JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency

Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

August 21, 2015

Eliot Fishman, Director
State Demonstrations Group
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Ms. Mehreen Hossain
Project Officer
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-02-26
Baltimore, MD 21244-1850

Ms. Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services, Region IX
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

QUARTERLY PROGRESS REPORT FOR THE PERIOD 04/01/2015 THROUGH 06/30/2015 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Mr. Fishman, Ms. Hossain, and Ms. Sam-Louie:

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 Ten, which covers the period from April 1, 2015 through June 30, 2015.

If you or your staff have any questions or need additional information regarding this report, please contact Angeli Lee at (916) 324-0184.

Sincerely,

Mari Cantwell
Chief Deputy Director

Enclosure

cc: Sarah Brooks
Deputy Director
Health Care Delivery Systems
Sarah.Brooks@dhcs.ca.gov

Hannah Katch
Assistant Deputy Director
Health Care Delivery Systems
Hannah.Katch@dhcs.ca.gov

TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Ten (07/01/14-10/31/15)
Fourth Quarter Reporting Period: 04/01/2015-06/30/2015

INTRODUCTION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

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

Enrollment information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
April 2015 – June 2015

County	Total Member Months
Alameda	91,923
Contra Costa	51,762
Fresno	70,768
Kern	56,360
Kings	7,755
Los Angeles	566,324
Madera	7,480
Riverside	93,355
San Bernardino	107,510
San Francisco	51,767
San Joaquin	51,450
Santa Clara	66,013
Stanislaus	37,499
Tulare	33,149
Sacramento	115,401
San Diego	116,667
Total	**1,525,183**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
April 2015 – June 2015

County	Total Member Months

County	Total Member Months
Alameda	49,529
Contra Costa	21,222
Fresno	26,696
Kern	17,858
Kings	2,748
Los Angeles	1,038,533
Madera	2,756
Marin	18,967
Mendocino	17,479
Merced	47,695
Monterey	47,660
Napa	13,908
Orange	353,441
Riverside	145,617
Sacramento	47,025
San Bernardino	143,976
San Diego	212,219
San Francisco	31,318
San Joaquin	18,995
San Luis Obispo	25,176
San Mateo	70,776
Santa Barbara	45,447
Santa Clara	98,433
Santa Cruz	30,871
Solano	57,918
Sonoma	52,354
Stanislaus	9,622
Tulare	13,009
Ventura	83,827
Yolo	25,968
Total	**2,771,043**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
April 2015 – June 2015

County	Total Member Months

County	Total Member Months
Alpine	95
Amador	1,343
Butte	22,342
Calaveras	2,170
Colusa	813
El Dorado	5,944
Glenn	1,941
Imperial	13,244
Inyo	767
Mariposa	836
Mono	266
Nevada	3,821
Placer	9,826
Plumas	1,288
San Benito	289
Sierra	173
Sutter	6,574
Tehama	5,986
Tuolumne	3,055
Yuba	7,173
Total	**87,946**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
April 2015 – June 2015

County	Total Member Months
Del Norte	8,060
Humboldt	27,020
Lake	18,967
Lassen	4,104
Modoc	2,028
Shasta	41,130
Siskiyou	10,861
Trinity	3,084
Total	**115,254**

Enrollment (April 2015 – June 2015)
During the quarter, mandatory SPDs had an average choice rate 58.25%, an auto-assignment default rate of 19.58%, a passive enrollment rate of 0.01%, a prior-plan default rate of 0.69%, and a transfer rate of 21.47%. In June, overall SPD enrollment in Two-Plan and GMC counties was 522,268 (point-in-time), a 1.15% decrease from March's enrollment of 528,349. For monthly aggregate and Medi-Cal managed care health plan (MCP)-level data, please see the attachment "DY10-Q4 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

Medi-Cal Managed Care Performance Dashboard (April 2015 – June 2015)
During the reporting period, the Managed Care Quality and Monitoring Division (MCQMD) issued a new Medi-Cal Managed Care Performance Dashboard which assists DHCS, MCPs and other stakeholders to identify trends and better observe and understand the program on multiple levels—statewide, by managed care plan model (i.e., COHS, GMC, Two-Plan, Regional, San Benito and Imperial) and by individual MCP. On June 21, 2015, MCQMD released the sixth iteration of the dashboard via public webinar. It includes, but is not limited to, metrics that quantify and track quality of care, enrollee satisfaction, utilization and continuity of care. The dashboard also stratifies reported data by beneficiary population including Medi-Cal-only SPDs, dual eligibles, children transitioned from the Healthy Families Program and the ACA optional expansion population.

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

Operational/Policy Issues:

Network Adequacy
Between April and June 2015, the Department of Managed Health Care (DMHC) completed a provider network review of all Two Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provided DHCS with an updated list of providers that SPDs may contact to receive care. DHCS and DMHC conducted a joint review of each MCP's provider network. The two departments continue to work with the MCPs to ensure that all areas of network adequacy are addressed.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee
On May 20, 2015, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no specific discussions relating to SPDs. Full documentation from the meeting is available at:
http://www.dhcs.ca.gov/Pages/May20MeetingMaterials.aspx

Managed Care Advisory Group
On June 11, 2015, DHCS's Managed Care Advisory Group (MCAG) convened. There were no specific discussions relating to SPDs. Full documentation from the meeting is available at:
http://www.dhcs.ca.gov/services/Pages/MCAG-Meeting-Materials-6-11-2015.aspx

Office of the Ombudsman (April 2015 – June 2015)
The Office of the Ombudsman experienced an overall increase in customer calls between the periods January-March 2015 (DY10-Q3) and April-June 2015 (DY10-Q4). During DY10-Q4, the Ombudsman received 44,927 total calls, of which 15,968 concerned mandatory enrollment and 2,647 were from SPDs. During DY10-Q3, the Ombudsman received 40,537 total calls, of which 12,832 concerned mandatory enrollment and 1,845 were from SPDs. This represents a 10.83% increase in total calls, a 24.44% increase in calls regarding mandatory enrollment, and a 43.47% increase in calls regarding mandatory enrollment from SPDs.

For DY10-Q4, 0.19% of SPD and 0.02% of non-SPD calls concerned access issues. This is a small change in SPD and non-SPD calls from DY10-Q3, during which 0.11% of SPD and 0.04% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) stayed the same from 865 in DY10-Q3 to 865 in DY10-Q4. The percentage of SHRs from SPDs decreased from 42% to 41%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs decreased from 216 in DY10-Q3 to 171 in DY10-Q4. The percentage of those requests from SPDs increased slightly from 35% 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 "DY10 Q4 Ombudsman Report" and "DY10 Q4 State Hearing Report."

