,571,379**	**$269,474,082**		**$207,879,799**

Quality Assurance/Monitoring Activities:

DHCS continues to request, track and analyze information submitted by local LIHPs to ensure compliance with LIHP contracts

DHCS continues to review local LIHP submissions for contract compliance, and to correspond with LIHPs as needed to ensure compliance in the following areas:

- General LIHP Contractor Provisions
- Quality Improvement Provisions
- Utilization Management Provisions
- Enrollee Rights & Services Provisions
- Privacy Provisions

DHCS continued 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.
DHCS reviewed Requests for State Hearing Re-hearings received from CDSS. DHCS conducted analysis of the rehearing requests, supporting documents and authorities, and provided determinations.

DHCS continued to track and compile submissions of Maintenance of Effort information from local LIHPs to ensure compliance with LIHP contracts.

Enclosures/Attachments:

Utilization Data

DY 8 and DY 9 utilization data will be sent under separate cover in the near future. LIHP utilization data includes physical health, mental health, substance use, and emergency services, and documents the number of LIHP covered services provided to LIHP enrollees within a quarter. Units of service can include the number of patient days, visits (encounters), services, items, or trips. Physical health data are generated using claims/encounter data provided by the LIHPs on a quarterly basis, and are based on CMS place of service codes.

The utilization reports contain counts of services for physical health, mental health, and substance use that occurred in the following settings: inpatient hospital, outpatient hospital, clinic, and physician services. Coverage of out-of-network emergency services is required for MCE enrollees. The utilization reports contain counts of out-of network emergency services, out-of-network post stabilization services, and in-network emergency services.

COMMUNITY BASED ADULT SERVICES (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, sought to challenge the elimination of ADHC services. In settlement of this lawsuit, ADHC was eliminated as a payable benefit under the Medi-Cal program effective March 31, 2012, to be replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. The Department of Health Care Services (DHCS) amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR waiver) to include CBAS, which was approved by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2012. CBAS is operational under the BTR waiver for the period of April 1, 2012, through August 31, 2014.

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to State Plan beneficiaries that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing, Medicaid , and waiver program standards; 2) provide services in accordance with the participant's physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements identified in the CMS approved BTR waiver; and 4) demonstrate ongoing compliance with above requirements.

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

The State must assure CBAS access/capacity in every county in which ADHC services had been provided on December 1, 2011.[2] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) (See Attachment 4) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans (available in two counties), along with the final COHS county (Ventura) also transitioning at that time. As of October 1, 2012, Medi-Cal FFS only provides CBAS coverage for those CBAS eligible beneficiaries who: 1) do not qualify for managed care enrollment, 2) have an approved medical exemption, or 3) reside in CBAS geographic areas where managed care is not available (four counties: Shasta, Humboldt, Butte; Imperial).

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

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

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

Enrollment and Assessment Information:

Community Based Adult Services (CBAS) Enrollment:

The monthly CBAS Enrollment data for both FFS and Managed Care Organizations (MCO) beneficiaries for DY 9, Quarter 3 is shown in Table 2 at the end of this report section.

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

Given this change in reporting process and format, Table 2 reflects that the CBAS participation remains relatively flat, between 26,000 and 27,000 statewide. Using FFS Claims data in part, there is a delay in FFS data in this report.

CBAS Assessments:

During DY9, Quarter 3 (January 2014 through March 2014), managed care plans reported that they conducted 1,965 face-to-face CBAS assessments by registered nurses. Of these new assessments 98% were found eligible for CBAS. Plans' median response time from receiving request for an assessment to making an eligibility determination was 4.5 days, a response time that is within the 30 days standard.

During the same quarter, approximately 320 new CBAS eligibility assessments for FFS beneficiaries were completed by DHCS' registered nurses. Of these new assessments 96% were found eligible for CBAS.

Enhanced Case Management (ECM):

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

Due to State Fair Hearing decisions, the ECM FFS participation initially dropped during the 2012 and early 2013 calendar years. The State Fair Hearings found many beneficiaries eligible for CBAS benefits, so they were removed from ECM. Additionally, many beneficiaries continue to move into managed care health plans, resulting in an ongoing decline in FFS ECM-eligible members. Many beneficiaries change between Managed Care plans, going back into FFS for intervals of time, and back to Managed Care. Given this frequent movement, incoming ECM participants continue to be slightly fluid month-to-month with eligibility changes. However, overall the FFS ECM population continues to drop as more beneficiaries move to Managed Care Plans.

