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

DHCS

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

November 27, 2013

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QUARTERLY PROGRESS REPORT FOR THE PERIOD 07-01-2013 THROUGH 09/30/2013 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Ms. Gerrits, Mr. Nelb, 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 first quarterly progress report for Demonstration Year Nine, which covers the period from July 1, 2013 through September 30, 2013.

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

Sincerely,

Toby Douglas
Director

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

INTRODUCTION:

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

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

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

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

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

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

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

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

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

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

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

Enrollment information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
July 2013 – September 2013

County	Total Member Months
Alameda	89,273
Contra Costa	47,601
Fresno	68,719
Kern	54,932
Kings	7,541
Los Angeles	588,978
Madera	7,328
Riverside	93,672
San Bernardino	110,290
San Francisco	52,226
San Joaquin	50,416
Santa Clara	66,799
Stanislaus	31,160
Tulare	31,931
Sacramento	112,599
San Diego	118,301
Totals	**1,531,766**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2013 – September 2013

County	Total Member Months
Alameda	38,628
Contra Costa	14,495
Fresno	19,900
Kern	12,520

County	Total Member Months
Kings	1,811
Los Angeles	187,443
Madera	1,787
Marin	18,300
Mendocino	17,248
Merced	45,403
Monterey	43,778
Napa	13,278
Orange	323,251
Riverside	30,143
Sacramento	34,364
San Bernardino	31,793
San Diego	37,077
San Francisco	22,030
San Joaquin	12,455
San Luis Obispo	24,609
San Mateo	66,667
Santa Barbara	43,552
Santa Clara	29,670
Santa Cruz	28,723
Solano	54,798
Sonoma	49,125
Stanislaus	5,223
Tulare	8,886
Ventura	76,960
Yolo	24,118
Totals	**1,109,118**

Enrollment (July 2013 – September 2013)
During the quarter, mandatory SPDs had an average choice rate of 52.78%, an auto-assignment default rate of 31.39%, a prior-plan-default rate of 1.44%, and a transfer rate of 14.39%. In September, overall SPD enrollment in Two-Plan and GMC counties was 505,797 (point-in-time), a 0.16% decrease over June's enrollment of 506,600. For monthly aggregate and Medi-Cal managed care plan (MCP)-level data, please see the attachment "DY9-Q1 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

With funding from the California HealthCare Foundation (CHCF), Medi-Cal Managed Care Division (MMCD) engaged a vendor, Navigant, to create a dashboard for the Medi-Cal managed care program. An initial draft of the dashboard was delivered to MMCD early this quarter and has since undergone extensive executive level review and subsequent modification. Once completed, the dashboard will help DHCS and its stakeholders to better observe and understand Managed Care Plan (MCP) activities on all levels: statewide, by managed care model (i.e., COHS, GMC, and Two-Plan), and within an individual MCP. It will include metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, finances, care coordination, and continuity of care. It will also stratify reported data by beneficiary populations including Medi-Cal-only SPDs. Navigant Consulting will be providing DHCS with a final recommendations report with future dashboard considerations by November 2013.

By January 2014, MMCD will complete several quarterly iterations of the dashboard internally to validate the timeliness and accuracy of the data and ensure it is ready for public release. After completing a period of thorough testing, DHCS will prepare a public version of the dashboard for posting to its external website.

Operational/Policy Issues:

Network Adequacy
Between July 2013 and September 2013, 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 August 5, 2013, the DHCS Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened and discussed the following items:

Coordination of benefits between county mental health plans and MCPs
MMCD continues to work with stakeholders to develop policies and procedures that improve the exchange of beneficiary and program information between MCPs and county mental health plans (MHPs). DHCS's executive team is communicating with representatives of county agencies, advocacy groups, and legislators to craft the details of these policies and procedures. MMCD and DHCS's Mental Health and Substance Use Disorder Services program are clarifying the scope of benefits available through the 1115 Waiver, the Specialty Mental Health Services Waiver, and the Drug Medi-Cal Waiver, and how to coordinate the provision of these services between MHPs and

MCPs. As the executive team more clearly defines these program and procedural components, it will engage a broader range of stakeholders from MCPs and county agencies to determine how existing provider networks will be properly trained and made available to all Medi-Cal beneficiaries and how these provider networks will communicate among and between themselves so that the networks work correctly. The same benefits will be available to fee-for-service (FFS) beneficiaries. MMCD staff members are working through existing systems to assess how to monitor MCP cooperation in coordinating care with MHPs.