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

Nothing to report.

Health Risk Assessment Data (October 2014 – December 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 25,484 SPDs between October 2014 and December 2014. Of those, MCPs stratified 11,771 (46.19%) as high-risk SPDs and 12,602 (49.45%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 49.17% by phone and 57.09% by mail. Of the total high-risk SPDS, 44.30% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 27.22% by phone and 59.48% by mail. Of the total low-risk SPDS, 20.58% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 4,933 SPDs to be in the other risk category, which is 19.36% of the total

enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q4 2014 Risk Data."

Continuity of Care Data (January 2015 – March 2015)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,556 continuity-of-care requests between January and March 2015. Of these, MCPs approved 1,082 requests (69.54% of all requests); held 4 requests (0.24%) in process; and denied 470 requests (30.21%). Of the requests denied, 79.57% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2015 Continuity of Care."

Plan-Reported Grievances (January 2015 – March 2015)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 4,010 grievances between January and March 2015. Of these grievances, 0.70% were related to physical accessibility, 8.23% were related to access to primary care, 4.91% were related to access to specialists, 1.35% were related to out-of-network services, and 84.41% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2015 SPD Grievance."

Medical Exemption Requests (MERs) Data (January 2015 – March 2015)
During 2015, from January through March, 3,638 SPDs submitted 4,371 MERs, an average of 1.2 MERs per SPD who submitted a MER. MCQMD approved 2,724 SPD MERs, denied 1,619, and found 28 to be incomplete. The top five MER diagnoses were Complex (668), Cancer (179), Neurological (152), Transplant (107), and Dialysis (43). Summary data is available in the attachment "Q1 2015 MERs Data."

Health Plan Network Changes (January 2015 – March 2015)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 1,106 primary care physicians (PCPs) and removed 1,091 PCPs across all networks, resulting in a total PCP count of 27,466. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2015 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (April 2015 – June 2015)

Nothing to report.

Encounter Data (April 2015 – June 2015)

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

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

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

Outcome Measures and All Cause Readmissions (April 2015 – June 2015)

Healthcare Effectiveness Data Information Set (HEDIS) Measures

As HEDIS rates are reported annually. New data is currently being reported and will be available in the next quarterly report. DHCS has posted the 2015 and 2016 External Accountability Set on DHCS's Managed Care Quality and Monitoring Division's Quality Improvement & Performance Measurement Reports website: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/ExtAcctSetforMeasurementYears2014_2015.pdf. MCPs will report the following indicators for SPDs versus other members: all cause readmissions to the hospital, ambulatory visits (outpatient and emergency department), monitoring for patients on persistent medications, and children and adolescents' access to primary care practitioners. For measures DHCS holds plans to a minimum performance level (MPL), DHCS has determined and Health Services Advisory Group (HSAG) shared this MPL with MCPs through an FTP site. HSAG is DHCS's contracted External Quality Review Organization (EQRO).

Consumer Assessment of Healthcare Providers and Systems

Nothing to Report

Statewide Collaborative All Cause Readmissions

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

HSAG and the MCPs in May. The Statewide Collaborative concluded on June 30, 2015. The Remeasurement 1 Report will be submitted by HSAG in the next quarter.

Utilization Data (April 2014 – June 2014)
During the period April through June 2014, MCPs in Two-Plan and GMC counties enrolled 542,801 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 13.44% (72,972) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.68 times.
- Each SPD who visited an ER generated an average of 2.66 ER claims.

Pharmacy Services:

- 67.95% (368,814) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 13.8 claims.

Outpatient Services:

- 49.17% (266,871) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.12 visits.
- Each SPD who accessed outpatient services generated an average of 9.75 claims.

Inpatient Services:

- 4.47% (24,245) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 2.88 visits.
- Each SPD who accessed inpatient services generated an average of 3.78 claims.

Hospital Admissions:

- 5.3% (28,795) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 1.91 visits.

Top Ten Services Accessed by SPDs

11,994,402 total claims

	Apr 2014 – Jun 2014
1	Prescribed Drugs
2	Lab and X-Ray
3	Physicians
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 2,773,809 encounters. Mental Illness was in the top rank with 37.07% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 12.80%. In the third position, "Diseases of the nervous system and sense organs" was 8.92%. The remaining seven categories ranged from 8.25% to 3.33% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment "DY9 Q4 Utilization Data."

Enclosures/Attachments:

- "DY10 Q4 Defaults Transfers 2Plan GMC"
- "DY10 Q4 Ombudsman Report"
- "DY10 Q4 State Hearing Report.
- "Q4 2014 Risk Data"
- "Q1 2015 Continuity of Care"
- "Q1 2015 SPD Grievance"
- "Q1 2015 MERs Data"
- "Q1 2015 Network Adequacy"
- "DY9 Q4 Utilization Data"
- "Managed Care AG Meeting Minutes June 11, 2015"

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

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

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

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

Enrollment information:

The current quarter monthly enrollment for Health Plan of San Mateo (HPSM) CCS Demonstration Program (DP) is reflected in the table below. Eligibility data is extracted from the Children's Medical Services Network (CMSNet) utilization management system and is verified by the Information Technology Services Division (ITSD) using the Medi-Cal Eligibility Data System (MEDS). This data is then forwarded to the Office of HIPAA Compliance (OHC) and, in turn, provided to the HPSM. The HPSM is reimbursed based on a capitated per-member-per-month payment methodology using the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference
Prior Quarter March 2015	1,302	
April 2015	1,276	-26
May 2015	1,250	-26
June 2015	1,199	-51

Outreach/Innovative Activities:

HPSM

CCS DP Evaluation

During June 2015, the Systems of Care Division (SCD) was in the planning stages of conducting an annual member satisfaction phone survey (Member Survey), provider satisfaction survey (Provider Survey), and conduct site visits at HPSM and San Mateo County (SM County). SCD anticipates the following events will occur next quarter:

- The SCD will conduct the second annual HPSM CCS DP Member Survey in Fall 2015.[1] The objective of the Member 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 SCD will develop a Provider Survey to gather baseline data for the HPSM DP as another component of the operational review process. The providers will be

[1] SCD collected "baseline" data for the Member Survey, which was developed and implemented during the months July through September 2014 for HPSM CCS DP. SCD was able to contact 385 HPSM families. Of those contacted, 380 families (98.7%) agreed to complete the survey. SCD conducted this survey to satisfy one of several components of the operational review for the CCS DP.

asked to provide feedback to help evaluate the current level of success of the HPSM DP and to identify areas that may need improvement. The Provider Survey will be administered to providers Fall 2015.

