DHCS

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

TOBY DOUGLAS
DIRECTOR

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August 29, 2014

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 04-01-2014 THROUGH 06/30/2014 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

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

Enclosed is the Quarterly Progress Report required by Paragraph 20 and Attachment I of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the fourth quarterly progress report for

Demonstration Year Nine, which covers the period from April 1, 2014, through June 30, 2014.

If you or your staff have any questions or need additional information regarding this report, please contact Oksana Giy, Health Reform Advisor, at (916) 440-7408.

Sincerely,

[redacted]

Toby Douglas
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Enclosure

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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)
Fourth Quarter Reporting Period: 04/01/2014-06/30/2014

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.

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

Effective April 2013 an amendment was approved which allows (DHCS to make supplemental payments to Indian Health Service (IHS) and tribal facilities for uncompensated care costs. Qualifying uncompensated encounters include primary care

encounters furnished to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a LIHP.
On August 29, 2013 DHCS received approval to expand Medi-Cal Managed Care into 20 additional counties, with phased-in enrollment beginning in September 2013.

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

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

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

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

April 2014 – June 2014

County	Total Member Months
Alameda	90,929
Contra Costa	49,789
Fresno	70,214
Kern	56,124
Kings	7,695
Los Angeles	601,821
Madera	7,434
Riverside	95,774
San Bernardino	112,756
San Francisco	52,906
San Joaquin	51,507
Santa Clara	69,508
Stanislaus	36,947
Tulare	33,085
Sacramento	115,763
San Diego	121,627
Total	**1,573,879**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
April 2014 – June 2014

County	Total Member Months
Alameda	43,727
Contra Costa	17,169
Fresno	22,457
Kern	14,411

County	Total Member Months
Kings	2,091
Los Angeles	219,371
Madera	2,133
Marin	18,784
Mendocino	17,394
Merced	46,681
Monterey	45,498
Napa	13,815
Orange	335,754
Riverside	42,741
Sacramento	40,541
San Bernardino	43,223
San Diego	58,137
San Francisco	25,467
San Joaquin	15,218
San Luis Obispo	25,137
San Mateo	69,390
Santa Barbara	44,701
Santa Clara	32,539
Santa Cruz	29,481
Solano	57,090
Sonoma	51,323
Stanislaus	7,027
Tulare	10,406
Ventura	80,085
Yolo	25,202
Total	**1,456,993**

Enrollment (April 2014 – June 2014)

During the quarter, mandatory SPDs had an average choice rate of 62.8%, an auto-assignment default rate of 12.95%, a passive enrollment rate of 0%, a prior-plan default rate of 1.04%, and a transfer rate of 23.21%. In June, overall SPD enrollment in Two-Plan and GMC counties was 516,483 (point-in-time), a 0.9% decrease from March's enrollment of 521,173. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY9-Q4 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:
The Medi-Cal Managed Care Division (MMCD) continues to update the MMCD Performance Dashboard for the Medi-Cal Managed Care program. On May 6, 2014, the MMCD released the Quarter 4, 2014, edition of the MMCD Dashboard. The dashboard assists 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, Two-Plan, and Rural Expansion), 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 August 2014, MMCD will post the Quarter 1 2014 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 April 2014 and June 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 May 7, 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/May072014SACmeeting.aspx.

Office of the Ombudsman (April 2014 – June 2014)
MMCD's Office of the Ombudsman experienced a decrease in customer calls between the periods January–March 2014 (DY9-Q3) and April-June 2014 (DY9-Q4). During DY9-Q4, the Ombudsman received 40,172 total calls, of which 13,591 concerned mandatory enrollment and 2,685 were from SPDs. During DY9-Q3, the Ombudsman received 12,041 total calls, of which 9,233 concerned mandatory enrollment and 1,231 were from SPDs. This represents a 233.63% increase in total calls, a 51.1% increase in calls regarding mandatory enrollment, and a 211.48% increase in calls regarding mandatory enrollment from SPDs.

For DY9-Q4, 0.34% of SPD and 0.06% of non-SPD calls concerned access issues. This is a small increase in SPD and non-SPD calls from DY9-Q3, during which 0.04% of

SPD calls and 0.01% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) increased for overall measures, but dropped slightly for SPD measures. Total SHRs increased from 584 in DY9-Q3 to 631 DY9-Q4. The percentage of SHRs from SPDs dropped from 49% to 44%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs increased slightly from 149 in DY9-03 to in 155 DY9-Q4. The percentage of those requests from SPDs decreased slightly from 40% to 39%. 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 Q4 Ombudsman Report" and "DY9 Q4 State Hearing Report."

Medical Exemption Requests (April 2014 – June 2014)
The number of MERs/EDERs during this quarter remained relatively unchanged from the previous quarter. The automation of the MER process has kept the number of outstanding MERs to a minimum and EDERs continued to be processed on a daily basis.