Responsibilities shared between MHPs and MCPs

With the full implementation of the 1115 Waiver, MCPs are providing enhanced acute care, preventive services, and care coordination to over 9 million persons. As MCPs perform initial health assessments that include behavioral health components, MCPs are able to appropriately refer persons for mental health and substance use disorder services. Now that basic mental health services are available through MCPs, there is a greater incentive for MCPs and MHPs to coordinate their care. Although these services are separately financed, DHCS is pushing in the direction of creating a seamless, integrated system of care. MCP providers conduct screening, perform brief interventions, and refer beneficiaries, as needed, to the mental health and substance use disorder system. DHCS continues to develop its expectations for how these assessments and services are provided to both adults and children. Federally qualified health centers and rural health centers, to the extent they are billing with required types of providers, are currently able to conduct claimable visits. All MCPs will have these benefits in their systems.

Mental health pharmacy

Pharmacy benefits will not change because it is a separate system, and the prior authorization system will not change. DHCS continues to review many questions about pharmacy benefits, including how to coordinate narcotic prescription drugs that are not county mental health benefits.

Eligibility and enrollment readiness

DHCS continues to fully engage the development of critical electronic data systems related to Medi-Cal eligibility and MCP enrollment. DHCS continues to work with the County Welfare Directors Association to determine how to serve the consumer and how these systems affect the flow business. Counties make a final determination on initial eligibility applications. If they are all electronic, it happens through the system; otherwise, enrollment can be more complex and time-consuming. MCPs must comply with Knox-Keene readiness requirements through the Department of Managed Health Care. DHCS is working with CMS to obtain CMS approval of DHCS's payment system for primary care providers. DHCS anticipates receiving CMS approval and funding this fall so MCPs can pay their providers backward to January 2013 and going forward.

Full documentation from the meeting can be found at:
http://www.dhcs.ca.gov/Pages/August52013SACMeeting.aspx

Office of the Ombudsman (July 2013 – September 2013)
MMCD's Office of the Ombudsman experienced a slight decrease in customer calls between the periods April–June 2013 (DY8-Q4) and July-September 2013 (DY9-Q1). During DY9-Q1, the Ombudsman received 15,076 total calls, of which 5,099 concerned mandatory enrollment, and 1,391 were from SPDs. In DY8-Q4, the Ombudsman received 15,090 total calls, of which 4,998 concerned mandatory enrollment, and 1,523 were from SPDs. This represents a 0.09% decrease in total calls, a 2.02% increase in calls regarding mandatory enrollment, and an 8.67% decrease in calls regarding mandatory enrollment from SPDs.

For DY9-Q1, 0.11% of SPD and 0% of non-SPD calls concerned access issues. This is a small increase in SPD calls and a small decrease in non-SPD calls from DY8-Q4, during which 0.05% of SPD calls and 0.03% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) decreased for all measures. Total SHRs decreased from 675 in DY8-Q4 to 595 in DY9-Q1. The percentage of SHRs from SPDs also decreased from 67% to 63%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs also decreased from 224 in DY8-Q4 to 166 in DY9-Q1. The percentage of those requests from SPDs stayed at 61%. The Ombudsman received no SHRs related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachment "DY9 Q1 Ombudsman Data."

Medical Exemption Requests (July 2013 – September 2013)
DHCS continued to devote a significant amount of staff time and resources during this quarter to processing Medical Exemption Requests (MERs) and Emergency Disenrollment Requests (EDERs) for SPDs and other beneficiaries affected by the two errors related to the processing of MERs. Despite efforts to address the high volume of MERs by reprioritizing staff responsibilities and on streamlining and automating the review process, the number of outstanding MERs continued to increase. MMCD has requested other DHCS divisions to assign their nurses to help MMCD review MERs. MMCD established an intra-DHCS MOU, which is in discussion. MMCD will conduct MER training for nurses in October 2013.