- The SCD will conduct the second annual site visits in October 2015 with both HPSM and SM County.[2]

Youth Committee

HPSM is in the preliminary stages of implementing a Youth Committee within the Demonstration Project Advisory Committee (DPAC) to gain a greater understanding of issues that are important to youth and young adults. The Youth Sub-Committee is scheduled to have its first meeting in July 2015.

Operational/Policy Issues:

Health Plan of San Mateo Demonstration Project

Department Communications with HPSM

Reoccurring conference calls between SCD and HPSM are conduct on a bi-weekly basis to discuss various issues such as financial/accounting, information technology, and other deliverables.

Contract Amendment

A contract amendment was executed on May 12, 2015, to address retroactive capitated rate adjustments, carve-out of specific coagulation factor products; redefined definition of other health coverage; and correction of contract term to a period of three (3) years with two (2) one-year (1-year) options to extend the term. The rates adjustment covered the time periods from April 1, 2013 through June 30, 2015 and reflects the following: Elimination of the inpatient provider payment reduction, AB 1422, AB 78, ACA 1202, mental health benefits, increased case management costs and Hepatitis C payment.

Aid Code to allow CCS State-Only children to Enroll in CCS DPs

SCD worked with ITSD to implement a 9D aid code which will allow CCS State-Only children to enroll in CCS DPs. [3] The 9D aid code for "CCS State-Only beneficiaries" is expected to be activated in October 2015.

Executed MOU - HPSM and SM County

HPSM executed a Memorandum of Understanding (MOU) with SM County on May 7,

---

[2] On October 17, 2014, SCD conducted site visits with HPSM and SM County for the first annual review of the CCS DP. Discussions were focused on what was working well and what were challenges with the CCS DP. Overall, the program was working well.

[3] February 10, 2014, SCD received the approved memorandum from MCED to ITSD and CA-MMIS to request the development and implementation of a new aid code "9D" for CCS State-Only beneficiaries.

2015 and forwarded a copy to the SCD on May 28, 2015. The MOU between HPSM and SM County was not updated prior to HPSM CCS DP operational date April 1, 2013.

Utilization Management
The HPSM has improved access to care by eliminating pre-authorization of routine CCS and non-CCS services for Lucille Packard Children's Hospital (Lucille Packard Children's Hospital) which provides medical services to approx. 80% of CCS DP members; unburdening the SM County staff's time which can be redirected to focusing on a member's care coordination.

Transition Process
Discussions began this quarter for transitioning members who age-out of the CCS DP and placed into appropriate adult care.

<u>Rady Children's Hospital of San Diego Demonstration Project</u>

The SCD has been collaborating with Rady Children's Hospital of San Diego (RCHSD) and the local county CCS program regarding implementation of the RCHSD demonstration. Discussions have taken place around contract documents (scope of work, reporting requirements, etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, future county roles including eligibility determination and transition of population from a fee for service based system to a capitated model.

Cost Utilization Data
On April 27, 2015, DHCS released revised cost utilization data to RCHSD for analysis and rate discussion.[4]

Capitated Rates
The Department's Capitated Rates Development Division (CRDD) continued to work with actuaries on rate development. Discussions continue regarding conditions covered, pharmaceuticals covered, and risk corridors.

Department Communications with RCHSD
SCD participated in weekly conference calls with RCHSD to discuss and resolve various issues such as:

- PHARMACEUTICALS / PHARMACEUTICAL BENEFITS MANAGEMENT
  RCHSD continued to pursue partnerships with several Pharmaceutical Benefits Management (PBM) firms; however, this was a challenge due to PBMs' reluctance

[4] On December 11, 2014, the Department executed a RCHSD Data Library Confidentiality Agreement (DUA) which allowed the Department to release cost utilization data for three fiscal years (FY) FY 2011 to 2012 through FY 2013 to 2014 for the conditions Sickle Cell, Cystic Fibrosis, Hemophilia, and the additions of Acute Lymphoblastic Leukemia (A.L.L.) and Diabetes Type I and II [ages 1-10 yrs of age (Diabetes)]. On March 18, 2015, DHCS released the cost utilization data to RCHSD.

to contract for services with an initial small population size. In June, DHCS informed RCHSD that they would be required to cover all pharmaceuticals.

- MEMBER HANDBOOK
  On June 25, 2015 RCHSD provided SCD a revised draft, version 7, of the Member Handbook (MH).

- PROVIDER MANUAL
  RCHSD continues to develop the provider manual to satisfy a Readiness Review component.[5]

- BEHAVIORAL HEALTH AND RECOVERY SERVICES AND MENTAL HEALTH
  On May 26, 2015, RCHSD provided SCD a draft of the Behavioral Health and Recovery Services (BHRS) and Mental Health policy and procedures (P&P) to satisfy a Readiness Review component. SCD is currently reviewing the P&P.

- SITE REVIEW DEPARTMENT STANDARDS
  RCHSD collaborated with Healthy San Diego (HSD) Site Review Committee to satisfy the site review Readiness Review requirement. A Memorandum of Agreement (MOA) was drafted for HSD's review. HSD agreed for RCHSD to participate in the review process.

- MEMBER ELIGIBILITY FILE
  RCHSD IT verified they could accept a "test" eligibility file and ensured the infrastructure worked appropriately. RCHSD requested a modification to the eligibility file, to utilize an existing column in the eligibility table and to convert it into a diagnosis column not currently captured in the eligibility table.

- RCHSD READINESS REVIEW DELIVERABLES
  On July 2, 2014, RCHSD began submitting to SCD their P&Ps as indicated in the Readiness Review document.[6] As of June 30, 2015, 63 out of 67 deliverables have been approved by SCD.

- CLINICAL EVALUATION METRICS
  RCHSD is currently reviewing the clinical evaluation metrics that DHCS provided on February 26, 2015.[7]

---

[5] As of March 30, 2015, SCD is waiting for a revised Provider Manual, pending further discussion of pharmacy and contract language.

[6] SCD gave RCHSD a Readiness Review document indicating required deliverables (P&Ps) in Summer/Fall 2013.

[7] On November 24, 2014, RCHSD submitted initial outcomes, measures, and interventions to identify baseline data. January 15, 2015, RCHSD submitted another draft of disease specific clinical evaluation criteria that RCHSD would be conducting during the DP. By February 26, 2015, DHCS limited the evaluation/metrics to two clinical measures per diagnosis.

- CONTRACT ITEMS
  Multiple requests have been received from RCHSD for numerous changes to the contract and include Exhibit G:
  HIPAA BAA department standards. DHCS Privacy Office and Information Security Office have been consulted to review requested changes to Exhibit G during this reporting period.