Many ECM clients contacted by DHCS nurses for care management decline the need for ongoing contact or further coordination of services. Their overall care coordination has been established and the need for further interaction has diminished. Many of the ECM clients have enrolled in Managed Care and receive their care management through their Plan membership. ECM-eligible members continue to drop due to participants being managed care eligible. While ECM clients continue to drop during this quarter, there has been a leveling of eligible participants during January through March 2014. The chart below tracks the Quarterly FFS ECM Participant Data for FFS ECM-eligible participants since ECM began in April 2012 (Original Count) to this current Quarter 3 in DY 9:

ECM Average Quarterly Data			
Report Quarters	**Average Qrtly. Enrollment**	**Average Qrtly. Incoming Members***	**Average Qrtly. Outgoing Members****
Original Count	1560		
DY7 - Q 4			
April-June'12	1422	66	107
DY8 - Q1			
July-Sept'12	1546	79	45
DY8 - Q2			
Oct.-Dec.'12	1126	20	210
DY8 - Q3			
Jan.-Mar'13	918	23	48
DY8 - Q4			
April-June'13	708	17	33
DY9 - Q1			
July-Sept.'13	646	16	74
DY9 - Q2			
Oct.-Dec. '13	459	13	200
DY9 - Q3			
Jan.-Mar. '14	453	19	25
		DHCS ECM data 4/01/2014	

Outreach/Innovative Activities:

During DY9 Q3, DHCS continued to work closely with CBAS Center providers and Managed Care Plans regarding CBAS program benefits and eligibility of participants.

Operational/Policy Development/Issues:

CBAS Centers/Provider Issues:

As of March 31, 2014, CDA, the Department that certifies and provides oversight of CBAS Centers, had 245 CBAS Center providers open and operating in California. During DY9 Q3, two centers opened in the Los Angeles County area (Golden Age ADHC in January, and East Valley ADHC in February). Additionally, one center closed in the San Diego County area (North County ADHC in January). Participants were discharged from the closed center and were able to transition to another center within the vicinity.

The Table below documents CBAS Center status since CBAS began, April 1, 2012, through the end of 2013:

CBAS Center History

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

CDA Data as of 4/01/2014

Unbundled Services:

DHCS continues to review any possible impact on participants by CBAS Center closures. Prior to any Center closure, the CBAS Center is required to notify California Department of Aging (CDA) on their planned closure date and to conduct discharge planning with all their CBAS participants. While most CBAS Centers notify CDA and carefully link participants with appropriate services or community resources, not all CBAS Centers do so. Occasionally, Centers will close, shutting their doors without any notification to participants, vendors, or CDA. Unfortunately, CDA often finds out about the sudden Center closure from CBAS participants or other CBAS Centers in the local communities.

CBAS participants affected by a Center closure, and that are unable to attend another local CBAS Center, can receive unbundled services. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within the participant's local area. The large, statewide volume of In-Home Supportive Service (IHSS) providers is a key characteristic of California's home and community-based services that help substitute institutional care for seniors and persons with disabilities. Participants can engage/employ their IHSS providers of choice and can self-direct their own care in their home setting.

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

During DY 9 Quarter 3 period, there was only one closure, and two openings/change of ownership (see 'CBAS Center History', page 5). Prior to the center closing, the majority of participants were relocated to another center. There were only 5 participants affected by the closed CBAS center that needed unbundled services. The participants that were affected were able to receive unbundled services (i.e., IHSS, physical therapy, occupational therapy, speech therapy, and/or other HCBS waiver services).

CBAS Fair Hearings:

CBAS Fair Hearings continue to be held through the normal State Hearing process, with the California Department of Social Services (CDSS) Administrative Law Judges' hearing all cases filed.
During DY 9 Quarter 3, a total of 12 cases were filed/heard (from the approximate 26,300 participants), or an average of 4 cases per month, throughout the State. One of the 12 Hearings was in regard to FFS eligibility. The other 11 Hearings all related to increases in service days with Managed Care Plan members.
Fair hearing issues are related to CBAS eligibility and plans authorization of days of attendance.

CBAS Transition to Managed Care:

All 58 counties in California are covered by Managed Care plans, with CBAS fee-for-service benefits continuing in only four counties (Shasta, Humboldt, Butte, and Imperial). These four counties are the only rural counties that have CBAS Centers. CBAS is tentatively scheduled to move to a Managed Care benefit in the above four counties before the end of 2014.