DHCS continued to develop an electronic system for clinical staff to process MERs. This electronic system will decrease the time the clinical staff requires to process MERs, decrease the potential for errors, and streamline the reporting process. DHCS conducted testing of the electronic system in June 2013 and launched the system on July 8, 2013. DHCS conducted staff training on July 1, 2013.

In 2012, DHCS established a MER Workgroup that included key advocates, stakeholders, and staff members from DHCS and the State Legislature. The purpose of the MER Workgroup is to revise the MER application form, draft new informing

materials, create call-center scripts, and improve the MER process and its efficiency. To achieve these goals, DHCS continues to meet at least once each month with the MER Workgroup. Ongoing issues for discussion included publishing a MER Continuity of Care APL, revising beneficiary notifications (such as approval and denial letters), clarifying MER denial codes, and revising the MER form. The MER Workgroup is instrumental in providing important and valuable feedback. DHCS achieved these goals during this quarter.

Health Risk Assessment Data (January 2013 – March 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs newly enrolled 28,802 SPDs between January 2013 and March 2013. Of those, MCPs stratified 8,521 (29.58%) as high-risk SPDs and 19,871 (68.99%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 90.45%, and, of those contacted, 25.45% completed a Health Risk Assessment Survey. Of the low-risk SPDs, MCPs contacted 72.93%, and, of those contacted, 57.54% completed a Health Risk Assessment Survey. After the Risk Assessment Surveys were completed, MCPs determined 3,456 SPDs to be in the other risk category, which is 12% of the total enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2013 Risk Data."

Continuity of Care Data (April 2013 – June 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,938 continuity of care requests between April and June 2013. Of these, MCPs approved 1,665 requests (85.91% of all requests); held 3 requests (0.2%) in process; and denied 270 requests (13.93%). Of the requests denied, 21.48% of the requests were because the provider and MCP could not agree to a payment rate. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2013 Continuity of Care."

Plan-Reported Grievances (April 2013 – June 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,640 grievances between April and June 2013. Of these grievances, 0.18% were related to physical accessibility, 12.2% were related to access to primary care, 6.4% were related to access to specialists, 1.22% were related to out-of-network services, and 80% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2013 SPD Grievance."

MERs Data (April 2013 – June 2013)
During the period April 2013 through June 2013, data is not available due to the transition from a manual to automated electronic system.

Health Plan Network Changes (April 2013 – June 2013)
According to the data reported by MCPs operating under the Two-Plan and GMC models, MCPs added 1,075 primary care physicians (PCPs) and removed 1,173 PCPs across all networks, resulting in a total PCP count of 20,888. Quarterly aggregate and

MCP-level data is available in the attachment "Q2 2013 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report

Quality Assurance/Monitoring Activities:

SPD Evaluation (July 2013 – September 2013)
DHCS staff have reviewed all data collected to date and composed a list of recommended questions to include in the evaluation. In addition, DHCS hired consultants to provide a cost-value analysis of SPD program before and after transitioning into managed care. A draft of the evaluation design will be discussed with CMS in the next couple of months. A final evaluation design of SPDs' transition will be issued before the end of calendar year 2013.

Encounter Data (July 2013 – September 2013)
During the reporting period, the Encounter Data Quality Unit (EDQU) continued its work implementing and maintaining 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 the Department's data warehouse, and reporting on data quality internally and externally. As part of this plan, EDQU continued to develop metrics that will objectively measure the quality of MCP-submitted encounter data in the dimensions of completeness, timeliness, reasonableness, and accuracy. EDQU also continued to identify specific MCOs with missing encounter data to work with them to resolve the deficiencies. Although these efforts did not specifically target SPDs, improving the quality of the Department's encounter data will enable better monitoring of the services and care provided to this population.