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

- Announcement of a pilot to CCS Member enrolled in a GMC Plans;
- Pilot would coordinate health care services for 5 medical conditions [Hemophilia, Cystic Fibrosis, Sickle Cell, Diabetes Type I and II (age 1-10 years) and Acute Lymphoblastic Leukemia];
- No changes in member's health, dental, vision coverage and remain with current medical doctor;
- Enhanced benefits (coordination of health needs, community referrals, resources for parenting, education, and emotional support);
- Date automatic enrollment and health benefit coverage would occur;
- Receipt of an identification card for doctor visits, pharmacy, and hospital; and
- Phone number for questions.

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

Demonstration Schedule

It is anticipated the RCHSD Demonstration will be operational in January 2016. It should be noted the projected implementation timetable is contingent on a number of factors including development and acceptance of capitated rates by RCHSD, the ability of the contractor to demonstrate readiness to begin operations, and approvals by the Centers for Medicare and Medicaid Services (CMS).

Complaints, Grievances, and Appeals

On May 4, 2015, HPSM submitted a "CCS Quarterly Grievance Report" for the first quarter, January – March 2015. The CCS Quarterly Grievances Report reflected that the adjudication of eight grievances.

The Grievances Report includes type of grievance, accessibility, benefits/coverage, referrals, and quality of care/Service.

- Six grievances were designated as Quality of Care/Service and were coded as "Plan denial of treatment"; two were resolved in favor of the CCS Member, and four were resolved in favor of Plan.
- Two grievances were labeled as "Other" and resolved in favor of the CCS Member.

Consumer Issues:

Redesign Stakeholder Advisory Board (RSAB)

The DHCS initiated a stakeholder process in late 2014 to promote the use of organized health care delivery systems for children eligible under the California Children's Services (CCS) program. A CCS Redesign Stakeholder Advisory Board (RSAB) composed of individuals from various organizations and backgrounds with expertise in CCS children and youth with special health care needs (CYSHCN) was assembled to lead this process. In addition, a series of topic-specific technical workgroups were conducted. The CCS RSAB process will be completed in July 2015. After July, the DHCS will continue stakeholder discussions on CCS Program improvements by transitioning the RSAB group to an ongoing CCS Advisory Group that will meet quarterly in Sacramento.

The CCS Program Redesign website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.aspx

On May 29, 2015, the RSAB held a webinar. The focus was on the "CCS Program Improvement Process and Technical Workgroups Updates". The following topics and documentation was presented on the May 29th RSAB webinar:

- Program Improvement Process Update
- Technical Workgroup (TWG) Updates: Data; Healthcomes/Care Coordination/Transition; Eligibility and Health Conditions; Outcomes Measures and Quality; and Other

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

On June 22, 2015, the RSAB held its fourth meeting. The focus was on the "Whole-Child Model". The following topics and documentation were presented at the June 22nd RSAB meeting:

- "Whole-Child Model" Presentation and Discussion
- Identification of Key Issues and Questions
- Small Group Sessions on Specific Topics
- Report Out from Small Group Discussions
- Public Comment Period for Audience Members
- Discussion of Next Steps

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

TWG conference calls were held during this quarter and meeting material links follow:

- Data TWG – May 8, 2015
  http://www.dhcs.ca.gov/services/ccs/Pages/DataTechnicalWorkgroup.aspx

- Outcome Measures / Quality TWG – April 10, 2015; May 7, 2015
  http://www.dhcs.ca.gov/services/ccs/Pages/OutcomeMeasures.aspx

DHCS Stakeholder Advisory Committee (SAC)

On May 20, 2015, the Director's Office provided an update on the CCS RSAB Workgroup at the DHCS Stakeholder Advisory Committee (SAC) Meeting. Attached is the CCS Redesign presentation link:
http://www.dhcs.ca.gov/Documents/5.20SACCCSRedesignPresentation.pdf

CCS Executive Committee

On June 4, 2015, SCD provided an update on the status of the 1115 DP at the CCS Executive Committee Meeting.

Financial/Budget Neutrality Development/Issues:

Health Plan of San Mateo (HPSM)

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

Quality Assurance/Monitoring Activities:

On May 8, 2015, HPSM submitted contractual report, "Enrollment and Utilization Table". Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
4/1/2013 – 6/30/2013	0	1,474	116	1,358	3,951

7/1/2013 – 9/30/2013	1,358	140	130	1,368	4,093
10/1/2013 – 12/31/2013	1,368	241	119	1,490	8,382
1/1/2014 – 3/31/2014	1,490	108	129	1,469	12,786
4/1/2014 – 6/30/2014	1,469	86	115	1,440	17,166
7/1/2014 – 9/30/2014	1,440	198	99	1,539	4,492
10/1/2014 – 12/31/2014	1,539	150	122	1,567	9,080
1/1/2015 – 3/31/2015	1,567	28	67	1,528	13,660

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

Report Name	Date Due	Received	Pending Review	SCD Approved
Provider Network Reports (Rpt #8)	4/30/2015	5/8/2015		YES
Grievance Log/Report (Rpt #8)	4/30/2015	4/30/2015		YES
Provider Manual 2	4/30/2015	5/28/2015		YES
DMHC Required Financial Reporting Forms 2	5/1/2015	4/30/2015		YES
Financial Audit Report (Rpt #2)	5/1/2015	6/11/2015		YES
Quarterly Financial Statements (Rpt #8)	5/15/2015	5/8/2015	✓	
Report of All Denials of Services Requested by Providers (Rpt #7)	5/15/2015	- - -	- - -	N/A
Annual Forecasts (Rpt #2)	6/30/2015	6/30/2015		YES

Evaluations:

On April 1, 2015, the SCD shared the results of the Member Survey, conducted between the months July through September 2014 with HPSM and will use the Member Survey to establish a "baseline" of information to compare against in outlying years. This survey will help the Department improve services provided to CCS clients and determine how the DP is working for CCS clients enrolled within the CCS DP.

The HPSM responded to SCD on April 17, 2015, with feedback regarding the results of

the Member Survey.[8] Feedback from HPSM consisted of the following:

- Commendable that the Member Survey obtain 379 participants. Participation could have been higher if the Member Survey did not coincide with the time the Title V Needs Assessment survey was also conducted.

- Concern regarding a question, “Were you ever contacted by the HPSM or someone else to let you know about having a case manager?” HPSM believes the low response rate is due to CCS members knowing their case manager as their “nurse” and that the inclusion of the word “nurse” would provide a higher “Yes” response.

- Another concern was the high proportion of respondents stating they had not received the member handbook (MH) from HPSM. HPSM stated they would explore ways to increase awareness of the MH and the information contained within it.