Health Risk Assessment Data (October 2013 – December 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs newly enrolled 27,974 SPDs between October 2013 and December 2013[1]. Of those, MCPs stratified 6,757 (24.16%) as high-risk SPDs and 20,690 (73.96%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 88.58%, and, of those contacted, 32.9% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 57.34%, and, of those contacted, 26.8% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 2,502 SPDs to be in the other risk category, which is 8.94% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2013 Risk Data."

Continuity of Care Data (January 2014 – March 2014)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 711 continuity-of-care requests between January and March 2014. Of these, MCPs approved 448 requests (63% of all requests); held 15 requests (2.11%) in process; and denied 248 requests (34.89%). Of the requests denied, 17.74% 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 "Q1 2014 Continuity of Care."

Plan-Reported Grievances (January 2014 – March 2014)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,790 grievances between January and March 2014. Of these

[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.

grievances, 0.45% were related to physical accessibility, 8.94% were related to access to primary care, 3.52% were related to access to specialists, 1.73% were related to out-of-network services, and 85.36% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2014 SPD Grievance."

MERs Data (January 2014 – March 2014)
During 2014, from January through March, 4,212 SPDs submitted 4,907 MERs, an average of 1.17 MERs per SPD who submitted a MER. MMCD approved 3,702 MERs, denied 1,130, and found 75 to be incomplete. The top five MER diagnoses were Complex (547), Cancer (269), Neurological (119), Transplant (105), and Dialysis (63). Summary data is available in the attachment "Q1 2014 MERs Data."

Health Plan Network Changes (January 2014 – March 2014)
According to data reported by MCPs operating under the Two-Plan, GMC and some COHS models, MCPs added 1,186 primary care physicians (PCPs) and removed 2,123 PCPs across all networks, resulting in a total PCP count of 25392. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2014 Network Adequacy," including MCP-level changes in Specialists.

Quality Assurance/Monitoring Activities:
SPD Evaluation (April 2014 – June 2014)
Nothing to report.

Encounter Data (April 2014 – June 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 continued to develop the 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 transition to this new system continued 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.

Outcome Measures and All Cause Readmissions (April 2014 – June 2014)
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 measurement year 2012 was the first year for 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. In August 2014, DHCS plans to 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 36% for adults and 40% for children.

Statewide Collaborative All Cause Readmissions (ACR)
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 includes All Cause Readmission rates for SPD versus non-SPD for measurement years 2011 2012, before the interventions began in 2013. As the SPDs joined managed care, the number of SPD hospitalizations increased from 24,750 in 2011 to 65,818 in 2012; the ACR rates for these years was 16 and 17% respectively. As expected for an older group of members with more health problems, the ACR was 1.5 to 1.8 times higher than for non-SPDs.

Utilization Data (April 2013 – June 2013)
During the period April through June 2013, MCPs in Two-Plan and GMC counties enrolled 525,828 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 10.96% (57,608) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.57 times.
- Each SPD who visited an ER generated an average of 2.44 ER claims.

Pharmacy Services:

- 68.37% (359,486) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 13.88 claims.

Outpatient Services:

- 47.58% (250,191) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.83 visits.
- Each SPD who accessed outpatient services generated an average of 10.82 claims.

Inpatient Services:

- 5.16% (27,134) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 2.84 visits.
- Each SPD who accessed inpatient services generated an average of 3.46 claims.

Hospital Admissions:

- 5.91% (31,065) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 2.06 visits.

Top Ten Services Accessed by SPDs

11,821,233 total claims

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

For the top ten diagnosis categories, MCPs submitted data for a total of 2,967,153 encounters. Mental Illness was in the top rank with 38.36% of the encounters. “Symptoms; signs; and ill-defined conditions and factors influencing health status” accounted for 15.47%. In the third position, “Diseases of the circulatory system” was 8.06%. The remaining seven categories ranged from 7.97% to 3.15% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment Q4 2013 Utilization Data’

Enclosures/Attachments:

- “DY9 Q4 Defaults Transfers 2Plan GMC”
- “DY9 Q4 Ombudsman Report”
- “DY9 Q4 State Hearing Report.
- “Q4 2013 Risk Data”
- “Q1 2014 Continuity of Care”
- “Q1 2014 SPD Grievance”
- "2014 Q1 MERs Data”
- “Q1 2014 Network Adequacy”
- “Q4 2013 Utilization Data”

Please note that the MMCD Advisory Group Meeting was cancelled for the quarter.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

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

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

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

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

Month	HPSM Enrollment Numbers	Difference
Prior Quarter March 2014	1,468	
April 2014	1475	7
May 2014	1,464	-11
June 2014	1,438	-26

Outreach/Innovative Activities:
On June 17, 2014, in San Diego, the Department's Systems of Care Division (SCD) Management met in-person with Rady Children's Hospital San Diego (RADY) and San Diego County representatives. CCS Demonstration Project implementation discussion topics consisted of the following: patient population, patient identification (eligibility and enrollment), Imperial County (feasibility, timing, data analysis/rate impact), medical home assignment, provider network and Medi-Cal rates, geo-mapping requirements, pharmaceutical needs and utilization information (factor purchasing for Hemophilia patients), rates, Family Advisory Council, and outcomes – recommended project evaluation approach.