Consumer Issues:

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

Most issues are related to consumers changing managed care plans, changing between Medi-Cal FFS and managed care plans, as well as changing of their Medi-Cal eligibility.

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

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA, for the most part, the complaints are from CBAS providers. Summarized below, are the complaints that came in during the 2013 Quarters:

Year	Demo Year 9 Quarters	Beneficiary Complaints	Provider Complaints	Total Complaints	Percent to Total
2013	DY9 - Qrt 1 (Jul 1 - Sep 30)	7	3	10	0.46%
2013	DY9 - Qrt 2 (Oct 1 - Dec 31)	8	9	17	0.93%
2014	**DY 9 - Qrt 3** (Jan 1 - Mar 31)	**6**	**2**	**8**	**0.44%**
			CDA data - Phone & Email Complaints		

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

DHCS continues to monitor CBAS Center locations and accessibility and considers provider requests as part of its ongoing monitoring of CBAS access as required under the Bridge To Reform Waiver. AB 97 (Chapter 3, Statutes of 2011) imposed a 10% rate reduction on specified Medi-Cal providers including ADHCs. Based on DHCS' Medi-Cal Access Study of ADHCs, certain ADHCs were exempted from the 10% provider reduction. All rate reductions and exemptions applicable to ADHC were applicable to CBAS beginning on April 1, 2012. Centers may submit requests to DHCS for review of possible exemption to the 10% rate reduction, due to various hardships in their county area. DHCS and CDA review specifics to determine if exemptions need to be reviewed by the administration and approved for possible implementation. The table below indicates the consistency of each county's licensed capacity since the CBAS program became a Waiver benefit in April 2012.

The Capacity used below also shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 60% statewide. There is space available in almost all counties where CBAS is available to allow for access to CBAS by Medi-Cal beneficiaries.

TABLE 1:

County	CBAS Centers Licensed Capacity									
	Apr- Jun 2012	Jul- Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	DY9-Q1 Jul-Sept 2013	DY9-Q2 Oct-Dec 2014	DY9-Q3 Jan-Mar 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	415	355	355	355	355	355	**355**	0%	**83%**
Butte	60	60	60	60	60	60	60	**60**	0%	**40%**
Contra Costa	190	190	190	190	190	190	190	**190**	0%	**58%**
Fresno	590	590	530	530	547	572	572	**572**	0%	**81%**
Humboldt	229	229	229	229	229	229	229	**229**	0%	**29%**
Imperial	250	250	250	315	315	315	330	**330**	0%	**69%**
Kern	200	200	200	200	200	200	200	**200**	0%	**54%**
Los Angeles *	17,735	17,590	17,430	17,505	17,506	17,613	17,810	**18,084**	2%	**60%**
Marin	75	75	75	75	75	75	75	**75**	0%	**22%**
Merced	109	109	109	109	109	109	109	**109**	0%	**55%**
Monterey	290	290	290	-	-	110	110	**110**	0%	**17%**
Napa	100	100	100	100	100	100	100	**100**	0%	**53%**
Orange	1,897	1,897	1,747	1,747	1,747	1,847	1,847	**1,847**	0%	**53%**
Riverside	640	640	640	640	640	640	640	**640**	0%	**42%**
Sacramento	529	529	529	529	529	529	529	**529**	0%	**57%**
San Bernardino	320	320	320	320	320	320	320	**320**	0%	**60%**
San Diego*	2,132	2,052	1,957	1,992	1,992	2,007	2,007	**1,923**	-4%	**61%**
San Francisco	803	803	803	803	803	803	866	**866**	0%	**72%**
San Mateo	120	120	120	120	120	120	120	**120**	0%	**44%**
Santa Barbara	55	55	55	55	55	55	55	**55**	0%	**63%**
Santa Clara	820	820	820	820	750	770	770	**770**	0%	**56%**
Santa Cruz	90	90	90	90	90	90	90	**90**	0%	**68%**
Shasta	85	85	85	85	85	85	85	**85**	0%	**29%**
Solano	120	120	120	120	120	120	120	**120**	0%	**26%**
Sonoma	45	-	-	-	-	-	-	-	0%	0%
Stanislaus	80	80	80	80	-	-			0%	0%
Ventura	806	806	806	806	806	806	806	**806**	0%	**67%**
Yolo	224	224	224	224	224	224	224	**224**	0%	**79%**
SUM =	29,009	28,739	28,214	28,099	27,967	28,344	28,619	**28,809**	0.66%	**60%**

CDA Licensed Capacity as of 03-31-2014

San Diego - 1 center closed / 1 center decreased licensed capacity

Los Angeles - 2 centers increased capacity/ 2 centers opened

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

As the STCs require, if a county experiences a negative change of more than 5% in provider licensed capacity, a corrective action plan is to be in place. There is no drop of 5% or more during this reported time period. During this quarter, there was one county with an increase capacity (Los Angeles) and one county (San Diego) with a decrease in licensed capacity due to a center closure and center requesting a decrease in licensed capacity. With current enrollment numbers for participants in counties with CBAS centers, there is ample licensed capacity for enrollment with the current capacity levels being utilized at 60%.