Outcome Measures and Avoidable Hospitalizations (July 2013 – September 2013)
DHCS employs multiple strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures
DHCS is responsible for ensuring that HEDIS reporting complies with the requirements of the Section 1115 Medicaid Waiver. In November 2012, DHCS released the final HEDIS measures for 2013 (measurement year 2012) and the final SPD stratification method for MCPs to use for selected measures. HEDIS 2013 (measurement year 2012) is the first time that MCPs were required to stratify measures for the SPD/non-SPD population and is therefore the first time comparisons between these populations can be analyzed. For services delivered in 2012 (HEDIS reporting year 2013), the HEDIS measures show better results for SPDs than non-SPDs for all the diabetes care indicators (except blood pressure control) and monitoring people on persistent medications. SPDs utilized more ambulatory care visits per 1000 member months than

non-SPDs, and had higher rates of hospital readmissions. DHCS is currently analyzing these data in more depth to better understand the findings. It is important to note that these results need to be considered preliminary, because not all SPDs had transitioned to managed care by January 1, 2012.

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

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

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

The survey closed in May with a response rate of 35% for adults and 39% for children. The final report will be published in the first quarter of 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 managed care plan (MCP) members. DHCS worked with MCPs and DHCS's external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to develop guiding principles, a HEDIS-like measure specific to the Medi-Cal population, and a collaborative evaluation plan.

In 2012, MCPs submitted their *All-Cause Readmissions (ACR) Collaborative QIP* proposals, which included their historical calendar year (CY) 2011 data, to the Medi-Cal Managed Care Division (MMCD). The QIP proposals were reviewed by MMCD and validated by HSAG.

During the first quarter of CY 2013, MCPs submitted documentation of the barrier analyses and planned interventions to DHCS and HSAG for review. All MCPs participated in individualized technical assistance calls with DHCS and HSAG to discuss their barrier analyses and planned interventions and receive feedback to optimize their ability to achieve improved outcomes. Six MCPs were required to revise and resubmit their barrier analyses and interventions. The resubmissions strengthened the six MCPs' Quality Improvement Plans by providing Plan-specific data, prioritizing the barriers, fully describing the proposed interventions, and including measurable outcomes for each intervention. Follow-up technical assistance calls were held with each of these MCPs from May to June, 2013

From February 2013 to April 2013, HSAG conducted HEDIS Compliance Audit[1] of the MCPs CY 2012 measurement period rates, which included the *ACR* collaborative QIP outcome measure. In June 2013, HSAG submitted an interim report that detailed the activities of the ACR Collaborative through the study design phase of the QIP. In July 2013, HSAG conducted a technical assistance call with all MCPs to review the updated Quality Improvement Assessment Guide for Medi-Cal Managed Care Plans and updated QIP Summary Forms. In August 2013, HSAG conducted a technical assistance call with all MCPs to discuss the requirements for the *ACR* collaborative QIP baseline submissions due to HSAG for validation by September 30, 2013.

In September, 2013, MMCD notified MCPs of DHCS's ACR Statewide Collaborative Goal. The ACR statewide goal is that the MCPs achieve a statistically significant decrease in their ACR rate between baseline and their first re-measurement period. Each MCP will need to identify the numerical decrease required to demonstrate a statistically significant decrease in its readmission rate and list that as the ACR statewide goal on the QIP Summary Form. HSAG provided MCPs with a methodology to assist with calculation of an MCP-specific statistically significant goal.

Case Management and Coordination of Care Survey
Nothing to report.

State Audits
Nothing to report.

Utilization Data (July 2012 – September 2012)
During the period July through September 2012, 522,640 unique SPDs were enrolled in MCPs in Two-Plan and GMC counties. Below is a breakdown of the SPD utilization of services.

Regarding ER services:

- 15.63% (71,831) of the SPD population visited the ER.
- Each SPD that visited the ER went an average of 1.76 times.
- Each SPD that visited the ER generated an average of 2.86 ER claims.