SCD developed a "DHCS Member Satisfaction Phone Survey" (Survey) for the HPSM CCS DP during this quarter. It is anticipated that SCD will be contacting 970 HPSM families during August 2014, once the Survey beta testing is completed in July. The objective of this Survey is to assess the families' knowledge and satisfaction of the CCS DP, their knowledge and satisfaction with their care coordinator, their access and satisfaction with providers, and their satisfaction with the medical services provided. The Department intends to share the results of the survey with HPSM and the San Mateo County CCS program.

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

Health Plan San Mateo (HPSM) Demonstration Project

Department Communications with CMS

The Department participates in pre-scheduled reoccurring meetings with the Center for Medicare and Medicaid Services (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.

Department Communications with HPSM

The Department and HPSM have been participating in bi-weekly scheduled conference calls to discuss issues related to financial, information technology, reporting, and the upcoming site visit requirements scheduled for late Summer 2014.

Capitated Reimbursement Rates

SCD is in the process of enrolling the CCS State-Only children in San Mateo County into the HPSM CCS Demonstration Pilot (DP). The goal is to automate enrolling the CCS State-Only children and for payment to occur through CAPMAN payment system.[2]

In May 2014, the 9D aid code was established and was made retroactive to November 1, 2013. In May 2014, the 9D aid code was activated for the CCS-Only population and it is anticipated that the implementation will occur in the next quarter.

Aid Codes

January 1, 2014, a list of new Affordable Care Act (ACA) aid codes became available, SCD staff determined which aid codes should be available for HPSM's use for the enrollment of children into the CCS DP. Discussions held in May 2014 with HPSM revealed additional aid codes that may be available for the enrollment of children into the CCS DP. SCD has begun the process of incorporating the identified aid codes (07, 43, and 49) for "foster care" into the CCS DP Table 0242.

Effective August 1, 2014, 27 additional enrollment aid codes are anticipated to be available for HPSM's to enroll children into the CCS DP.

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

DHCS has been working with the Rady Children's Hospital of San Diego (RADY) on a number of items including reimbursement rates, contract documents (scope of work, reporting requirements etc.), readiness review documents and other operational issues.

Capitated Reimbursement Rates

Continuing from mid-October 2011, DHCS has been working on development of

[2] February 10, 2014 SCD received the approved memorandum from MCED to ITSD and CA-MMIS to request the development 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.

reimbursement rates with the Department's rate development branch along with the 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

On April 8, 2014, SCD provided RADY with threshold languages in San Diego County. RADY needed this information for the future translation of notices to potential members. An updated draft contract (including Readiness Review and CMS Checklist) was forwarded to RADY for their review and comment on April 9, 2014. As of April 18, 2014, RADY is reviewing the contract, Readiness Review and CMS Checklist. On May 8, 2014, SCD supplied a template to RADY to utilize which would allow them to satisfy 32 deliverables found in the Readiness Review document. RADY submitted on May 20, 2014, to SCD for review drafts of the Member Services Handbook and Evidence of Coverage (EOC). RADY has begun drafting policies and procedures (P&Ps) and anticipates submitting their P&Ps to SCD in July 2014.

The Department has been participating in weekly scheduled conference calls with RADY to discuss issues regarding:

Pharmaceuticals:

- In an effort to control costs, especially those associated with blood factors, RADY is proposing to contract with preferred pharmaceutical vendors (three to five).
- April 18, 2014, RADY is analyzing the benefits of limiting the number of pharmaceutical vendors that providers could select from to control pharmaceutical costs.

Conditions/Rates:

- May 8, 2014, RADY was considering additional CCS conditions for inclusion into the DP. At that time, current conditions analyzed were Diabetes, Cardiovascular, Leukemia. RADY would request rates after the conditions were finalized.
- May 29, 2014, RADY was analyzing clinical data to add leukemia. SCD ran a preliminary population on all leukemia ICD-9 codes and for Acute Lymphoblastic Leukemia (ALL) ICD-9 codes per RADY's request.
- June 6, 2014, RADY informed SCD of another CCS condition, Types I and II Diabetes, for inclusion in the CCS population.
- SCD supplied RADY with population counts for the original 3 diseases (Hemophilia, Cystic Fibrosis, and Sickle Cell): 145. ALL: 187. Type I and II Diabetes: 588.
- June 26, 2014, the CCS population had not been finalized. DHCS's actuarial contractor, Mercer, will determine RADY's rates once a consensus on the CCS population is reached.

Knox-Keene:

- Knox-Keene Requirements; RADY is currently reviewing the Knox-Keene protections to ensure compliance with the requirements.

Member Handbook/Evidence of Coverage:

- RADY historically has not operated as a health plan; as such, RADY is in the process of developing a Member Services Guide, a Provider Network Guide, and various P&Ps.
- May 18, 2014, RADY was creating the Member Services Guide/EOC, Provider Network Guide, and P&Ps not currently in place.
- May 22, 2014, RADY provided to SCD drafts of the Member Services Handbook and EOC to satisfy many deliverables in the Readiness Review document.
- June 26, 2014, SCD provided feedback on three-fourths (3/4) of the Member Services Handbook and anticipates completing the remainder of the review by July 1, 2014.