The following Table 2 - *Preliminary CBAS Unduplicated Participant Data for FFS and MCO Enrollment* indicates the Quarterly data count for enrollment continues to slightly lag. This preliminary data reflects a slightly lower count of participants than those actually serviced during this time period due to the lag in data.

DHCS continues to monitor access to CBAS Centers, average utilization rate, and available capacity. There is enough CBAS capacity (60% overall) to serve Medi-Cal

beneficiaries in the counties with CBAS centers. With such excessive capacity in counties where there are multiple CBAS providers, closure of individual CBAS Centers (or consolidation of CBAS providers) continues to minimal impact.

TABLE 2:

CBAS Unduplicated Participant - FFS and MCO Enrollment Data							
County	DY9 Q1 July - Sept 2013		DY9 Q2 Oct - Dec 2013		**DY9 Q3 Jan - Mar 2014**		**DY3-Q3 Capacity Used**
	FFS	MCO	FFS	MCO	**FFS**	**MCO**	
Alameda	10	490	9	535	**8**	**465**	83%
Butte	46		42		**39**		40%
Contra Costa	12	193	14	185	**10**	**119**	58%
Fresno	10	615	9	604	**7**	**659**	81%
Humbolt	234		116		**110**		29%
Imperial	394		389		**380**		69%
Kern		113		85		**89**	54%
Los Angeles	1,193	15,256	1,039	15461	**1,020**	**15179**	60%
Merced		114		110		**111**	55%
Monterey				66		**66**	17%
Orange	12	1870	9	1899	**5**	**2515**	53%
Riverside	22	386	21	425	**18**	**389**	42%
Sacramento	28	578	25	398	**30**	**549**	57%
San Bernardino	20	429	19	477	**14**	**411**	60%
San Diego	41	1549	33	1418	**36**	**1403**	61%
San Francisco	68	666	58	746	**53**	**659**	72%
San Mateo		142		146		**136**	44%
Santa Barbara		4		4		**4**	63%
Santa Clara	2	734	4	592		**559**	56%
Santa Cruz		104		105		**100**	68%
Shasta	82		40		**40**		29%
Ventura	8	486	7	959	**10**	**911**	67%
Marin, Napa, Solano, Yolo	3	41	3	45	**2**	**181**	45%
TOTALS	2,185	23,770	1,837	24,260	**1,782**	**24,528**	**60%**
COMBINED TOTAL	**25,955**		**26,097**		**26,310**		

Enclosures/Attachments:

None

FINANCIAL/BUDGET NEUTRALITY

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
Total:					
DSRIP					
Total:					
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr 3)	$ 93,892,699		$ 93,892,699	DY 9 (Jan-March)	$ 187,785,398
Total:	$ 93,892,699		$ 93,892,699		$ 187,785,398

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 $ 93,892,699 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.

For quarter 3 of Demonstration Year 9, DHCS calculated $77,749,000 in SNCP payments to designated public hospitals. These payments were calculated at the end of quarter 3, and will be made to the hospitals in quarter 4 of Demonstration Year 9.

III. DELIVERY SYSTEM REFORM INCENTIVE POOL PAYMENT UPDATE

Hospitals submit semi-annual reports to DHCS in March and September each year for payment under the Delivery System Reform Incentive Pool (DSRIP) program. DHCS calculates payments, requests intergovernmental transfers (IGTs), and make payments based on reported achievement. By March 31, 2014, hospitals submitted their first semi-annual reports for Demonstration Year 9. These reports included carry forward funds from other Demonstration Years. DHCS calculated payments at $762,507,002.86 in total funds, and $381,253,501.43 in IGTs based on the first semi-annual report in Demonstration Year 9. These payments were made to hospitals in quarter 4 of Demonstration Year 9.

California Children Services (CCS) Member Months and Expenditures

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

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

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