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*.

[8] During the months of July through September 2014, SCD developed and administered a Member Survey to HPSM CCS DP families. SCD was able to contact 385 HPSM families. Of those contacted, 379 families agreed to complete the survey.

LOW INCOME HEALTH PROGRAM (LIHP)

The Low Income Health Program (LIHP) included two components distinguished by family income level: Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). MCE enrollees had family incomes at or below 133 percent of the federal poverty level (FPL). HCCI enrollees had family incomes above 133 through 200 percent of the FPL. LIHP ended December 31, 2013 and, effective January 1, 2014, local LIHPs no longer provided health care services to former LIHP enrollees. Additionally, pursuant to the Affordable Care Act, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

DHCS continued working to obtain CMS approval for the revised county specific cost claiming protocols submitted by Alameda and San Bernardino LIHPs under Attachment G Supplement 1, Section K, Total Funds Expenditures of Other Governmental Entity, to add other entities that could provide CPEs for claiming purposes. On January 7, 2015, CMS denied the requested revisions to the Alameda and San Bernardino county specific cost claiming protocols. On February 26, 2015, DHCS requested that CMS reconsider their denial of the revisions to the two county specific cost claiming protocols. On May 18, 2015 CMS confirmed their prior denial and will be sending the Department a formal denial letter.

DHCS continued working to obtain CMS approval for the revised Attachment G - Supplement 2 *Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health program-Claims Based on Capitation (*Attachment G - Supplement 2). On January 7, 2015, CMS notified DHCS that Attachment G - Supplement 2 was not approved. On February 13, 2015, DHCS requested that CMS reconsider their denial of Attachment G - Supplement 2. On May 18, 2015 CMS confirmed their prior denial and will be sending the Department a formal denial letter.

DHCS continued collaboration with the University of California Los Angeles (UCLA), Center for Health Policy Research, the independent evaluator for the LIHP, to draft the evaluation report.

The Department worked with local LIHPs to determine compliance with the Maintenance of Effort (MOE) contract requirement that total non-federal

expenditures in each Demonstration Year meet or exceed the annual MOE amount through December 31, 2013.

In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- Designated Public Hospitals (DPHs) submitted their semi-annual report for DY10.
- DHCS reviewed the DPHs' semi-annual reports.

Consumer Issues:

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

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
CDCR (Qtr. 4)	$470,723.24	$0.00	$941,446.48	DY 7	$470,723.24
Health Care (Qtr. 4)	$69,611,353.08	$0.00	$139,222,706.16	DY 7	$69,611,353.08
	$207,327,641.99	$0.00	$414,655,283.98	DY 8	$207,327,641.99
	$5,577,802.13	$0.00	$11,155,604.26	DY 9	$5,577,802.13
IGT	$1,303,172.00	$1,303,172.00	$0.00	DY 7	$2,271,390
Admin (Qtr. 4)	$7,600,847.50	$0.00	$15,201,695.00	DY 7	$7,600,847.50
	$20,235,810.50	$0.00	$40,471,621.00	DY 8	$20,235,810.50
	$10,260,670.00	$0.00	$20,521,340.00	DY 9	$10,260,670.00
Total	**$322,388,020.44**	**$1,303,172.00**	**$642,169,696.88**		**$323,356,238.44**

Quality Assurance/Monitoring Activities:

Nothing to report.

Enclosures/Attachments:

Nothing to report.

Enclosures/Attachments:
"DY10 Q4 LIHP Evaluation Design Progress Report April 1, 2015 – June 30, 2015"

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$0		$0		$0
(Qtr 2)	$44,250,000		$44,250,000	DY 10 (Jul-Sept)	$88,500,000
(Qtr 3)	$38,510,492		$38,510,492	DY 9	$77,020,984
(Qtr 3)	$73,750,002		$73,750,002	DY 10 (Oct-Dec)	$147,500,004
(Qtr 4)	$58,999,998		$58,999,998	DY 10 (Jan-Mar)	$117,999,996
(Qtr 4)	$39,333,332		$39,333,332	DY 10 (Apr-May)	$78,666,664
Total:	**$254,843,824**		**$254,843,824**		**$509,687,648**
DSRIP					
(Qtr 1)	$0	$0			$0
(Qtr 2)	$328,893,774 $0	$328,893,774 $0			$657,787,548 $0
(Qtr 3)	$0	$0			$0
(Qtr 4)	$330,830,478	$330,830,478			$661,660,956
Total:	**$659,724,252**	**$ 659,724,252**			**$1,319,448,504**

Designated State Health Program (DSHP)

Payment	FFP Claim		(CPE)	Service Period	Total Claim
State of California					
(Qtr1)	$381,935		$(477,246)	DY 6 (Oct-Jun)	$(95,331)
(Qtr1)	$15,520,725		$15,440,725	DY 9 (Jul-Jun)	$30,961,450
(Qtr1)	$48,721,450		$48,775,451	DY 10 (Jul-Sept)	$97,496,901
(Qtr 2)	$(8,369,990)		$(6,020,068)	DY 6 (Sept-Oct)	$(14,390,058)
(Qtr 2)	$79,804,676		$79,804,676	DY 10 (Jul-Dec)	$159,609,352
(Qtr 3)	$(2,171,254)		$(1,539,460)	DY 5 (Feb-Aug)	$(3,710,714)
(Qtr 3)	$(798,553)		$1,432,596	DY 6 (Sept-Jun)	$634,043
(Qtr 3)	$(6,858,168)		$(6,858,168)	DY 7 (Jul-Jun)	$(13,716,335)
(Qtr 3)	$12,088,794		$12,088,794	DY 10 (Oct-Dec)	$24,177,588
(Qtr 3)	$79,346,738		$79,346,743	DY 10 (Jan- Mar)	$158,693,480
(Qtr 4)	$21,853,516		$13,628,732	DY 5 (Feb-Aug)	$35,482,247
(Qtr 4)	$4,276,293		$8,350,237	DY 6 (Sept-Jun)	$12,626,529
(Qtr 4)	$645,358		$645,359	DY 7 (Jul-Jun)	$1,290,718
(Qtr 4)	$25,167,989		$25,167,990	DY 8 (Jul-Jun)	$50,335,979
(Qtr 4)	$36,651,604		$36,651,604	DY 9 (Jul-Jun)	$73,303,208
(Qtr 4)	$158,869,237		$158,869,244	DY 10 (Apr-Jun)	$317,738,481
Total:	**$ 465,130,350**		**$ 465,307,209**		**$ 930,437,559**

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 **$ 247,463,996** in federal fund payments for SNCP eligible services.