Disenrollment/Enrollment:

- Discussions related to the process for disenrollment of eligible clients from five San Diego GMC plans and enrollment into the CCS demonstration.

FQHC:

- RADY is in the process of enhancing their provider network to include additionally Federally Qualified Health Centers (FQHCs) that are currently serving the target population. RADY continues to identify FQHC providers serving the targeted population and has added them into their network.

Access Standards:

- RADY does not have GeoMap capabilities; as such, ongoing efforts continue to explore various mechanisms to satisfy statue requirements for geographical access. Attempts include utilizing Microsoft Excel to comply with the requirements for geographical access by using both PCP and patient zip codes as 'distance criteria' to satisfy the access requirements.

RADY – Site Visit

On June 17, 2014 the SCD Management met in-person, in San Diego, with RADY and San Diego County representatives to discuss implementation efforts.

Pilot Schedule

It is anticipated the 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 has been the 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.

Complaints, Grievances, and Appeals

On April 30, 2014, HPSM submitted a “Pending and Unresolved Grievances Quarterly Report” for the first quarter, January - March 2014. The Grievances Report shows during the first quarter:

- 12 grievances were received; (1 for Coverage / Benefit and 11 for Medical Necessity)
- 12 grievances were resolved
- 0 grievances unresolved within 30 days

The Grievances Report further disseminates the types of grievances that are tracked and follow: Coverage/Benefit, Medical Necessity, Quality of Care, Access, Customer

Service, Privacy Issues, Quality of Care, Fraud/Waste/Abuse, and Other. See the attachment Q1 2014 CCS Grievances Report.

Consumer Issues:

On May 7, 2014, DHCS presented an update on the CCS pilots to members of the DHCS Waiver Stakeholder Advisory Committee (SAC), a meeting forum open to the public, which is composed of subject matter experts and consumer advocates. Full documentation from the meeting is available at: http://www.dhcs.ca.gov/Pages/May072014SACmeeting.aspx.

Financial Activities:
HPSM

Enrolling CCS-Only
SCD has met with ITSD, Medi-Cal Eligibility Division (MCED) and OHC multiple times during this quarter to enroll the CCS-Only children into San Mateo County into the HPSM CCS Demonstration Pilot. The goal is to have an automated process with invoicing occurring through CAPMAN. The automated process is expected to take several months to implement, in the interim, SCD has been manually enrolling and invoicing the HPSM Demonstration.

Financial Review
SCD completed a financial review on HPSM's DP quarterly reports; specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with 85%< being the target. Please refer to attachment *CCS HPSM Plan Analysis DY9 Q4.*

Quality Assurance/Monitoring Activities:

On May 9, 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
1/1/2014 – 3/31/2014	1,490	108	129	1,469	12,786

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

Report Name	Date Due	Received	Pending Review	SCD Approved
Provider Network Reports (Rpt #4)	4/30/2014	5/1/2014		YES
Grievance Log/Report (Rpt #4)	4/30/2014	4/30/2014		YES
DMHC Required Financial Reporting Forms (Rpt #1)	5/1/2014	4/28/2014		YES Changed from October to May
Financial Audit Report (Rpt #1)	5/1/2014	5/2/2014		YES
Quarterly Financial Statements (Rpt #4)	5/15/2014	5/12/2014		YES
Report of All Denials of Services Requested by Providers (Rpt #3)	5/15/2014	7/16/2014	✓	
Annual Forecasts (Rpt #1)	6/30/2014	6/30/2014		YES

Evaluations:
Nothing to report.

Enclosures/Attachments:
Attached enclosures: "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*, CCS HPSM Plan Analysis DY9 Q4 and Q1 2014 CCS Grievances Report.

LOW INCOME HEALTH PROGRAM (LIHP)

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

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

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

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

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

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

Enrollment Information:

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:

Nothing to report.

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, but have been focusing on LIHP administrative 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.

DHCS submitted a revised county specific cost claiming protocol for San Bernardino LIHP to add district hospitals under Attachment G, Supplement 1, Section K as Other Governmental Entities in April 2014. These district hospitals provided services to LIHP enrollees and can report CPEs for claiming purposes from January 1, 2012 through December 31, 2013 for these LIHP services.

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

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

With the May 21, 2014 technical corrections to the Special Terms and Conditions (STCs), DHCS received CMS approval of an edit to Attachment G, Supplement 1 to make necessary revisions regarding the cost claiming process for mental health services, 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 STCs.

With the May 21, 2014 technical corrections to the STCs, DHCS received CMS

approval to correct the close-out period date reference from 2013 to 2014 in the Attachment J protocol.

