DHCS
JENNIFER KENT
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

DEC 2 4 2015

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

Ms. Heather Ross
Acting Project Officer
Centers 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
Centers for Medicare and Medicaid Services, CMS Region IX
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

QUARTERLY PROGRESS REPORT FOR THE PERIOD 07/01/2015 THROUGH 10/31/2015 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)

Dear Mr. Fishman, Ms. Ross, 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 fifth quarterly progress report for Demonstration Year Ten, which covers the period from July 1, 2015 through October 31, 2015.

If you or your staff have any questions or need additional information regarding this report, please contact Angeli Lee by phone at (916) 324-0184 or by email at Angeli.Lee@dhcs.ca.gov. Thank you!

Sincerely,

[redacted]

Ms. Mari Cantwell
Chief Deputy Director
Health Care Programs

Enclosure

cc: See next page

DEC 2 4 2015

cc: Ms. Anastasia Dodson
Associate Director for Policy
Department of Health Care Services
Anastasia.Dodson@dhcs.ca.gov

Ms. Sarah Brooks
Deputy Director of Health Care Delivery Systems
Department of Health Care Services
Sarah.Brooks@dhcs.ca.gov

Ms. Hannah Katch
Assistant Deputy Director of Health Care Delivery Systems
Department of Health Care Services
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)
Fifth Quarter Reporting Period: 07/01/2015-10/31/2015

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.

On July 31, 2015, DHCS received approval of a waiver amendment to expand full-scope coverage to pregnant women 109%-138% of the federal poverty limit. Pregnant women with incomes up to and including 138% of the FPL are also required to enroll in a Medi-Cal managed care health plan in the counties in which such plans are available.

In addition, DHCS received CMS approval on August 13, 2015 for the Drug Medi-Cal Organized Delivery System waiver amendment. This amendment authorizes the state to launch a pilot program and to provide a continuum of care for Medi-Cal beneficiaries with substance use disorders.

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
July 2015 – October 2015

County	Total Member Months
Alameda	122,132
Contra Costa	69,297
Fresno	94,516
Kern	75,325
Kings	10,307
Los Angeles	752,469
Madera	9,989
Riverside	123,859
San Bernardino	142,271
San Francisco	67,759
San Joaquin	68,512
Santa Clara	86,057
Stanislaus	50,297
Tulare	43,861
Sacramento	153,271
San Diego	153,104
Total	**2,023,026**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
July 2015 – October 2015

County	Total Member Months
Alameda	68,154
Contra Costa	29,694
Fresno	37,228
Kern	25,318
Kings	3,922
Los Angeles	1,493,129
Madera	3,944
Marin	25,337
Mendocino	23,507
Merced	63,586
Monterey	63,726
Napa	18,626
Orange	477,385
Riverside	202,631
Sacramento	65,572
San Bernardino	200,380
San Diego	298,226
San Francisco	44,278
San Joaquin	26,738
San Luis Obispo	33,122
San Mateo	94,356
Santa Barbara	60,585
Santa Clara	165,454
Santa Cruz	41,256
Solano	77,667
Sonoma	70,098
Stanislaus	13,979
Tulare	18,084
Ventura	112,506
Yolo	34,805
Total	**3,893,293**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
July 2015 – October 2015

County	Total Member Months
Alpine	133
Amador	1,818
Butte	30,509
Calaveras	2,962
Colusa	1,211
El Dorado	8,372
Glenn	2,679
Imperial	18,481
Inyo	1,041
Mariposa	1,167
Mono	386
Nevada	5,393
Placer	13,582
Plumas	1,811
San Benito	408
Sierra	241
Sutter	8,983
Tehama	8,201
Tuolumne	4,247
Yuba	9,753
Total	**121,378**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
July 2015 – October 2015

County	Total Member Months
Del Norte	10,761
Humboldt	36,039
Lake	25,221
Lassen	5,568
Modoc	2,496
Shasta	54,997
Siskiyou	14,494
Trinity	4,138
Total	**153,714**

Enrollment (July 2015 – October 2015)
During the quarter, mandatory SPDs had an average choice rate 58.72%, an auto-assignment default rate of 19.96%, a passive enrollment rate of 0%, a prior-plan default rate of 0.86%, and a transfer rate of 20.45%. In October, overall SPD enrollment in Two-Plan and GMC counties was 516,438 (point-in-time), a 1.12% decrease from June's enrollment of 522,268. For monthly aggregate and Medi-Cal managed care health plan (MCP)-level data, please see the attachment "DY10-Q5 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

Medi-Cal Managed Care Performance Dashboard (July 2015 – October 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 to 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 September 16, 2015, MCQMD released the seventh 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 eighth edition of the dashboard will be released in December, 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 (July 2015 – October 2015)
Between July 2015 and September 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 October 14, 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/October14MeetingMaterials.aspx

Managed Care Advisory Group
On September 10, 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/MCAGMeetingMaterials091015.aspx

Office of the Ombudsman (July 2015 – October 2015)
Due to the reporting period of four months instead of three, the Office of the Ombudsman experienced an overall increase in customer calls between the periods April-June 2015 (DY10-Q4) and July-Oct 2015 (DY10-Q5). During DY10-Q5, the Ombudsman received 53,321 total calls, of which 15,968 concerned mandatory enrollment and 2,647 were from SPDs. During DY10-Q4, the Ombudsman received 44,927 total calls, of which 15,968 concerned mandatory enrollment and 2,647 were from SPDs. This represents an 18.68% increase in total calls, a 50.23% increase in calls regarding mandatory enrollment, and a 19.76% increase in calls regarding mandatory enrollment from SPDs.