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

Regarding <u>pharmacy services</u>:

- 68.08% (355,156) of the SPD population accessed pharmacy services.
- Each SPD that accessed pharmacy services generated an average of 13.33 claims.

Regarding <u>outpatient services</u>:

- 52.82% (239,068) of the SPD population accessed outpatient services.
- Each SPD that accessed outpatient services generated an average of 5.63 visits.
- Each SPD that accessed outpatient services generated an average of 9.77 claims.

Regarding <u>inpatient services</u>:

- 5.6% (25,925) of the SPD population accessed inpatient services.
- Each SPD that accessed inpatient services generated an average of 2.58 visits.
- Each SPD that accessed inpatient services generated an average of 3.07 claims.

Regarding <u>hospital admissions</u>:

- 6.53% (30,121) of the SPD population were admitted to a hospital.
- Each SPD that was admitted to a hospital generated an average of 1.83 claims.

Top Ten Services Accessed by SPDs

10,931,585 total claims

	Quarter 1: Jul 2012 – Sep 2012
1	Prescribed Drugs
2	Lab and X-Ray
3	Physicians
4	Other Clinics
5	Outpatient Hospital
6	Personal Care Services
7	Other 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 2,383,756 encounters. Mental Illness was in the top rank with 34.55% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 13.69%. In the third position, "Diseases of the circulatory system" was

9.08%. The remaining seven categories ranged from 8.57% to 3.58% of the encounters.

Quarterly aggregate and MCP-level data can be found in the attachment "DY9 Q1 Utilization Data."

Enclosures/Attachments:

- "DY9 Q1 Defaults Transfers 2Plan GMC"
- "DY9 Q1 Ombudsman Data"
- "Q1 2013 Risk Data"
- "Q2 2013 Continuity of Care"
- "Q2 2013 SPD Grievance"
- "Q2 2013 Network Adequacy"
- "DY9 Q1 Utilization Data"
- "MMCD AG Meeting Minutes June 13, 2013"

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

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

1. Health Plan of San Mateo: 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 Systems of Care Division (SCD) methodology for the monthly enrollment for Health Plan San Mateo (HPSM) has been revised from the previous quarter, Demonstration Year (DY) 8, Quarter Reporting (Q) 4, Period: 04/01/2013 – 06/30/2013. Both the revised and current quarter monthly enrollment for HPSM is shown in the table that follows. Please note that these numbers will now be based on Capitation Eligibles from the monthly CAPMAN invoices. Eligibility is derived 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 sent to HPSM and an invoice is generated from the CAPMAN system.

REVISED - DY 8 / Q4			DY 9 / Q1		
Month	HPSM Enrollment Numbers	Difference	Month	HPSM Enrollment Numbers	Difference
April 2013	1,238		July 2013	1,370	7
May 2013	1,367	129	August 2013	1,364	-6
June 2013	1,363	-4	September 2013	1,369	5

Outreach/Innovative Activities:

On July 12, 2013 the Department of Health Care Services (DHCS) SCD staff met in-person with HPSM and County Staff and UCLA. The meeting consisted of the following:

HPSM/UCLA reviewed the evaluation component of the California Children's Service (CCS) Demonstration Program. During this meeting, HPSM also provided a short review of the HPSM CCS Pilot for UCLA. Included within this review were challenges HPSM personnel felt at the onset of this program.

UCLA provided a handout with what they envision the evaluation should encompass and the information necessary to be obtained. However, this document was created prior to UCLA and SCD discussions on reducing the Scope of Work (SOW) for the evaluation.

Operational/Policy Issues:

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

each location such as covered populations and health conditions, general organizational structure, reporting requirements, etc.

Health Plan San Mateo (HPSM) Demonstration Project

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

Department Communications with CMS
DHCS participates in pre-scheduled reoccurring meetings with 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. DHCS's SCD also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Department Communications with HPSM
HPSM is behind in submitting the required deliverables and DHCS has produced a matrix outlining which deliverables are currently due to the Department. A conference call has been scheduled between HPSM and SCD Management to discuss the deliverables that are required in the SOW. 2

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

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

Department Communications with RADY
DHCS received questions from RADY regarding the most current draft contract on July 18, 2013.