DHCS is awaiting a CMS decision on the request submitted December 27, 2013, regarding the exclusion of HCCI for the Primary Care Provider (PCP) increased payment per the CMS ruling on 42 CFR Part 438, 441, and 447 which entitles the LIHP PCPs to receive the increased amount for the calendar year (CY) 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.

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

- DHCS Coordinated with 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 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 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 has requested guidance from CMS on how amendments to previously expired contracts should be handled for LIHP.

DHCS worked with CAASD-DHCS and CDSS on the completion of the interagency agreement (IA) for the LIHP State Fair Hearings and Appeals. The IA was executed on June 27, 2014.

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:

- DHCS reviewed the aggregate annual report submitted by California Health Care Institute for DY8.
- DHCS reviewed the semi-annual report for DY9.
- DHCS worked to clarify the Category 5 HIV carry-forward process for milestones not fully achieved by DPHs in a particular demonstration year.

DHCS serve as the liaison between UCLA and CMS regarding the UCLA DSRIP External Evaluation. DHCS reviewed and provided input on the Category 5 HIV Interview questions.

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. DHCS executed DUAs for the following LIHPs: Orange, San Diego, and Ventura. DHCS finished the DUA execution process by establishing DUAs with these final three LIHPs.

DHCS continued the process to initiate the reimbursement of funds, from all 19 LIHPs, for reimbursement of costs DHCS has and will be incurring related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

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.

Consumer Issues:

DHCS 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 operational and transition activities.

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

- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition to health care coverage under Medi-Cal of individuals diagnosed with HIV, who had been receiving health care services through the Ryan White programs and had transitioned to a local LIHP prior to January 1, 2014. In addition, 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**
Administrative Activities (Qtr. 4)	$19,124	$0.00	$38,248	PY 1	$19,124
	$525	$0.00	$1,050	PY 3	$525
CDCR (Qtr. 4)	$109,109	$0.00	$218,218	DY 7	$109,109
	$2,928,913	$0.00	$5,857,826	DY 8	$2,928,913
	$6,481,750	$0.00	$12,963,500	DY 9	$6,481,750
Health Care (Qtr. 4)	$2,031,797	$0.00	$4,063,594	PY 2	$4,063,594
	$1,452,053	$0.00	$2,904,106	PY 3	$1,452,053
	$1,983,528	$0.00	$3,967,056	DY 7	$1,983,528
	$12,344,016	$0.00	$24,688,032	DY 8	$12,344,016
	$116,278,570	$0.00	$232,557,140	DY 9	$116,278,570
	$1,950,511	$1,950,511	$0.00	DY7	$3,901,022
	$6,528,773	$6,528,773	$0.00	DY8	$13,057,546
	$656,070	$656,070	$0.00	DY9	$1,312,140
Total	**$152,764,739**	**$9,135,354**	**$287,258,770**		**$163,931,890**

Quality Assurance/Monitoring Activities:

DHCS continues to monitor activities and analyze information submitted by local LIHPs to ensure final compliance with LIHP contracts.

Enclosures/Attachments:
Nothing to report.

Community-Based Adult Services (CBAS)

Assembly Bill (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, and was replaced with a new program called Community-Based Adult Services (CBAS) effective April 1, 2012. The Department of Health Care Services (DHCS) amended the "California Bridge to Reform" 1115 Demonstration Waiver (BTR Waiver) to include CBAS, which was approved by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2012. CBAS is operational under the BTR Waiver for the period of April 1, 2012, through August 31, 2014.

In anticipation of the end of the CBAS BTR Waiver period, DHCS and California Department of Aging (CDA) conducted extensive stakeholder input regarding the continuation of CBAS. DHCS submitted an amendment to the CBAS BTR waiver to extend CBAS for another five year, with an effective date of September 1, 2014. CMS has extended the current CBAS BTR Waiver end date until October 31, 2014 to complete its review of the proposed amendment.

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 eligibility 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 eligibility 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 plan of care 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 a face-to-face assessment is performed.

The State must assure CBAS access/capacity in every county in which ADHC services had been provided on December 1, 2011.[3] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) began providing CBAS as a

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

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 currently not available (four counties: Shasta, Humboldt, Butte; Imperial).

If there is insufficient CBAS center capacity to satisfy the demand in counties which had 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 is 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 4 is shown in Table 2, *Preliminary CBAS Unduplicated Participant Data for FFS and MCO Enrollment,* 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, enrollment data reflects that the CBAS participation remains under 30,000 statewide. FFS Claims data, which has a lag factor, is used for the FFS enrollment data.

CBAS Assessments:
During DY9, Quarter 4 (April 2014 through June 2014), Managed Care Plans reported that they conducted 1,965 face-to-face CBAS assessments by registered nurses. Of these new assessments 98.5% were found eligible for CBAS; only 30 were found not eligible or 1.5% of the assessments. 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 290 new CBAS eligibility assessments for FFS beneficiaries were requested and completed by DHCS' registered nurses. Of these new assessments 97% were found eligible for CBAS.