For DY10-Q5, 0.26% of SPD and 0.03% of non-SPD calls concerned access issues. This is a small change in SPD and non-SPD calls from DY10-Q4, during which 0.19% of SPD and 0.02% of non-SPD calls were related to access issues.

Due to the reporting period of four months instead of three, the number of State Hearing Requests (SHRs) rose from 865 in DY10-Q4 to 1,090 DY10-Q5. However, the percentage of SHRs from SPDs only slightly increased from 41% to 42%. Due to the four month reporting period, the number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs increased from 171 in DY10-Q4 to 202 in DY10-Q5. The percentage of those requests from SPDs increased from 39% to 43%. 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 Q5 Ombudsman Report" and "DY10 Q5 State Hearing Report."

Health Risk Assessment Data (January 2015 – March 2015)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 25,571 SPDs between January 2015 and March 2015. Of those, MCPs stratified 11,114 (43.46%) as high-risk SPDs and 13,608 (53.22%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 44.73% by phone and 60.02% by mail. Of the total high-risk SPDs, 44.72% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 31.70% by phone and 61.88% by mail. Of the total low-risk SPDs, 25.56% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 4,370 SPDs to be in the other risk category, which is 17.09% of the total

enrolled in the quarter. Quarterly aggregate and MCP-level data is available in the attachment "Q1 2015 Risk Data."

Continuity of Care Data (April 2015 – June 2015)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 639 continuity-of-care requests between April and June 2015. Of these, MCPs approved 425 requests (66.51% of all requests); held 81 requests (12.68%) in process; and denied 133 requests (20.81%). Of the requests denied, 55.64% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2015 Continuity of Care."

Plan-Reported Grievances (April 2015 – June 2015)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 4,471 grievances between April and June 2015. Of these grievances, 0.74% were related to physical accessibility, 11.81% were related to access to primary care, 4.85% were related to access to specialists, 1.52% were related to out-of-network services, and 81.08% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2015 SPD Grievance."

Medical Exemption Requests (MERs) Data (April 2015 – June 2015)
During 2015, from April through June, 3,735 SPDs submitted 4,490 MERs, an average of 1.2 MERs per SPD who submitted a MER. MCQMD approved 2,335 SPD MERs, denied 2,145, and found 10 to be incomplete. The top five MER diagnoses were Complex (758), Cancer (185), Neurological (143), Transplant (138), and Dialysis (34). Summary data is available in the attachment "Q2 2015 MERs Data."

Health Plan Network Changes (April 2015 – June 2015)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 1,356 primary care physicians (PCPs) and removed 1,416 PCPs across all networks, resulting in a total PCP count of 27,015. Quarterly aggregate and MCP-level data is available in the attachment "Q2 2015 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (July 2015 – October 2015)
Nothing to report.

Encounter Data (July 2015 – October 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 developed and implemented metrics that will objectively measure the quality of encounter data in the dimensions of completeness, accuracy, reasonability and timeliness. EDQU completed its development of an encounter data monitoring database that calculates an Encounter Data Quality Grade for each Medi-Cal MCP based on these metrics. EDQU continued its development of a monitoring database to track encounter data submissions and report valuable data quality information to Medi-Cal MCPs, DHCS data users and other stakeholders.

EDQU continued its work with Medi-Cal MCPs in reporting high quality encounter data through DHCS' new encounter data processing system, Post Adjudicated Claims and Encounters System (PACES). All 23 Medi-Cal MCPs successfully transitioned to PACES and began operationally submitting encounter data in May 2015. 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 (July 2015 – October 2015)

Healthcare Effectiveness Data Information Set (HEDIS) Measures

DHCS 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. The MCP performance on these quality indicators are now available to DHCS for Reporting Year (RY) 2015, based on Measurement Year (MY) 2014 data.

MCPs reported the following indicators for SPDs versus other members: All Cause Readmissions (ACR), Ambulatory Care-Outpatient Visits (AMB-OP), Ambulatory Care-Emergency Department Visits (AMB-ED), Annual Monitoring for Patients on Persistent Medications-Angiotensin Converting Enzyme Inhibitors or Angiotensin Receptor Blockers (MPM-ACE), Annual Monitoring for Patients on Persistent Medications-Digoxin (MPM-DIG), Annual Monitoring for Patients on Persistent Medications-Diuretics (MPM-DIU), Children and Adolescents' Access to Primary Care Practitioners-12 to 24 Months (CAP-12 to 24 mos), Children and Adolescents' Access to Primary Care Practitioners-25 months to 6 Years (CAP-25 mos to 6 yrs), Children and Adolescents' Access to Primary Care Practitioners-7 to 11 Years (CAP-7 to 11 yrs), and Children and Adolescents' Access to Primary Care Practitioners-12 to 19 Years (CAP-12 to 19 yrs).