On August 13, 2013, DHCS had a conference call with RADY to discuss the impact of the Knox-Keene Waiver and health plan requirements (i.e. network, ID cards, credentialing).

Children's Hospital Orange County (CHOC) Demonstration Project

Department Communications with MMCD
On July 18, 2013, SCD emailed to Medi-Cal Managed Care Division (MMCD) the current proposed CalOptima language to be reviewed for both Amendment 10 and Attachment 20.

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2 The conference call between HPSM and SCD Management took place on October 10, 2013.

Alameda County Health Care (Alameda) Demonstration Project

Department Communications with Alameda
DHCS provided a current version of the contract to Alameda on July 18, 2013 for their review and comment.

Pilot Schedule

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

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

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

• RADY - 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.

Operational Issues

Addendum to the Capitated Rate Data Library Confidentiality Agreement (Addendum) / Rates with Awardees

The SCD was required by DHCS's Office of Legal Services (OLS) to have the Contractors sign and return a two-page Addendum prior to receiving cost utilization data.[3]

LA Care
- On July 30, 2013, LA Care returned to the SCD a signed Addendum which allows DHCS to release cost utilization data to the Demonstration contractor and complies with the Department's HIPAA security and confidentiality requirements.

Cal Optima / CHOC
- On August 6, 2013, CalOptima returned to the SCD a signed Addendum which allows DHCs to release cost utilization data to the Demonstration contractor and complies with the Department's HIPAA security and confidentiality requirements.

RADY
- On July 12, 2013, RADY returned to the SCD a signed Addendum which allows DHCS to release cost utilization data to the Demonstration contractor and complies with the Department's HIPAA security and confidentiality requirements.

Milestones

- On July 15, 2013, DHCS released cost utilization data to RADY for analysis and rate discussion.

- On August 19, 2013, DHCS released cost utilization data to both LA Care and CalOptima data for analysis and rate discussion.

Complaints, Grievances, and Appeals

On July 29, 2013, HPSM submitted a "Pending and Unresolved Grievances and Appeals Quarterly Report" (Grievances and Appeals Report) for the second quarter, April – June 2013. The Grievances and Appeals Report shows during the second quarter:

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[3] On June 21, 2013 an email was sent to each of the Contractors, who were asked to sign and return a two-page Addendum. The Addendum specifically addressed the following: Instructions for data destruction at the end of the use period; an agreement end date; Addendum reference and link to original exhibits A, B, and C; identification of a Data Custodian, associated with the Contractor's location; and signature block for a DHCS representative.

0 grievances and appeals were received
0 grievances and appeals were resolved

The Grievances and Appeals Report further disseminates the types of grievances/appeals that are tracked and follow: Coverage, Medical Necessity, Quality of Care, Access to Care (including appointments), Quality of Service, Untimely PCP Assignment, Accessing Specialists, and demographic data on the members.

Consumer Issues:

Nothing to report

Financial/Budget Neutrality:

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. However, the automated process will take several months to implement.

Quality Assurance/Monitoring Activities:

Nothing to report

Evaluations:

An interagency agreement with UCLA to provide program evaluation of the Demonstration Project, as required by the CMS 1115 Waiver Standard Terms and Conditions as well as Senate Bill 208, is currently being developed and is expected to be completed soon. This interagency agreement addresses the SOW and budget detail items for the evaluation. The evaluation will examine patient, family and physician satisfaction and the financial impacts of the pilot programs, as well as provide technical assistance at the request of DHCS.

UCLA conducted site visits on July 12, 2013
- UCLA's site visit included a meeting schedule, an agenda for meeting with the various HPSM departments (IT, legal, etc.), a review of how the HPSM programs work, the integration of the CCS Demonstration, changes that have been made since the operational date of the pilot, how the implementation of the pilot was working, timelines, goals/objectives to measure progress over a time span, etc.
- UCLA provided a handout with what they envisioned the evaluation would encompass and the necessary information needed. However, this document was created prior UCLA and SCD had discussions on reducing the SOW for the evaluation.