Enhanced Case Management (ECM):

The ECM Participant Average Quarterly data (Table below) shows the number of ECM-eligible individuals. These individuals were served at a local ADHC Center from July 1, 2011 through 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 care needs, coordinating services and reaching out for community referrals.

Due to State Fair Hearing decisions, the ECM-FFS participation dropped during the later part of 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 ECM-FFS 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 ECM-FFS 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 clients continue to drop during Quarter 4. The Table below tracks the ECM-FFS Participant Average Quarterly Data since ECM began in April 2012 (Original Count) to this current DY 9, Quarter 4:

ECM Participant Average Quarterly Data			
Report Quarters	**Average Qrtly. Enrollment**	**Average Qrtly. Incoming Members***	**Average Qrtly. Outgoing Members****
Original Count	**1560**		
DY7 - Q 4			
April-June'12	1422	66	107
DY8 - Q1			
July-Sept'12	1546	79	45
DY8 - Q2			
Oct.-Dec.'12	1126	20	210
DY8 - Q3			
Jan.-Mar'13	918	23	48
DY8 - Q4			
April-June'13	708	17	33
DY9 - Q1			
July-Sept.'13	646	16	74
DY9 - Q2			
Oct.-Dec. '13	459	13	200
DY8 - Q3			
Jan.-Mar'13	453	19	25
DY8 - Q4			
April-June'13	**414**	**11**	**50**
			DHCS ECM Data 07/01/2014

Outreach/Innovative Activities:

During DY9 Q4, DHCS continued to work closely with CBAS Center providers and various Managed Care Plans regarding CBAS program benefits and eligibility of participants.

Operational/Policy Development/Issues:

CBAS Centers/Provider Issues:

As of June 30, 2014, CDA, the state 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 on April 1, 2012, through June 30, 2014 (DY9, Quarter 4):

CBAS Center History

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

CDA Data as of 7/1/2014

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 the California Department of Aging (CDA) on their planned closure date and to conduct discharge planning for all their CBAS participants. While most CBAS Centers notify CDA and carefully link participants with 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 4 period, there was one Center closure (San Diego County), and one opening/change of ownership in Santa Clara County (see CBAS Licensed Capacity Table). Prior to the center closing, the majority of participants were relocated to another center. There were only 21 participants affected by the closure that needed unbundled services. The participants affected were able to receive unbundled services (i.e., IHSS, physical therapy, occupational therapy, speech therapy, and/or other HCBS waiver services). The Table below shows the amount of time for participants to connect with another available service. Additionally, there were 5 participants that remained in the community with family support and had no further claims associated with unbundled services or CBAS.

	Within 1 Week	Within 2 Week	Within 3 Week	Within 1 Month	Within 2 Months	Within 3 Months	Within 5 Months	TOTAL
CBAS	5	3	2	0	2	2	1	15
Unbundled	19		2					21
No Services	5							5
DHCS / CDA Compiled Data 7/2014							Total	41

CBAS Fair Hearings:

CBAS Fair Hearings continue to be held through the normal State Hearing process, with the California Department of Social Services (CDSS) Administrative Law Judges' hearing all cases filed. As of DY 9, Quarter 4, a total of 16 cases were filed/heard (from the approximate 29,000 participants), averaging about four per quarter, throughout the State.
Several of the Hearings have been related to Managed Care enrollment; other Hearings relate to increases in service days or authorization of days of attendance.

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 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 four Quarters:

Demonstration Year 9 - Data on CBAS Complaints					
Year	**Demo Year 9 Quarters**	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
2013	DY9 - Qrt 1 (Jul 1 - Sep 30)	7	3	10	0.46%
2013	DY9 - Qrt 2 (Oct 1 - Dec 31)	8	9	17	0.93%
2014	DY 9 - Qrt 3 (Jan 1 - Mar 31)	6	2	8	0.44%
2014	**DY 9 - Qt 4** (Apr 1 - Jun 30)	**5**	**18**	**23**	**0.08%**
				CDA data - Phone & Email Complaints	

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activity:

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

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

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	DY9-Q4 Apr-Jun 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	415	355	355	355	355	355	355	**355**	0%	**83%**
Butte	60	60	60	60	60	60	60	60	**60**	0%	**40%**
Contra Costa	190	190	190	190	190	190	190	190	**190**	0%	**58%**
Fresno	590	590	530	530	547	572	572	572	**572**	0%	**81%**
Humboldt	229	229	229	229	229	229	229	229	**229**	0%	**29%**
Imperial	250	250	250	315	315	315	330	330	**330**	0%	**69%**
Kern	200	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	**18,184**	0.6%	**60%**
Marin	75	75	75	75	75	75	75	75	**75**	0%	**22%**
Merced	109	109	109	109	109	109	109	109	**109**	0%	**55%**
Monterey	290	290	290	-	-	110	110	110	**110**	0%	**17%**
Napa	100	100	100	100	100	100	100	100	**100**	0%	**53%**
Orange*	1,897	1,897	1,747	1,747	1,747	1,847	1,847	1,847	**1,910**	3%	**53%**
Riverside	640	640	640	640	640	640	640	640	**640**	0%	**42%**
Sacramento	529	529	529	529	529	529	529	529	**529**	0%	**57%**
San Bernardino	320	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	**1,873**	-2.6%	**61%**
San Francisco	803	803	803	803	803	803	866	866	**866**	0%	**72%**
San Mateo*	120	120	120	120	120	120	120	120	**135**	12.5%	**44%**
Santa Barbara	55	55	55	55	55	55	55	55	**55**	0%	**63%**
Santa Clara*	820	820	820	820	750	770	770	770	**840**	9.1%	**56%**
Santa Cruz	90	90	90	90	90	90	90	90	**90**	0%	**68%**
Shasta	85	85	85	85	85	85	85	85	**85**	0%	**29%**
Solano	120	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	**806**	0%	**67%**
Yolo	224	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	**29,007**	0.69%	**60%**