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 **$ 98,333,330.00** in federal fund payments for SNCP eligible services.

COMMUNITY BASED ADULT SERVICES (CBAS)

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

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. CMS approved an amendment to the CBAS BTR waiver which extended CBAS for the length of the overall BTR Waiver, with an effective date of December 1, 2014.

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition

services, and transportation to State Plan beneficiaries that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing, Medicaid , and waiver program standards; 2) provide services in accordance with the participant's physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements identified in the CMS approved BTR waiver; and 4) demonstrate ongoing compliance with above requirements.

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

The State must assure CBAS access/capacity in every county in which ADHC services had been provided prior to CBAS starting on April 1, 2012.[9] 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 Systems (COHS) (See Attachment 4) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans (available in two counties), along with the final COHS county (Ventura) also transitioning at that time. As of December 1, 2014, Medi-Cal FFS only provides CBAS coverage for those CBAS eligible beneficiaries who have an approved medical exemption from enrolling in managed care. The final four rural counties (Shasta, Humboldt, Butte and Imperial) were transitioned to managed care with the CBAS benefit available as of December 2014.

If there is insufficient CBAS center capacity to satisfy the demand in counties with CBAS centers as of April 1, 2012, 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 local senior centers to engage beneficiaries in social/recreational activities and group programs, home health nursing and/or 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 resides in a Coordinated Care Initiative county, through the beneficiary's Medi-Cal or Cal MediConnect managed care health plan.

[9] CBAS access/capacity must be provided in every county except those that did not previously have ADHC centers: 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.

Enrollment and Assessment Information

CBAS Enrollment and County Capacity (STC 99.a):

The CBAS Enrollment data (per STC. 99) for both Medi-Cal managed care plans (MCPs) and FFS beneficiaries per county for DY10, Quarter 4 is shown at the end of this section in Table 2, *Preliminary CBAS Unduplicated Participant Data for MCP and FFS Enrollment*. Table 1 provides the CBAS capacity available per county, which is also incorporated into Table 2.

CBAS Enrollment data is based on self-reporting by the MCPs (Table 2), which is reported quarterly, along with claims data for CBAS individuals remaining in FFS. Some MCPs report enrollment data based on their covered geographical areas, which includes multiple counties. The Enrollment data reflects this grouping of some counties in the quarterly reporting.

Enrollment data continues to reflect that CBAS participation remains under 29,000 statewide. FFS claims data, which has a lag factor, is used for the FFS Enrollment data.

CBAS Assessments Determined Eligible and Ineligible:

DY 10	MCPs			FFS		
	New Assessments	Eligible	Not Eligible	New Assessments	Eligible	Not Eligible
Quarter 1 (7/1-9/30/2014)	2,299	2,251 (98%)	48 (2%)	260	256 (98.5%)	4 (1.5%)
Quarter 2 (10/1-12/31/2014)	2,860	2,812* (98%)	48 (2%)	62*	60 (96.8%)	2 (3.2%)
Quarter 3 (1/1-3/31/2015)	2,497	2,433 (97.4%)	64 (2.6%)	51*	49 (96.8%)	2 (3.2%)
Quarter 4 (4/1-6/30/2015)	2,994	2,941 (98.2%)	53 (1.8%)	43	42 (97.7%)	1 (2.3%)
5% Negative Change between last Quarter	NA	NA	NA	NA	NA	NA

*Note: Eligible FFS and MCP beneficiaries changed significantly due to ALL CBAS counties being covered by Managed Care as of December 1, 2014.

During Quarter 4, there were 86 eligibility inquiry requests submitted to DHCS, of which 43 were FFS eligible, and 25 were referred to managed care for CBAS benefits. Additionally, 7 FFS face-to-face assessments were completed from a request submitted in the prior Quarter (one from January and six from March).

CBAS Provider-Reported Data (per CDA) (STC 99.b)
No new participant statistics are available since the last Quarterly data:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	201
*Non-Profit Centers	20
*For-Profit Centers	181
ADA @ 201 Centers	20,027
*ADA per Centers	100

CDA – MSSR data 6/2015

Outreach/Innovative Activities

With the approval by CMS of the CBAS amendment to the BTR Waiver on November 28, 2014, DHCS and CDA began a new stakeholder process to develop a Home and Community-Based (HCB) Settings transition plan for the CBAS program which would amend California's Statewide HCB Settings Transition Plan. DHCS and CDA hosted three meetings/webinars in February, March and April 2015 focused on developing the CBAS HCB Settings transition plan, released a draft CBAS HCB Settings Transition Plan for public comment in May 2015, and presented the comments and CBAS Plan revisions in July 2015 for incorporation into California's Statewide Transition Plan. Updates and progress on the HCB Settings transition plan for CBAS can be found at: www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/HCB_Settings_Stakeholder_Process/

Based on stakeholder input and milestones identified in the CBAS amendment of the BTR Waiver, DHCS and CDA convened two workgroups in July 2015 to develop a CBAS quality strategy and revise the current CBAS individual plan of care (IPC) emphasizing person-centered planning. The workgroups are comprised of MCPs, CBAS providers, advocates, and state staff and will meet every other month through June 2016.

Operational/Policy Development/Issues

DHCS and CDA continue to work with CBAS providers and MCOs to provide clarification regarding the CBAS benefit, operational, and policy issues. In addition to stakeholder meetings, workgroup activities, and routine discussions, DHCS and CDA have recently engaged MCPs and CBAS providers regarding the development of an application process for prospective new CBAS providers. No new CBAS centers have been opened since the program started in April 2012, consequently, MCO and provider input has been instrumental to the development of a high quality application and certification process for new centers.

Consumer Issues

CBAS Beneficiary / Provider Call Center Complaints (FFS / MCP) (STC 99.e.iv)

DHCS continues to regularly respond to issues and questions, in writing or by telephone, from CBAS participants, CBAS providers, MCPs, members of the Press, and members of the Legislature on various aspects of the CBAS program, as requested.

DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Emails are directed to CBAS@dhcs.ca.gov from providers and beneficiaries for answering a variety of questions.