DHCS holds MCPs to a minimum performance level (MPL) for MPM-ACE and MPM-DIU. 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). The Medi-Cal statewide weighted average for SPDs

remained above the MPL from MPM-ACE and MPM-DIU for RY 2015. The rates for these two indicators also improved from 85.32% to 87.51% for MPM-ACE and from 85.39% to 87.88% in RY 2015 compared to RY 2014.

While DHCS does not hold MPCs to a MPL for the other indicators, the Medi-Cal statewide weighted average for SPDs in RY 2015 also improved compared to RY 2014 from 83.96% to 84.66% for CAP-25 months to 6 years, from 84.98% to 86.58% for CAP 7 to 11 years, and from 79.90% to 81.62% for CAP 12 to 19 yrs. The rate for CAP-12 to 24 months decreased from 87.75% to 84.88% from RY 2014 to RY 2015. The rate for ACR increased from 16.35% in RY 2014 to 21.4% for RY 2015 while the number of visits per 1,000 member months decreased from 458.45 to 429.63 for AMB-OP and from 67.01 to 63.29 for AMB-ED from RY 2014 to RY 2015.

While MCPs were held to a MPL for MPM-DIG in RY 2014, in RY 2015 DHCS did not hold MCPs to a MPL for this indicator due to the high number of reporting units being unable to report a rate for this indicator due to small denominator sizes. In RY 2015, only 18 of 53 reporting units, about one-third, had a denominator size of at least 30 to be able to report a rate for MPM-DIG. The Medi-Cal statewide weighted average for SPDs for MPM-DIG decreased from 87.65% in RY 2014 to 52.56% in RY 2015. Incomplete data capture and reporting may contribute significantly to this decrease, and the rate may not accurately reflect services delivered, due to MCPs not being held to a MPL for this indicator in RY 2015.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
The EQRO began planning with DHCS for the 2016 CAHPS Survey and began communicating information regarding the 2016 Survey with MCPs. The 2016 CAHPS survey will be conducted in the spring of 2016.

Statewide Collaborative All Cause Readmissions
The Statewide Collaborative Quality Improvement Project (QIP) began in July 2011 and focused on reducing All-Cause Readmissions (ACR) within 30 days of an inpatient discharge among MCP members. For the ACR statewide collaborative, MCPs reported baseline rates for ACR in RY 2013 and remeasurement occurred in RY 2014. Each MCP set its own target to achieve in RY 2014 a statistically significant decrease in the proportion of readmissions compared to RY 2013. The ACR Medi-Cal Managed Care weighted average for all beneficiaries, SPDs, and non-SPDs improved from RY 2013 to 2014. For SPDs improvement was seen from 17.04% to 16.27%. The statewide collaborative concluded June 2015, though MCPs continue to report rates for the ACR measure. In RY 2015 the ACR the Medi-Cal statewide weighted average for SPDs increased from 16.35% in RY 2014 to 21.4%. While this statewide collaborative may not have clearly achieved and sustained its original objective and this collaborative has now concluded, DHCS remains confident that new approaches using rapid-cycle quality improvement methods will help lead to broader improvements in all measures including ACR. DHCS will continue to work with its EQRO to conduct more detailed analyses of these results to determine the statistical significance of the statewide efforts.

Utilization Data (July 2014 – October 2014)

During the period July through October 2014, MCPs in Two-Plan and GMC counties enrolled 548,181 unique SPDs. Due to the reporting period of four months instead of three, all of the measures are slightly higher than the previous report. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 16.05% (87,975) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.86 times.
- Each SPD who visited an ER generated an average of 3 ER claims.

Pharmacy Services:

- 69.97% (383,565) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 19.17claims.

Outpatient Services:

- 53.49% (293,228) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 7.66 visits.
- Each SPD who accessed outpatient services generated an average of 11.42 claims.

Inpatient Services:

- 4.57% (25,030) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 3.27 visits.
- Each SPD who accessed inpatient services generated an average of 3.82 claims.

Hospital Admissions:

- 5.77% (31,636) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 2.05 visits.

Top Ten Services Accessed by SPDs

15,221,099 total claims

	Jul 2014 – Oct 2014
1	Prescribed Drugs
2	Other Clinics
3	Physicians
4	Lab and X-Ray
5	Other Services
6	Personal Care Services

7	Targeted Case Management
8	Rural Health Clinics
9	Outpatient Hospital
10	Home and Community Based Waivers

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 39.83% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 13.83%. In the third position, "Diseases of the nervous system and sense organs" was 8.40%. The remaining seven categories ranged from 7.81% to 3.32% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment "DY9 Q5 Utilization Data."