CDA Licensed Capacity as of 06-30-2014

Los Angeles - 3 centers increased license capacity
Orange - 1 center increased license capacity
San Diego - 1 center closed
San Mateo - 1 center increased license capacity
Santa Clara - 1 center opened

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

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 Quarter. Three counties increased capacity (Santa Clara, LA, San Mateo) while one county (San Diego) had a decrease in licensed capacity due to a Center closure. 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 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 minimally impact the program or beneficiaries served.

TABLE 2:

Preliminary **CBAS Unduplicated Participant - FFS and MCO Enrollment Data with County Capacity of CBAS**

	DY9 Q1 July - Sept 2013			DY9 Q2 Oct - Dec 2013			DY9 Q3 Jan - Mar 2014			**DY9 Q4 Apr - June 2014**		
County	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used
Alameda	10	490	83%	9	535	90%	8	465	79%	7	480	81%
Butte	46		45%	42		41%	39		38%	40	0	39%
Contra Costa	12	193	64%	14	185	62%	10	119	40%	6	182	58%
Fresno	10	615	68%	9	604	67%	7	659	69%	13	788	83%
Humbolt	234		60%	116		30%	110		28%	111	0	29%
Imperial	394		70%	389		70%	380		68%	389	0	70%
Kern		113	34%		85	26%		89	26%	0	186	55%
Los Angeles	1,193	15,255	55%	1,039	15461	55%	1,020	15177	54%	1145	17667	61%
Merced		99	54%		110	60%		101	55%	0	99	54%
Monterey			0%		66	35%		66	35%	0	69	37%
Orange	12	1,870	60%	9	1899	61%	5	2515	81%	5	1708	53%
Riverside	22	386	38%	21	425	41%	18	389	38%	14	401	38%
Sacramento	28	578	68%	25	398	47%	30	549	65%	17	567	65%
San Bernardino	20	412	80%	19	477	92%	14	411	78%	18	311	61%
San Diego	41	1,549	47%	33	1418	43%	36	1403	42%	38	1922	62%
San Francisco	68	666	50%	58	746	55%	53	659	49%	69	961	70%
San Mateo		142	70%		146	72%		136	67%	0	88	38%
Santa Barbara		4	4%		4	5%		3	3%	0	56	60%
Santa Clara	2	728	56%	4	592	46%		559	43%	9	717	51%
Santa Cruz		104	72%		105	73%		100	66%	0	104	68%
Shasta	82		57%	40		28%	40		28%	42	0	29%
Ventura	8	486	36%	7	959	71%	10	911	67%	8	900	67%
Yolo*	3	227	61%	3	225	60%	2	220	59%	2	215	57%
Marin, Napa, Solano**		271	54%		220	44%		224	45%	0	235	47%
Total	**2,185**	**24,227**	**54%**	**1,837**	**24,660**	**54%**	**1,782**	**24,791**	**54%**	**1,933**	**27,656**	**60%**
Combined Totals	**26,412**			**26,497**			**26,573**			**29,589**		

*Yolo updated data

DHCS / CDA Enrollment Data 7/2014

Enclosures/Attachments:
Nothing to report.

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$ 0		$ 0	DY 7	$ 0
(Qtr 1)	$ 32,166,667		$ 32,166,667	DY 8	$ 64,333,334
(Qtr 1)	$ 77,749,999		$ 77,749,999	DY 9 (Jul-Sept)	$ 155,499,998
(Qtr 2)	$ 77,750,000		$77,750,000	DY 9 (Oct-Dec)	$ 155,500,000
(Qtr 4)	$ 77,750,000		$ 77,750,000	DY 9 (Jan-Mar)	$ 155,500,000
(Qtr 4)	$ 51,833,334		$ 51,833,334	DY 9 (Apr-Jun)	$ 103,666,668
Total:	**$ 317,250,000**		**$ 317,250,000**		**$ 634,500,000**
DSRIP					
(Qtr 2)	$ 1,061,212.50	$ 1,061,212.50		DY 7	$ 2,122,425.00
(Qtr 2)	$ 367,054,154.24	$ 367,054,154.24		DY 8 (Jan-Jun)	$ 734,108,308.48
(Qtr 4)	$ 499,500.00	$ 499,500.00		DY 7	$ 999,000.00
(Qtr 4)	($ 183,062.50)	($ 183,062.50)		DY 8	($ 366,125.00)
(Qtr 4)	$ 380,937,063.93	$ 380,937,063.93		DY 9 (Jul-Dec)	$ 761,874,127.86
Total:	**$ 749,368,868.17**	**$ 749,368,868.17**			**$ 1,498,737,736.34**
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr 1)	$ 41,382,406		$ 41,382,406	DY 9 (Jul-Sep)	$ 82,764,811
(Qtr 2)	$ 62,154,551		$ 62,154,551	DY 9 (Oct-Dec)	$ 124,309,102
(Qtr 3)	$ 126,186,806		$ 126,186,806	DY 9 (Jan-Mar)	$ 252,373,612
(Qtr 4)	$ 115,769,434		$ 115,769,434	DY 9 (Apr-Jun)	$ 231,538,868
Total:	**$ 345,493,197**		**$ 345,493,197**		**$ 690,986,394**