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA. Complaint data received by the MCPs from beneficiaries and providers are also summarized below:

Demonstration Year 10 - Data on CBAS Complaints				
Demo Year 10 Quarters	Beneficiary Complaints	Provider Complaints	Total Complaints	Percent to Total
DY10 - Qrt 1 (Jul 1 - Sep 30)	12	3	15	0.05%
DY10 - Qrt 2 (Oct 1 - Dec 30)	5	10	15	0.05%
DY10 - Qrt 3 (Jan 1 - Mar 31)	5	5	10	0.03%
DY10 - Qrt 4 (Apr 1 - Jun 30)	5	5	10	0.03%
		CDA data - Phone & Email Complaints		

Demonstration Year 10 - Data on CBAS Managed Care Plan Complaints				
Demo Year 10 Quarters	Beneficiary Complaints	Provider Complaints	Total Complaints	Percent to Total
DY10 - Qrt 1 (Jul 1 - Sep 30)	13	3	16	0.06%
DY10 - Qrt 2 (Oct 1 - Dec 30)	18	2	20	0.07%
DY10 - Qrt 3 (Jan 1 - Mar 31)	28	1	29	0.10%
DY10 - Qrt 4 (Apr 1 - Jun 30)	16	2	18	0.06%
			Plan data - Phone Center Complaints	

CBAS Grievances / Appeals (FFS / MCP) (STC 99.e.iii)

CBAS grievances are held through the MCPs and in Quarter 4; there was 1 grievance filed with the MCP that was resolved.

The State Fair Hearings / Appeals 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 10, Quarter 4, there was one case related to Managed Care filed/heard (from the approximate 29,000 participants), throughout the State.

Quality Assurance/Monitoring Activity

DHCS continues to monitor CBAS Center locations, accessibility and capacity for monitoring access as required under the BTR Waiver. The table below indicates the consistency of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. Licensed Capacity table (Table 1 below), shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 52% statewide. There is unused capacity in almost all counties where CBAS is available to allow for access by Medi-Cal beneficiaries.

Table 1:

County	CBAS Centers Licensed Capacity								
	DY7-Q4 Apr- Jun 2012	DY8-Q4 Apr-Jun 2013	DY9-Q4 Apr-Jun 2014	DY10-Q1 Jul-Sep 2014	DY10-Q2 Oct-Dec 2014	DY10-Q3 Jan-Mar 2015	DY10-Q4 Apr-Jun 2015	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	355	355	**355**	**330**	-7.0%	83%
Butte	60	60	60	60	60	**60**	**60**	0.0%	26%
Contra Costa	190	190	190	190	190	**190**	**190**	0.0%	63%
Fresno	590	547	572	572	572	**572**	**572**	0.0%	64%
Humboldt	229	229	229	229	229	**229**	**229**	0.0%	25%
Imperial	250	315	330	330	330	**330**	**330**	0.0%	32%
Kern	200	200	200	200	200	**200**	**200**	0.0%	28%
Los Angeles *	17,735	17,506	18,184	18,284	18,284	**18,180**	**18,238**	0.3%	60%
Marin	75	75	75	75	75	**75**	**75**	0.0%	22%
Merced	109	109	109	109	109	**109**	**109**	0.0%	47%
Monterey	290	-	110	110	110	**110**	**110**	0.0%	46%
Napa	100	100	100	100	100	**100**	**100**	0.0%	53%
Orange	1,897	1,747	1,910	1,960	1960	**1960**	**1960**	0.0%	68%
Riverside	640	640	640	640	640	**640**	**640**	0.0%	37%
Sacramento	529	529	529	529	529	**529**	**529**	0.0%	66%
San Bernardino	320	320	320	320	320	**320**	**320**	0.0%	100%
San Diego *	2,132	1,992	1,873	1,873	1,873	**2,117**	**2,068**	-2.3%	50%
San Francisco	803	803	866	866	866	**866**	**866**	0.0%	48%
San Mateo	120	120	135	135	135	**135**	**135**	0.0%	68%
Santa Barbara *	55	55	55	55	55	**60**	**60**	0.0%	3%
Santa Clara	820	750	840	830	830	**830**	**830**	0.0%	39%
Santa Cruz	90	90	90	90	90	**90**	**90**	0.0%	62%
Shasta	85	85	85	85	85	**85**	**85**	0.0%	31%
Solano	120	120	120	120	120	**120**	**120**	0.0%	36%
Ventura	806	806	806	851	851	**851**	**851**	0.0%	63%
Yolo	224	224	224	224	224	**224**	**224**	0.0%	19%
SUM =	29,009	27,967	29,007	29,192	29,192	**29,337**	**30,396**	3.6%	52%

CDDA Licenced Capacity as of 6/30/2015

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

There is no drop in provider capacity of 5% or more during this Quarter; STCs 99(e)(v) requires DHCS to provide probable cause upon a negative 5% change from quarter to quarter in CBAS provider capacity per county and an analysis that addresses such variance.

With participant enrollment numbers in counties with CBAS centers, there is ample licensed capacity with the current capacity levels. Table 2 - *Preliminary CBAS Unduplicated Participant Data for FFS and MCP Enrollment* reflects a slightly lower count of participants than those actually serviced during this time period due to the lag in data collection.

Access Monitoring (STC 99.e.)
DHCS and CDA continue to monitor CBAS centers access, average utilization rate, and available capacity. Currently CBAS capacity is adequate to serve Medi-Cal beneficiaries in counties with CBAS centers. With such excessive capacity in counties with multiple CBAS providers, closure of individual CBAS Centers (or consolidation of CBAS providers) continues to minimally impact the program or beneficiaries served.

Unbundled Services (95.b.iii.)

For DY 10, Quarter 4, CDA, the Department that certifies and provides oversight of CBAS Centers, reported one CBAS Center closure in June 2015 and one center that opened in April 2015. Unbundled services relating to the closure to the one CBAS Center will be provided in a future report as self-directed information has not been provided at this time. The unbundled services table will be updated on the next quarter.

DY10_Q4 UNBUNDLED SERVICES

Services Started:	Within 1 Week	Within 2 Week	Within 3 Week	Within 1 Month	Within 2 Months	Within 3 Months	Within 5 Months	**TOTAL**
CBAS-Transfers	-	-	-	-	-	-	-	**-**
Unbundled Services	-	-	-	-	-	-	-	**-**
No *New* Services	-	-	-	-	-	-	-	**-**
DHCS/CDA Complied Data 8/2015							**TOTAL**	**-**

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 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 other local CBAS Centers 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 finds out about the sudden or unexpected Center closure from CBAS participants or other CBAS Centers in the community.

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 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 and community setting.