Enclosures/Attachments:

- "DY10 Q5 Defaults Transfers 2Plan GMC"
- "DY10 Q5 Ombudsman Report"
- "DY10 Q5 State Hearing Report.
- "Q1 2015 Risk Data"
- "Q2 2015 Continuity of Care"
- "Q2 2015 SPD Grievance"
- "Q2 2015 MERs Data"
- "Q2 2015 Network Adequacy"
- "DY9 Q5 Utilization Data"

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

The pilot projects under the Bridge to Reform Demonstration Waiver 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 the 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 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 June 2015	1,199	
July 2015	1,158	-41
August 2015	1,125	-33
September 2015	1,086	-39
October 2015	1,050	-36

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

Health Plan of San Mateo Demonstration Project

Department Communications with HPSM
The Systems of Care Division (SCD) and HPSM conduct bi-weekly scheduled conference calls to discuss various issues, inclusive of those related to financial, information technology, and deliverable reporting.

Contract amendment
A contract amendment (draft originally submitted to HPSM on 2/3/2015) continues to be revised. The Department's Capitated Rates Development Division (CRDD) is determining capitated rate revisions and percent reduction to the county allocation fund paid directly to the county for care coordination. The contract amendment is anticipated to be finalized next quarter.

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 the CCS State-Only population to enroll in the CCS DPs. This will permit all CCS eligible children in the health plan's catchment area to enroll in the CCS demonstration in San Mateo County. [1] Enrollment in the CCS demonstration is expected early 2016. The 9D aid code for "CCS State-Only beneficiaries" was activated October 1, 2015.

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

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

Rady Children's Hospital of San Diego Demonstration Project

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 the CCS population from a fee-for-service based system to a capitated model.

Capitated Rates
The Department's CRDD continued to work with actuaries on rate development and risk corridor contract language. Concerns that affect rate derivation regarding drug pricing and pharmacy access have been resolved and data discrepancies have been validated. Updated rates are being prepared and are expected to be shared with RCHSD in early November.

Department Communications with RCHSD
The SCD and RCHSD continued to participate in weekly conference calls. Topics discussed include:

- PHARMACEUTICALS / PMB

RCHSD continued to pursue partnerships with several pharmaceuticals benefits manager (PBM) firms. As of September 1, 2015, RCHSD was in the preliminary stages of contracting with MedImpact Healthcare Systems (MedImpact) to be their PBM. On September 1, 2015, RCHSD submitted to SCD MedImpact's provider directory to be reviewed by SCD's pharmacist.

- MEMBER HANDBOOK

SCD provided comments on the Member Handbook (MH) (Version 7) to RCHSD at the end of July. Currently, RCHSD is holding onto the MH until the pharmacy/pharmaceutical component is resolved.

- FINANCIAL REPORTS

On August 14, 2015, RCHSD submitted financial reports to SCD for review which revealed the health plan is in sound financial standing.

- PROVIDER MANUAL

RCHSD continues to develop the provider manual to satisfy a readiness review component.[2] RCHSD submitted the provider manual (version 3) to SCD on August 12, 2015 for review. In September 2015 SCD provided some recommended changes to the provider Manual and on November 2, 2015, SCD completed the review and supplied

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

additional recommendations. Significant pending items include grievance and appeals process and enhancement of the pharmacy section.

- MEMBER ELIGIBILITY FILE

RCHSD requested a modification to the eligibility file to utilize an existing column in the eligibility table and to convert into a diagnosis column not currently captured in the eligibility table. Due to system limitations this request was denied, however San Diego County CCS staff have agreed to provide a separate report once operations begin that will include the needed data.

- RCHSD READINESS REVIEW DELIVERABLES

On July 2, 2014, RCHSD began submitting to SCD for review their policies and procedures (P&Ps) as indicated in the Readiness Review document.[3] As of October 31, 2015, 63 out of 67 deliverables have been approved by SCD.

- CLINICAL EVALUATION METRICS

On January 15, 2015, RCHSD provided a draft of clinical measures proposed to be evaluated during the course of the demonstration. Clinical measures will include two specific measures for each of the five conditions upon which eligibility is based. On September 21, 2015, RCHSD provided additional feedback and recommendations to the requirements. These are currently being reviewed by SCD.

- CONTRACT ITEMS

On July 13, 2015, SCD provided to RCHSD a draft contract packet (including SOW, Exhibit B Budget Detail and Payment, and Exhibit E Additional Provisions). On August 24th, SCD provided the Exhibit G: HIPAA BAA Department standards for RCHSD consideration, which included approved edits by both DHCS Privacy Office and Information Security Office. On August 28th, an updated version of Exhibit E: Additional Provisions were approved/accepted by both SCD and RCHSD.

90-Day, 60-Day, and 30-Day Notices

During this quarter, SCD forwarded draft notices (for patients, providers, and the GMC plans) to RCHSD and San Diego County. These notices will be used to communicate the disenrollment of eligible CCS DP clients from five Geographic Managed Care (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);

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

- 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 the Medi-Cal Managed Care Division.