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 $ 115,769,434 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 $ 129,583,334 in federal fund payments for SNCP eligible services.

III. DELIVERY SYSTEM REFORM INCENTIVE POOL PAYMENT UPDATE

Nothing to report.

IV. WAIVER EXPENDITURES/MEMBER MONTH REPORTING

As previously reported to CMS, the budget neutrality (member months and expenditures) reporting for the 1115 Waiver experiences an ongoing data lag (a minimum of 30 days beyond the 60 day for reporting) due to limitations of the Department's CAPMAN payment processing system. The Department expects to report on DY 9 Quarter 3 (01/01/14 – 03/31/14) in September of 2014. The report for Quarter 4 (04/01/14-06/30/14) will experience an additional delay due to correcting and clearing of delayed capitation payments which impacted invoices starting in April 2014. The monthly capitation cycle is currently estimated to take 12 days and the system cannot be accessed to generate reports during that time. Additionally, the Waiver summary report templates (expenditures and member months) will need to be updated to reflect additional Medicaid Eligibility Categories that have been added (Optional Expansion, Coordinated Care Initiative, etc.) which creates additional workload on key staff in our rates development and accounting programs. We are anticipating submission of the DY 9 Q4 report by the end of October 2014.

TRANSITION OF THE HEALTHY FAMILIES PROGRAM TO MEDI-CAL MANAGED CARE

DHCS continues to find no significant impact to the transition and has determined that there has been minimal to no disruption to services during this report period. DHCS publishes monthly reports which include the following information: health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks including provider enrollment and disenrollment changes, and eligibility performance standards. Monthly reports can be found at http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

ACA OPTIONAL EXPANSION: NEW ADULT GROUP

Beginning January 1, 2014, adults between the ages of 19-64 and with incomes at or below 138% FPL became eligible for Medi-Cal and enrollment into a managed care plan. In addition, Low Income Health Plan (LIHP) beneficiaries who were formally served at the counties were also transitioned into Medi-Cal managed care. As of March 2014, approximately 700,000 beneficiaries were enrolled in Medi-Cal managed care due to the ACA optional expansion. The optional expansion enrollment data for Quarter 3 and 4 will be included in the Annual Report.

COORDINATED CARE INITIATIVE (CCI) AND CAL MEDICONNECT PROGRAM (CMC)

DHCS implemented CCI April 1, 2014. The goal of CCI is to offer integrated care across delivery systems and rebalance service delivery away from institutional care and into the home and community. The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. This amendment also allows for the operation of a Program of All-Inclusive Care for the Elderly (PACE) in Humboldt County alongside the Humboldt County-Organized Health System (COHS) plan.

The total active enrollment for Cal MediConnect as of the end of Quarter 4 is 39,731 beneficiaries. Projected enrollment trends, as well as breakdown by plans, can be found on the Cal MediConnect Monthly Enrollment Dashboard at:
http://www.dhcs.ca.gov/Documents/CMC_EnrollmentDashboard(July2014).pdf
The July 1, 2014 report reflects data through June 30, 2014.

RURAL MANAGED CARE EXPANSION

On September 1, 2013, Medi-Cal Managed Care expanded into eight northern rural California counties, including; Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou and Trinity under the County Organized Health System model of managed care. On November 1, 2013, the remaining 20 Fee-For-Service counties, including; Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono,

Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne and Yuba were transitioned to managed care. In 19 of the 20 counties, there are two health plans. In San Benito, since there is only one health plan, managed care enrollment remains voluntary. DHCS submitted a waiver to transition SPDs into Medi-Cal managed care in the 20 non-COHS counties with an effective date of January 1, 2015. Additionally, the CBAS benefit will transition to the managed care plans in four rural counties: Shasta, Humboldt, Butte, and Imperial. These counties are the only new managed care counties that have CBAS Centers.

See attachment *Managed Care Rural Expansion Report 2014* for enrollment information.

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
DY9, Q4	April – June 2014	471,221	157,788	$281,705,513