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 be submitted to CMS in a separate note.

Outreach/Innovative Activities:

DHCS held the LIHP Conference, "At the Forefront: LIHP Transition Prepares California for Health Care Reform" on August 14-15, 2013, at the Sacramento Convention Center. There were over 150 attendees from numerous State agencies and stakeholder groups, including: Department of Managed Health Care, Legislative Analyst's Office, Covered California, local LIHP representatives, county social services department representatives, advocates, healthcare consultants, health plan representatives, Centers for Medicare & Medicaid Services (CMS) and other interested stakeholders.

Operational/Policy Issues:

CMS approved Tulare County's amendment A-01 to increase add-on health care services for their LIHP on July 24, 2013. San Bernardino County's amendment A-01, to amend Exhibit D, which was approved by CMS on December 20, 2012, was fully executed on July 26, 2013.

The county specific cost claiming protocol for Monterey County was approved by CMS, July 9, 2013. County specific cost claiming protocols for all 19 LIHPs have now been approved.

DHCS continued working 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 worked with local LIHPs on the increase in FPL for Placer County from 100% to 133% effective July 24, 2013, and Monterey and San Joaquin counties from 100% and 80% respectively, to 133% effective August 1, 2013.

DHCS approved requests for enrollment caps for Santa Cruz County, effective July 1, 2013, and Tulare County, effective September 23, 2013.

DHCS 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 began development of a contracting process with all 19 LIHPs, for reimbursement of costs incurred by DHCS related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

DHCS continues to work with the California Department of Public Health, Office of AIDS (OA), to develop program requirements and policies to ensure the smooth transition of eligible Ryan White clients currently in LIHP to Medi-Cal and Covered California. Special workgroups have been set up to discuss issues such as continuity of care, and HIV/AIDS drug formularies. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- DSRIP plan modifications from the Designated Public Hospitals (DPHs) in Alameda, Contra Costa, Kern, Riverside, Santa Clara, San Mateo, and San Diego counties were submitted to CMS for review. These plan modifications are for the purpose of adding the Category 5b performance improvement targets to the DPHs Category 5 plan.
- Plan modifications for Riverside, San Mateo and Ventura counties were approved by CMS.
- DPHs submitted DY 8 second semi-annual reports on September 30, 2013.
- Collaborated with DSRIP staff in the Office of the Medical Director (OMD) on the DSRIP External Evaluation.

DHCS continued collaboration with the University of California Los Angeles (UCLA), Center for Health Policy Research, 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.

DHCS collaborated with UCLA to plan the revisions to the expansion website architecture to increase accessibility for the public to the LIHP utilization and demographic data by county on the UCLA Center for Health Policy Research web site.

DHCS collaborated with UCLA in drafting and reviewing reports and publications on the program evaluation for the LIHP component of the Demonstration and various publications including the "Final HCCI Evaluation" report and the "Safety Net Delivery System Redesign in CA: Innovations in the LIHP" publication. The "Safety Net Delivery System Redesign in CA: Innovations in the LIHP" publication was released by UCLA in August 2013. The "Final HCCI Evaluation" report is expected to be released in the upcoming quarter.

DHCS continued collaboration with UCLA for LIHP year 2 program progress reports due to UCLA July 31, 2013.

DHCS staff and UCLA worked to develop an interagency agreement for the remaining years of the LIHP evaluation and LIHP transition activities. A draft of the scope of work and budgets is under review by DHCS and UCLA.

DHCS developed a draft protocol for internal review 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 protocol is required pursuant to Attachment G, Supplement 1, Section F, of the Special Terms and Conditions.

DHCS continued planning for the Primary Care Provider (PCP) bump increased payment per the CMS ruling 42 CFR Part 438, 441, and 447 which entitles the LIHPs 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."