Demonstration Schedule

It is anticipated RCHSD CCS DP will be operational in Fall 2016. It should be noted the projected implementation time table 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 approval by CMS.

Complaints, Grievances, and Appeals

CCS Quarterly Grievance Report #9
On August 21, 2015, HPSM submitted a "CCS Quarterly Grievance Report" for the second quarter, April - June 2015. The CCS Quarterly Grievances Report reflected 7 adjudicated grievances.

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

- Four grievances were designated as Quality of Care/Service and were coded as "Plan denial of treatment"; 3 were resolved in favor of the CCS Member and 1 was resolved in favor of Plan.
- Three grievances were labeled as "Other" and were coded as "Access" or "Privacy/Confidentiality," and all were resolved in favor of the CCS Member.

CCS Quarterly Grievance Report #10
On October 30, 2015, HPSM submitted a "CCS Quarterly Grievance Report" for the third quarter, July - September 2015. The CCS Quarterly Grievances Report reflected 4 adjudicated grievances.

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

- Three grievances were designated as Quality of Care/Service and were coded as "Plan denial of treatment" and 3 were resolved in favor of Plan.
- One grievance was labeled as "Other" and resolved in favor of the CCS Member.

Consumer Issues:

The DHCS implemented a stakeholder process to investigate potential improvements or changes to the CCS program. A CCS Redesign Stakeholder Advisory Board (RSAB)

composed of individuals from various organizations and backgrounds with expertise in both the CCS program and care for children with special health care needs, was assembled to lead this process. The CCS Program Redesign website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/CCSStakeholderProcess.aspx

On July 1, 2015, DHCS and HPSM hosted a webinar for HPSM and the San Mateo County CCS Program to provide a presentation focused on lessons learned from the HPSM DP. The presentation link is below:
http://www.dhcs.ca.gov/services/ccs/Documents/HPSMCCSPilot.pdf

CCS Redesign Stakeholder Advisory Board (RSAB)

On July 17, 2015, the CCS RSAB had its final meeting and focused on the Whole-Child Model. The following topics and documentation was presented at the July 17th RSAB meeting:

- Implementation Timeline, CCS Whole-Child Model Stakeholder Feedback, and Next Steps
- CCS Advisory Group and Technical Workgroups
- Discussions with COHS Health Plans, Counties, and Family Members
- Presentation and Discussion on CCS Data

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

CCS Advisory Group (AG)

DHCS continued stakeholder discussions on the CCS Program improvements by transitioning the RSAB group to an ongoing CCS Advisory Group (AG). The CCS AG was formed to continue with the Department's commitment to engaging stakeholders in program changes and specifically with improving the delivery of health care to CCS children and their families through an organized health care delivery model. The Department has developed a "Whole-Child Model" to be implemented in specified counties, no sooner than January 2017.

The CCS AG will meet quarterly in Sacramento; in addition to the AG, three topic-specific technical workgroups (TWG) will meet either on bi-monthly or quarterly.

The CCS AG website link is located below:
http://www.dhcs.ca.gov/services/ccs/Pages/AdvisoryGroup.aspx

On October 21, 2015, the CCS AG had its first meeting. The following topics and documentation was presented at the October 21st AG meeting:

- Key Updates, AB 187, and Future Meetings' Topics/Goals

- Care Coordination / Medical Home / Provider Access Technical Workgroup Update
- Los Angeles County Update on Case Management Redesign
- Partnership HealthPlan of California Care Coordination
- Data & Quality Measures Technical Workgroup Update, Available Statewide Data, and County CCS Measures

Attached is the meeting materials link:
http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsOct21.aspx

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

- Data and Quality Measures TWG – September 29, 2015

http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsSep.aspx

- Care Coordination / Medical Home / Provider Access TWG – October 9, 2015

http://www.dhcs.ca.gov/services/ccs/Pages/MeetingMaterialsOct.aspx

Financial/Budget Neutrality Development/Issues:

Health Plan of San Mateo (HPSM)

Financial Review
SCD completed a sixth 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 August 14, 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
4/1/2015 – 6/30/2015	1,555	176	135	1,596	18,391

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 #9)	7/30/2015	8/12/2015		YES
Grievance Log/Report (Rpt #9)	7/30/2015	8/14/2015		YES
Quarterly Financial Statements (Rpt #9)	8/17/2015	8/13/2015		YES
Report of All Denials of Services Requested by Providers (Rpt #8)	8/17/2015			YES
Provider Network Reports (Rpt #10)	10/30/2015	11/9/2015	✓	
Grievance Log/Report (Rpt #10)	10/30/2015	10/30/2015	✓	

Evaluations:

Nothing to report.

Enclosures/Attachments:

Attached enclosure "California Children Services (CCS) Member Months and Expenditures" consisting of *Number of Member Months in a Quarter, Number of Unique Eligibles Based on the First Month of Eligibility in the Quarter,* and *Expenditures Based on Month of Payment*.

LOW INCOME HEALTH PROGRAM (LIHP)

The Low Income Health Program (LIHP) 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.

