



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



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June 6, 2013

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**QUARTERLY PROGRESS REPORT FOR THE PERIOD 01-01-2013 THROUGH
03/30/2013 FOR THE CALIFORNIA BRIDGE TO REFORM DEMONSTRATION (11-W-00193/9)**

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

Enclosed is the Quarterly Progress Report required by Paragraph 20 and Attachment I of the Special Terms and Conditions of California's section 1115 *Bridge to Reform Demonstration* (11-W-00193/9). This is the third quarterly progress report for Demonstration Year Eight, which covers the period from January 1, 2013 through March 30, 2013.

If you or your staff have any questions or need additional information regarding this report, please contact Brian Hansen, Health Reform Advisor, at (916) 319-8518.

Sincerely,

Toby Douglas
Director

Enclosure

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TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Demonstration Year: Eight (07/01/12-06/30/13)

Third Quarter Reporting Period: 01/01/2013-03/31/2013

INTRODUCTION:

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

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

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

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

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

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

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

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

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

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

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

DHCS provides three types of managed care models:

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

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

Enrollment information:

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

**TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
Jan 2013 – Mar 2013**

County	Total Member Months
Alameda	89,349
Contra Costa	46,880
Fresno	68,142
Kern	54,608
Kings	7,332
Los Angeles	583,521
Madera	7,229
Riverside	91,347
San Bernardino	108,378
San Francisco	52,741
San Joaquin	49,098
Santa Clara	66,775
Stanislaus	29,416
Tulare	31,467
Sacramento	111,566
San Diego	116,823
Totals	1,514,672

**TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
Jan 2013 – Mar 2013**

County	Total Member Months
Alameda	35,333
Contra Costa	12,899
Fresno	18,790
Kern	11,445
Kings	1,569
Los Angeles	170,215
Madera	1,562
Marin	18,148
Mendocino	16,989
Merced	45,063
Monterey	43,292
Napa	12,950
Orange	318,069
Riverside	26,888
Sacramento	31,430
San Bernardino	28,556
San Diego	32,666
San Francisco	19,978
San Joaquin	10,673
San Luis Obispo	24,658
San Mateo	66,123
Santa Barbara	43,210
Santa Clara	27,639
Santa Cruz	28,543
Solano	54,570
Sonoma	48,759
Stanislaus	3,923
Tulare	8,007
Ventura	75,877
Yolo	23,730
Totals	1,261,554

Enrollment (January 2013 – March 2013)

Over the three months of the quarter, mandatory SPDs had an average choice rate of 47.93%, an auto-assignment default rate of 26.82%, a passive-enrollment rate of 7.53%, a prior-plan-default rate of 0.01%, and a transfer rate of 16.92%. “Passive

enrollment” refers to the transfer of beneficiaries from their current Medi-Cal managed care plans (MCPs) into new MCPs because their current MCPs no longer operate. In March, overall SPD enrollment in Two-Plan and GMC counties was 505,792 (point-in-time), a 0.61% increase over December’s enrollment of 502,736. For monthly aggregate and MCP-level data, please see the attachment “DY8-Q3 Defaults Transfers 2Plan GMC.”

Outreach/Innovative Activities:

With funding from the California HealthCare Foundation (CHCF), MMCD contracted with a vendor, Navigant, to create an online dashboard for the Medi-Cal Managed Care program (MCP). Navigant and MMCD continued their work to create this dashboard during the quarter. Once completed, the dashboard will help DHCS and its stakeholders to better observe and understand MCP activities on all levels: statewide, by managed care model (i.e., COHS, GMC, and Two-Plan), and within an individual MCP. It will include metrics submitted by MCPs that quantify and track quality of care, enrollee satisfaction, enrollee utilization, finances, care coordination, and continuity of care. It will also stratify reported data by beneficiary populations, including Medi-Cal-only SPDs.