DHCS continued planning the LIHP transition to Medi-Cal on January 1, 2014. Specific tasks and activities including but are not limited to:

- DHCS continued the LIHP Data Transition Monthly Report process, which involves requesting and compiling monthly reports from counties to determine status on providing LIHP enrollee information into MEDS to assist with LIHP transition.
- DHCS collaborated with the LIHPs and CMS to obtain CMS approval for redetermination delays occurring the last calendar quarter of 2013. DHCS developed the template with instructions for LIHPs on how this decision must be made and how to notify DHCS of the decision prior to implementation. The delays are optional for each LIHP with the additional option of a 1, 2, or 3 month delay. This option is not applicable to Tulare and Monterey counties; each has less than a year of LIHP implementation. Fifteen of the LIHPs are implementing a three month delay. Ventura and CMSP are implementing a two month delay.
- DHCS developed notices for HCCI Covered California: 60-day choice and 30-day choice reminder notices.
- The MCE first general notice was sent to the LIHPs on September 13, 2013, for distribution to their MCE enrollees no later than October 4, 2013.

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

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

Currently 17 of 19 operational local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state populations determined eligible for LIHP by DHCS. Monterey and Santa Clara counties have pending contracts with

CCHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

The UCLA quarterly progress report for DY9 Q1 regarding the implementation of the LIHP Evaluation Design will be submitted to CMS in a separate note.

Consumer Issues:

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

- DHCS staff participated in the planning of the curriculum, slides, and presentations for Community Based Organization trainings on the LIHP Transition in Los Angeles, San Francisco, Sacramento, and Visalia during the quarter. Trainings in Redding and San Diego counties are planned in the upcoming quarter.

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

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

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

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

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

- Weekly teleconferences with the LIHP Attachment J Administrative Cost Claiming Protocol (Attachment J) Workgroup continued throughout the quarter. The Workgroup participated in and contributed to the drafts of the Attachment J Protocol, Attachment J Implementation Plan, Time Study Train-The-Trainer Training material and additional supporting documents.

- Concurrent with the Attachment J Workgroup activities, DHCS conducted continuing discussions with CMS on the Attachment J Protocol, Implementation Plan, Time Study Train-The-Trainer Training material and supporting documents throughout the quarter. CMS approved the Time Study Train-the-Trainer Training material and the commencement of the LIHP Times Studies on September 20, 2013. DHCS conducted webinars for the local time study trainers for all LIHPs on September 25 and 27, 2013.

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

Financial/Budget Neutrality:

Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
CDCR (Qtr 1)	$12,673,848	$0.00	$25,347,696	DY 7	$3,014,532
				DY 8	$9,659,316
Health Care (Qtr 1)	$257,563,572	$0.00	$515,127,144	DY 7	$13,364,087
				DY 8	$244,199,485
Administrative (Qtr 1)	$17,095,254	$0.00	$34,190,508	PY1	$14,872,940
				PY2	$1,239,412
				DY7	$982,902
Total	**$287,332,674**	**$0.00**	**$574,665,348**		**$287,332,674**

Quality Assurance/Monitoring Activities:

DHCS sent a contract compliance request to all LIHPs which requests documentation supporting LIHP contract compliance in the following areas:

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

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

Enclosures/Attachments:

- Yr3Q1 Evaluation Design Progress Report Jul 1 2013 to Sept 30 2013

FINANCIAL/BUDGET NEUTRALITY

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
Total:	**$ 109,916,666**		**$ 109,916,666**		**$ 219,833,332**
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
Total:	**$ 368,115,366.74**	**$ 368,115,366.74**			**$ 736,230,733.48**
Designated State Health Program (DSHP)					

Payment	FFP Claim		(CPE)	Service Period	Total Claim
State of California					
(Qtr1)	$ 41,382,406		$ 82,764,811	DY 9 (Jul-Sept)	$ 41,382,406
Total:	**$ 41,382,406**		**$ 82,764,811**		**$ 41,382,406**

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 $ 41,382,406 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 $ 109,916,666 in federal fund payments for SNCP eligible services.

California Children Services (CCS) Member Months and Expenditures

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

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

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