DHCS also 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 February 26, 2015, DHCS requested that CMS reconsider their denial of the revisions to the two county specific cost claiming protocols. On February 27, 2015, CMS approved the revised Low Income Health Program Administrative Costs Claiming Protocol Implementation Plan which corrected the calculation error in the percentage of reallocated activities allowable for claiming. DHCS is beginning to process these administrative claims. The Department has been working with the counties in completing the time study survey and has been processing LIHP administrative claims since the approval of the revised Low Income Health Program Costs Claiming Protocol Implementation Plan.

On August 31, 2015, CMS denied both of the Department's appeal requests that were submitted in February 2015.

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

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality:

LIHP Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
CDCR (Qtr. 5)	$0.00	$0.00	$0.00		$0.00
Health Care (Qtr. 5)	$887,762.83	$0.00	$1,775,525.66	DY8	$887,762.83
	$1,777,575.29	$0.00	$3,555,150.57	DY9	$1,777,575.29
IGT	$0.00	$0.00	$0.00		$0.00
Admin (Qtr. 5)	$8,897,819.87	$0.00	$17,795,639.76	DY7	$8,897,819.87

	$19,768,739.92	$0.00	$39,537,479.85	DY8	$19,768,739.92
	$9,694,994.33	$0.00	$19,389,987.98	DY9	$9,694,994.33
Total	**$41,026,892.24**	**$0.00**	**$82,053,783.82**		**$41,026,892.24**

Quality Assurance/Monitoring Activities:

Nothing to report.

Enclosures/Attachments:

Nothing to report.

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 was 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 participants' 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 eligibility for the CBAS benefit is determined through a face-to-face review by a managed care plan registered nurse with level-of-care experience, using a standardized tool and protocol approved by DHCS. Initial face-to-face review is not required when a managed care plan determines that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan

possesses. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by the managed care plan to be clinically appropriate. Denial in services or reduction in the requested number of days for services requires a face-to-face review. 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.[4] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) (See Attachment 4) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans (available in two counties), along with the final COHS county (Ventura) also transitioning at that time. As of 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 is enrolled in managed care, through the beneficiary's Medi-Cal managed care health plan.

Enrollment and Assessment Information:

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

The CBAS Enrollment data (per STC. 99) for both Managed Care Organizations (MCO) 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 MCO 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 MCOs (Table 2), which is reported quarterly, along with claims data for CBAS individuals remaining in FFS. Some MCOs report enrollment data based on their covered geographical areas, which includes multiple counties. The Enrollment data reflects this grouping of some counties

[4] 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.

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 Ineligibility:

DY 10	MCOs			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 MCO changed significantly due to ALL CBAS counties being covered by Managed Care as of December 1, 2014. Information is not available for the months of July to October 2015 due to a delay in the availability of data for that month.

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)

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total CA Counties	58
Number of CBAS Centers	243
* Non-Profit Centers	61
* For-Profit Centers	182
ADA @ 243 Centers	20,697
* ADA per Centers	85

CDA – MSSR data 9/2015

Outreach/Innovative Activities:

CMS' approval of the CBAS amendment to the BTR Waiver occurred 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. DHCS submitted the amended Statewide Transition Plan, including the CBAS Plan, on August 14, 2015. 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 beginning in July 2015 to develop a CBAS quality strategy and to revise the current CBAS Individual Plan of Care (IPC) emphasizing person-centered planning. The workgroups are comprised of MCOs, CBAS providers, advocates, and state staff, which 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 MCOs 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, and MCO and provider input has been instrumental to the development of a high quality application and certification process for new centers. CDA has begun working with several interested applicants and anticipates receiving applications for new centers in early 2016.

Consumer Issues:

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

DHCS continues to regularly respond to issues and questions from CBAS participants, CBAS providers, MCOs, members of the Press, and members of the Legislature on various aspects of the CBAS program, as requested, in writing and/or by telephone. 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 MCOs 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**
DY10 - Qtr 5 (Jul 1 - Sep 30)	11	1	12

Demonstration Year 10 - Data on CBAS Managed Care Plan Complaints				
Demo Year 10 Quarters	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
DY10 - Qtr 5 (Jul 1 - Sep 30)	19	3	22	0.08%

Plan data - Phone Center Complaints

*Note: Information is not available for the month of October due to a delay in the availability of data for that month.