CBAS Center Utilization (Newly Opened/Closed Centers)

For DY 10, Quarter 4, CDA had 241 CBAS Center providers open and operating in California. One CBAS Center was open in April 2015 and there was one CBAS Center that closed in June 2015. Preliminary data on Center Utilization reflecting the 4th Quarter is as follows:

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
July 2015	241	0	0	0	241
June 2015	242	1	0	-1	241
May 2015	242	0	0	0	242
April 2015	241	0	1	1	242
March 2015	243	2	0	-2	241
February 2015	245	2	0	-2	243
January 2015	245	1	1	0	245
December 2014	245	0	0	0	245
November 2014	243	0	2	2	245
October 2014	244	1	0	-1	243
September 2014	245	1	0	-1	244
August 2014	245	0	0	0	245
July 2014	245	0	0	0	245
June 2014	244	0	1	1	245
May 2014	244	0	0	0	244
April 2014	245	1	0	-1	244
March 2014	245	0	0	0	245
February 2014	244	0	1	1	245
January 2014	244	1	1	0	244
December 2013	244	0	0	0	244
November 2013	245	1	0	-1	244
October 2013	245	0	0	0	245
September 2013	243	0	2	2	245
August 2013	244	1	0	-1	243
July 2013	243	0	1	1	244
June 2013	244	1	0	-1	243
May 2013	245	1	0	-1	244
April 2013	246	1	0	-1	245
March 2013	247	0	0	0	246
February 2013	247	1	0	-1	246*
January 2013	248	1	0	-1	247
December 2012	249	2	1	-1	248
November 2012	253	4	0	-4	249
October 2012	255	2	0	-2	253
September 2012	256	1	0	-1	255
August 2012	259	3	0	-3	256
July 2102	259	0	0	0	259
June 2012	260	1	0	-1	259
May 2012	259	0	1	1	260
April 2012	260	1	0	-1	259

There was no negative change of more than 5% from the prior quarter, so no analysis is

needed to addresses such variances.

<u>Review County Enrollment for CBAS vs. Capacity per County</u>

TABLE 2:

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

	DY10 Q1 Jul - Sept 2014			**DY10 Q2 Oct - Dec 2014**			**DY10 Q3 Jan - Mar 2015**			**DY10 Q4 Apr - June 2015**		
County	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used
Alameda	8	431	73%	5	490	82%	1	458	76%	0	466	83%
Butte	32	0	31%	1	42	42%	0	31	31%	0	26	26%
Contra Costa	6	194	62%	4	201	64%	3	194	61%	2	200	63%
Fresno	5	661	69%	11	625	66%	6	563	59%	3	619	64%
Humbolt	113	0	29%	0	105	27%	0	206	53%	0	98	25%
Imperial	367	0	66%	10	351	65%	0	340	61%	0	177	32%
Kern	0	110	32%	0	92	27%	0	91	27%	0	96	28%
Los Angeles	941	16,707	57%	744	17,270	58%	558	17,991	60%	261	18,173	60%
Merced	0	96	52%	0	89	48%	0	90	49%	0	86	47%
Monterey	0	75	40%	0	83	45%	0	87	47%	0	86	46%
Orange	6	2,313	70%	1	2,248	68%	3	2,194	66%	1	2,248	68%
Riverside	13	383	37%	14	377	36%	9	392	37%	7	390	37%
Sacramento	20	544	63%	31	561	66%	17	553	64%	17	575	66%
San Bernardino	16	456	87%	16	498	95%	6	526	98%	4	539	100%
San Diego	29	1,873	60%	32	1,530	49%	11	1,453	41%	3	1,762	50%
San Francisco	61	664	49%	63	686	51%	55	657	49%	49	657	48%
San Mateo	0	151	66%	0	148	65%	0	127	56%	0	155	68%
Santa Barbara	0	4	4%	0	2	2%	0	3	3%	0	3	3%
Santa Clara	1	544	39%	5	576	41%	2	500	36%	1	548	39%
Santa Cruz	0	107	70%	0	112	73%	0	107	70%	0	94	62%
Shasta	44	0	31%	1	42	30%	1	45	32%	0	44	31%
Ventura	1	940	65%	9	907	64%	6	899	63%	2	899	63%
Yolo	1	280	74%	1	274	72%	1	288	76%	0	72	19%
Marin, Napa, Solano**	0	177	35%	51	94	29%	51	90	28%	0	179	36%
Total	**1,664**	**26,727**	**57%**	**999**	**27,403**	**57%**	**730**	**27,885**	**58%**	**350**	**28,192**	**52%**
Combined Totals	**28,391**			**28,402**			**28,615**			**28,542**		

DHCS / CDA Enrollment Data 8/2015

** Counties with CBAS Center Closure where only one CBAS facility was in the county area; Participants may be served at CBAS Center in another local county

Note: Los Angeles data is an estimate based on previously reported by the Health Plan. The six percent change is reflecting Imperial and Yolo counties Managed Care enrollment data not being current. It will be reflected on the next quarter's report.

Financial/Budget Neutrality Development/Issue

Pursuant to Special Terms and Conditions item 101 (b), the MCP payments must be sufficient to enlist enough providers so that care and services are available under the MCP at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. The change has not affected the centers capacity to date and adequate networks remains for this population.

The extension of CBAS will have no effect on budget neutrality as it is currently a pass-through, meaning the cost of CBAS is assumed to be the same with the waiver as it would be without the waiver. As such, no savings can be realized from the program and the extension of the program will have no effect on overall budget neutrality room.

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

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

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

Report Number	Time Period	Number of Member Months in a Quarter	Number of Unique Eligibles Based on the First Month of Eligibility in a Quarter	Expenditures Based on Month of Payment
DY6, Q1	September – December 2010	551,505	138,443	$829,406,465
DY6, Q2	January – March 2011	406,113	135,693	$676,468,735
DY6, Q3	April – June 2011	404,674	134,774	$649,757,648
DY7, Q1	July – September 2011	408,149	135,612	$570,379,382
DY7, Q2	October – December 2011	403,452	135,812	$592,896,974
DY7, Q3	January – March 2012	405,879	136,489	$639,248,570
DY7, Q4	April – June 2012	409,451	137,496	$574,933,670
DY8, Q1	July – September 2012	404,973	135,775	$565,527,403
DY8, Q2	October – December 2012	409,169	137,698	$442,066,945
DY8, Q3	January – March 2013	426,875	142,507	$382,433,183
DY8, Q4	April - June 2013	457,711	152,598	$349,532,016
DY9, Q1	July – September 2013	449,582	149,612	$433,168,578
DY9, Q2	October – December 2013	457,645	153,488	$296,658,524
DY9, Q3	January – March 2014	463,509	154,851	$300,036,064
DY9, Q4	April – June 2014	471,221	157,788	$281,705,513
DY10, Q1	July – September 2014	478,266	160,331	$309,373,961
DY10, Q2	October – December 2014	483,945	162,656	$306,466,779
DY10, Q3	January – March 2015	487,153	163,267	$307,547,034
DY10, Q4	April – June 2015	485,699	164,495	$270,846,360