To help ensure the success of the dashboard, MMCD and CHCF worked during the quarter to form a Technical Advisory Group (TAG) that represents a diverse group of industry experts, including MCP and provider representatives, consumer groups, technical experts, and other stakeholders.

DHCS also worked to clarify a list of potential measures to include on the dashboard for which data are now readily available. The TAG will discuss these measures.

Operational/Policy Issues:

Network Adequacy

Between January 2013 and March 2013, the Department of Managed Health Care (DMHC) completed a provider network review for all Two-Plan and GMC model MCPs. DMHC’s reviews, based on quarterly provider network reports, provide DHCS with an updated list of providers SPDs may contact to receive care. DMHC conducted a thorough review of each MCP’s provider networks and identified no access-to-care issues.

Consumer Issues:

1115 Waiver Stakeholder Advisory Committee

On February 22, 2013, the DHCS 1115 Waiver Stakeholder Advisory Committee (SAC) convened and discussed the following items:

Healthy Families Transition to Med-Cal:

During Phase 1 of the Healthy Families Program (HFP) transition to Medi-Cal Managed Care, DHCS transitioned approximately 180,000 children into MCPs. All metrics indicate

that these children have transitioned with few-to-no problems. Phase 2 of the HFP transition began on April 1, 2013, for recipients who received HFP care through Health Net or through health plans that are subcontracted to MCPs.

Medi-Cal Managed Care Expansion to Rural Counties:

DHCS convened stakeholder meetings in the counties of Shasta, Imperial, San Benito, and Sacramento. DHCS received six applications to operate a MCP for the consortium of 26 northern counties and will award the request for proposal RFP to the approved applicant during the month of March. The counties of San Benito and Imperial will seek separate health plans to operate their MCPs.

Lessons Learned from Transitions:

The 1115 Waiver SAC engaged in a robust discussion regarding the lessons DHCS has learned from the SPD and HFP transitions. The group stated that it is too early to fully assess the lessons it has learned from the HFP transition, but acknowledged that it is closely tracking specific issues related to enrollment and eligibility. For the transition of SPDs, these issues include the ability of MCPs to provide continuity of care and how well MCPs have informed beneficiaries of the Medi-Cal Managed Care program, pharmacy benefits, billing procedures, and how to communicate with providers.

Coordinated Care Initiative:

DHCS provided the 1115 Waiver SAC with an update on the Memorandum of Understanding with CMS, MCP readiness criteria, and long-term services and supports (LTSS). The group discussed the next steps required of State agencies and MCPs to implement the Coordinated Care Initiative (CCI), including that the Department of Aging must focus on consumer outreach, and the 1115 Waiver SAC must evaluate lessons learned from implementing the CCI's requirements for In-Home Support Services (IHSS), mental and behavioral health, and education.

Update to the 1115 Waiver:

DHCS is working on an amendment to the payment method for non-designated public hospitals (NDPHs). DHCS is revising the payment method for NDPHs to a certified public expenditure (CPE) payment method; DHCS will include the NDPHs in the delivery-system-reform incentive pool and safety-net care pool. DHCS is also working to amend the Dual-Eligibles Demonstration, the rural managed care expansion, and the Low-Income Health Program (LIHP) for American Indian and Alaska Native populations. Medi-Cal optional benefits and covered services are eligible for 100% federal financial participation. DHCS submitted a waiver amendment for cost claiming in LIHP through the California Rural Indian Health Board.

Full documentation from the meeting can be found here:

<http://www.dhcs.ca.gov/Pages/February22,2013SACMeeting.aspx>

Office of the Ombudsman (January 2013 – March 2013)

The Office of the Ombudsman experienced a significant increase in customer calls between the periods October–December 2012 (DY8-Q2) and January–March 2013

(DY8-Q3). During DY8-Q2, the Ombudsman received 11,070 total calls, of which 3,846 concerned mandatory enrollment, and 1,354 were from SPDs. In DY8-Q3, the Ombudsman received 14,911 total calls, of which 5,176 concerned mandatory enrollment, and 1,662 were from SPDs. This represents a 35% increase in total calls, a 35% increase in calls regarding mandatory enrollment, and a 23% increase in calls regarding mandatory enrollment from SPDs.