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

CBAS grievances are held through the MCOs and in Quarter 5; there was 1 grievance filed with the MCO 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 5, 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. The Licensed Capacity (Table 1 below), illustrates that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 57% statewide. There is availability 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	DY10-Q5 Jul-Sept 2015	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	355	355	355	330	**330**	0%	73%
Butte	60	60	60	60	60	60	60	**60**	0%	31%
Contra Costa	190	190	190	190	190	190	190	**190**	0%	62%
Fresno	590	547	572	572	572	572	572	**572**	0%	69%
Humboldt	229	229	229	229	229	229	229	**229**	0%	29%
Imperial	250	315	330	330	330	330	330	**330**	0%	66%
Kern	200	200	200	200	200	200	200	**200**	0%	32%
Los Angeles *	17,735	17,506	18,184	18,284	18,284	18,180	18,238	**18,502**	1%	57%
Marin	75	75	75	75	75	75	75	**75**	0%	22%
Merced	109	109	109	109	109	109	109	**109**	0%	52%
Monterey	290	-	110	110	110	110	110	**110**	0%	40%
Napa	100	100	100	100	100	100	100	**100**	0%	53%
Orange	1,897	1,747	1,910	1,960	1960	1960	1960	**1960**	0%	70%
Riverside	640	640	640	640	640	640	640	**640**	0%	37%
Sacramento	529	529	529	529	529	529	529	**529**	0%	63%
San Bernardino	320	320	320	320	320	320	320	**320**	0%	87%
San Diego	2,132	1,992	1,873	1,873	1,873	2,117	2,068	**2,233**	8%	60%
San Francisco	803	803	866	866	866	866	866	**866**	0%	49%
San Mateo	120	120	135	135	135	135	135	**135**	0%	66%
Santa Barbara	55	55	55	55	55	60	60	**60**	0%	4%
Santa Clara	820	750	840	830	830	830	830	**830**	0%	39%
Santa Cruz	90	90	90	90	90	90	90	**90**	0%	70%
Shasta	85	85	85	85	85	85	85	**85**	0%	31%
Solano	120	120	120	120	120	120	120	**120**	0%	26%
Ventura	806	806	806	851	851	851	851	**851**	0%	65%
Yolo	224	224	224	224	224	224	224	**224**	0%	74%
SUM =	29,009	27,967	29,007	29,192	29,192	30,412	30,396	30,825	0%	57%

CDDA Licenced Capacity as of 09/2015

*Note: Information is not available for the month of October due to a delay in the availability of data for that month.

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 MCO 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 5, 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_Q5 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	-	-	-	-	-	-	-	-
							TOTAL	-

DHCS/CDA Complied Data 8/2015

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 In-Home Supportive Service (IHSS) providers is a key characteristic of California's Home and Community-Based Services that help substitute institutional care for seniors and persons with disabilities. Participants can engage/employ their IHSS providers of choice and can self-direct their own care in their home and community-based setting(s).

CBAS Center Utilization (Newly Opened/Closed Centers)

For DY 10, Quarter 5, CDA had 242 CBAS Center providers open and operating in California. Two CBAS centers opened and one CBAS center closed between July and September 2015.

CBAS Center History

Month	Operating Centers	Closures	Openings	Net Gain/Loss	Total Centers
October 2015	242	0	0	0	242
September 2015	242	1	1	0	242
August 2015	241	0	1	1	242
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 Q2 Oct - Dec 2014			DY10 Q3 Jan - Mar 2015			DY10 Q4 Apr - June 2015			DY10 Q5 Jul - Sep 2015		
County	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used	FFS	MCP	Capacity Used
Alameda	5	490	82%	1	458	76%	0	466	83%	0	24	4%
Butte	1	42	42%	0	31	31%	0	26	26%	0	0	0%
Contra Costa	4	201	64%	3	194	61%	2	200	63%	2	206	65%
Fresno	11	625	66%	6	563	59%	3	619	64%	3	522	54%
Humbolt	0	105	27%	0	206	53%	0	98	25%	1	106	28%
Imperial	10	351	65%	0	340	61%	0	177	32%	0	81	14%
Kern	0	92	27%	0	91	27%	0	96	28%	0	50	15%
Los Angeles	744	17,270	58%	558	17,991	60%	261	18,173	60%	340	18,744	62%
Merced	0	89	48%	0	90	49%	0	86	47%	0	96	52%
Monterey	0	83	45%	0	87	47%	0	86	46%	0	78	42%
Orange	1	2,248	68%	3	2,194	66%	1	2,248	68%	0	2,248	68%
Riverside	14	377	36%	9	392	37%	7	390	37%	7	389	37%
Sacramento	31	561	66%	17	553	64%	17	575	66%	26	622	72%
San Bernardino	16	498	95%	6	526	98%	4	539	100%	3	549	102%
San Diego	32	1,530	49%	11	1,453	41%	3	1,762	50%	5	1,776	56%
San Francisco	63	686	51%	55	657	49%	49	657	48%	56	664	49%
San Mateo	0	148	65%	0	127	56%	0	155	68%	0	154	67%
Santa Barbara	0	2	2%	0	3	3%	0	3	3%	0	4	4%
Santa Clara	5	576	41%	2	500	36%	1	548	39%	1	643	46%
Santa Cruz	0	112	73%	0	107	70%	0	94	62%	0	96	63%
Shasta	1	42	30%	1	45	32%	0	44	31%	1	40	28%
Ventura	9	907	64%	6	899	63%	2	899	63%	0	915	63%
Yolo	1	274	72%	1	288	76%	0	72	19%	0	81	21%
Marin, Napa, Solano**	51	94	29%	51	90	28%	0	179	36%	0	158	32%
Total	**999**	**27,403**	**57%**	**730**	**27,885**	**58%**	**350**	**28,192**	**52%**	**445**	**28,246**	**58%**
Combined Totals	**28,402**			**28,615**			**28,542**			**28,691**		

DHCS / CDA Enrollment Data 09/2015

** 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. Information for October 2015 is currently unavailable due to a delay in the availability of data for that month.

Financial/Budget Neutrality Development/Issue:

Pursuant to Special Terms and Conditions item 101 (b), the MCO payments must be sufficient to enlist enough providers so that care and services are available under the MCO 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.

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

On August 13, 2015, the Centers for Medicare and Medicaid Services (CMS) approved California's Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. By better organizing the comprehensive array of treatment services available under Medi-Cal, the waiver will help improve the success rate of individuals seeking substance use disorder treatment. The waiver gives California flexibility to establish a continuum of care to help ensure that services and treatment are delivered in the right place at the right time in the right setting for the individual's needs. The waiver also allows the state to expand DMC residential treatment coverage, an integral piece of the continuum of care. The DMC-ODS waiver includes residential treatment service for all DMC beneficiaries in facilities with no bed limit. The state DMC-ODS implementation is occurring in five phases, (1) Bay Area, (2) Kern and Southern California, (3) Central and Northern California, (4) Northern California, and (5) Tribal Partners. The Department of Health Care Services (DHCS) is currently assisting phase one and two implementation and has received implementation plans from two Bay Area Counties.

Enrollment Information:

Two implementation plans have been received from San Mateo and San Francisco. These implementation plans are currently in the review process.

San Francisco-SFHN-BHS estimates that 24,293 Medi-Cal beneficiaries would meet DSM 5 SUD diagnosis/medical necessity criteria for DMC-ODS Pilot treatment services. San Mateo-BHRS projects between 16,756 to 12,154 Medi-Cal beneficiaries have a SUD and could benefit from treatment.

Outreach/Innovative Activities:

- October 22, 2015 DHCS hosted DMC-ODS stakeholder webinar.
- October 28, 2015 Region 2 Implementation Meeting
- December 8, 2015 Follow up Region 2 implementation Meeting.

Operational/Policy Development/Issues:

Each County shall have an internal grievance process that allows a beneficiary, or provider on behalf of the beneficiary, to challenge a denial of coverage of services or a denial of payment for services by a participating County.

DHCS will provide beneficiaries access to a state fair hearing process. Each county's Quality Improvement Committee will collect the following at a minimum on a quarterly basis:

- Number of days to first DMC-ODS service at appropriate level of care after referral.
- Number, percentage of denied and time period of authorization requests approved or denied.

- No current data to report.

Consumer Issues:

Nothing to report.

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance/Monitoring Activity:

The intergovernmental agreement with the state and counties that opt into the waiver must require counties to have a Quality Improvement Plan that includes the county's plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services.

The county shall have a Quality Improvement committee to review the quality of substance use disorders services provided to the beneficiary. Each county's QI Committee should review required data at a minimum on a quarterly basis.

The state will monitor the counties at least once per year through the External Quality Review Organizations (EQRO). If significant deficiencies or significant evidence of noncompliance with the terms of this waiver, the county implementation plan or the state/county intergovernmental agreement are found in a county, DHCS will engage the county to determine if there challenges that can be addressed with facilitation and technical assistance. If the county remains noncompliant, the county must submit a corrective action plan (CAP) to DHCS.

Evaluation:

Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC-ODS Waiver. The design of the DMC-ODS evaluation will focus on four key areas: access, quality, cost, and integration and coordination of care. The evaluation design report was sent to CMS on October 13, 2015.

Enclosures/Attachments:

Nothing to report.

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$0		$0		$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
(Qtr 5)	$0		$0		$0
Total:	**$254,843,824**		**$254,843,824**		**$509,687,648**
DSRIP					
(Qtr 1)	$0	$0			$0
(Qtr 2)	$328,893,774	$328,893,774			$657,787,548
(Qtr 3)	$0	$0			$0
(Qtr 4)	$330,830,478	$330,830,478			$661,660,956
(Qtr 5)	$346,227,512	$346,227,512			$692,455,024
Total:	**$1,005,951,764**	**$1,005,951,764**			**$2,011,903,528**
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
(Qtr 5)	$714,261		$714,261	DY 10 (Apr-Jun)	$1,428,521
(Qtr 5)	$51,384,520		$51,384,520	DY 10 (Jul-Sept)	$102,769,042
(Qtr 5)	$17,119,849		$17,119,849	DY 10 (Oct-Dec)	$34,239,698
Total:	**$ 534,348,980**		**$ 534,525,839**		**$ 1,068,874,820**

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 **$ 69,218,630** 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 **$ 0** in federal fund payments for SNCP eligible services.

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

- California Children Services – Excludes CCS State-Only and CCS Healthy Families
- 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 date of payment, 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
DY10, Final	July – September 2015	483,955	161,540	$309,522,517