For DY8-Q3, 0.19% of SPD and 0.03% of non-SPDs calls concerned access issues. This is a decrease from DY8-Q2, during which 0.63% of SPD calls and 0.14% of non-SPD calls were related to access issues.

The number of State Hearing Requests increased for all measures, which might be associated with a special notice that DHCS sent to certain individuals who filed MERS, offering them the right to file a State Hearing. Total State Hearing Requests increased from 536 during DY8-Q2 to 1,075 during DY8-Q3. The percentage of requests that were from SPDs also increased from 72% to 77%. The number of requests regarding the denial of members' requests for exemption from mandatory enrollment into managed care also increased from 191 during DY8-Q2 to 589 during DY8-Q3. The percentage of those requests from SPDs increased from 77% to 84%. The Ombudsman received no State Hearing Requests related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachment "DY8 Q3 Ombudsman Data."

Medical Exemption Requests (January 2013 – March 2013)

DHCS continued to focus a significant amount of time during this quarter on processing Medical Exemption Requests (MERs) and Emergency Disenrollment Requests (EDERs) for SPDs and those who were affected by the two errors related to the processing of MERs. DHCS continued to address the high volume of MERs by reprioritizing staff responsibilities and focusing on streamlining and automation. As a result of these efforts, no outstanding MERs remained at the end of the quarter.

DHCS also continued to work on a project to create an electronic system for clinical staff to process MERs. This electronic system will decrease the time the clinical staff requires to process MERs, decrease the potential for errors, and streamline the reporting process. The electronic system is on schedule to launch June 2013. Additionally, DHCS sent a special notice to certain individuals who filed MERS, offering them the right to file a State Hearing.

In 2012, DHCS established a MER workgroup that includes key advocates, stakeholders, and DHCS and State Legislative staff. The purpose of the MER workgroup is to revise the MER application form, draft new informing materials, create call-center scripts, and participate in process and efficiency improvements.

Risk Data (July 2012 – September 2012)

According to the data reported by Two-Plan and GMC health plans, MCPs newly enrolled 34,987 SPDs between July 2012 and September 2012. Of those, MCPs stratified 17,209 (49.2%) as High-Risk SPDs and 17,775 (50.8%) as Low-Risk SPDs. Of the High-Risk SPDs, MCPs contacted 85.3%, and, of those contacted, 18.7% completed a Risk Assessment Survey. Of the Low-Risk SPDs, MCPs contacted 74.2%, and, of those contacted, 27.7% completed a Risk Assessment Survey. After the Risk Assessment Surveys were completed, MCPs determined 5,289 SPDs to be in the other risk category, which is 15.1% of the total enrolled in the quarter. Quarterly aggregate and health plan-level data is available in the attachment “Q3 2012 Risk Data.”

Continuity-of-Care Data (October 2012 – December 2012)

According to the data reported by Two-Plan and GMC health plans, SPDs submitted 1,780 continuity-of-care requests between October and December 2012. Of these, MCPs approved 1,335 requests (75% of all requests); held 3 requests (0.2%) in process; and denied 441 requests (24.8%). MCPs denied over half of the requests (64.9%) because the provider and health plan could not agree to a payment rate. Quarterly aggregate and health plan-level data is available in the attachment “Q4 2012 Continuity of Care.”

Plan-Reported Grievances (October 2012 – December 2012)

According to the data reported by Two-Plan and GMC health plans, SPDs submitted 1,536 grievances between October and December 2012. Of these grievances, 1.1% were related to physical accessibility, 10.9% were related to access to primary care, 6.5% were related to access to specialists, 1.0% were related to out-of-network services, and 80.5% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment “Q4 2012 SPD Grievance.”

MERs Data (October 2012 – December 2012)

During the period October 2012 through December 2012, 1,333 SPDs submitted 1,849 MERs, which is on average 1.39 MERs per SPD who submitted a MER. MCPs approved 934, denied 417, and determined that 498 were incomplete. The top five MER diagnoses were Complex (691), Cancer (434), Transplant (226), Neurological (187), and Dialysis (98). Summary data is available in the attachment “Q4 2012 MERs Data.”

Health Plan Network Changes (October 2012 – December 2012)

According to the data reported by Two-Plan and GMC health plans, MCPs added 875 primary care physicians (PCPs) and removed 523 PCPs across all networks, resulting in a total PCP count of 20,994. Quarterly aggregate and MCP-level data is available in the attachment “Q4 2012 Network Adequacy,” including health plan-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (January 2013 – March 2013)

DHCS engaged a consultant through funding from the Blue Shield of California Foundation (BCSF) to help the State identify an appropriate structure for the evaluation of the transition of the SPD population to managed care. The BCSF consultant will review all data collected to date pertaining to the transition and compose a list of recommended questions to include in the evaluation through interviews with external stakeholders and advocates, health plans, Legislative staff, and individuals employed by DHCS. The consultant is on schedule to issue a report in May 2013.

Encounter Data (January 2013 – March 2013)

DHCS has established an internal workgroup of subject-matter experts from throughout the department to review, recommend, and implement appropriate revisions to current policies, processes, and requirements related to encounter data submission. This workgroup has proposed new performance measures to enhance data monitoring and analysis. DHCS is developing these measures and reporting mechanisms to enable MCPs to provide prompt feedback and to take prompt action. In January 2013, DHCS employed newly developed trend analyses of beneficiary visits to identify potential gaps in data completeness. DHCS is sharing these analyses with MCPs to identify areas of concern and to establish how to determine the cause of these gaps in encounter data and to develop a method to resolve these gaps. These procedures will be used to work with MCPs to improve overall encounter data reporting.

Outcome Measures and Avoidable Hospitalizations (January 2013 – March 2013)

DHCS employs multiple strategies to facilitate positive outcomes of care, including reduction in avoidable hospitalizations, for all MCP members, including SPDs:

Healthcare Effectiveness Data Information Set (HEDIS) Measures

DHCS is responsible for ensuring that HEDIS reporting complies with the requirements of the Section 1115 Medicaid Waiver. HEDIS results will be reported by categories for MCPs and counties. In November 2012, DHCS released the final HEDIS measures for 2013 and the final SPD stratification method for MCPs to use for selected measures. DHCS is finalizing the annual update to the quality and performance improvement program requirements for 2013, and anticipates its release and posting to the MMCD website in April 2013 (available at this link:

<http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx>).

Consumer Assessment of Healthcare Providers and Systems

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

In February 2013, DHCS mailed 73,260 CAHPS Surveys to adult members and parents or caretakers of child members. Survey results will include member responses in four areas:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often.

Additionally, the results of five composite measures will reflect member experiences with:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making.

The survey will close to new responses in May; the final report will be published in January 2014.

Statewide Collaborative All Cause Readmissions (ACR)

The Statewide Collaborative Quality Improvement Project (QIP) began in July 2011 and focused on reducing readmissions for all causes with 30 days of discharge. DHCS worked with MCPs and the EQRO to develop guiding principles, a HEDIS-like measure specific to the Medi-Cal population, and a collaborative evaluation plan. All MCPs have submitted QIP proposals containing study design data, which have been validated by the EQRO. Additionally, MCPs conducted barrier analyses and developed interventions to address the identified barriers.

During the first quarter of CY 2013, MCPs submitted documentation of the barrier analyses and interventions to DHCS and the EQRO for review. DHCS and the EQRO conducted individual technical assistance calls with all of MCPs and provided feedback on their improvement strategies. Six MCPs will resubmit their barrier analyses and interventions for additional review after incorporating changes based on the feedback they received during their technical assistance calls. In January 2013, MCPs began implementing their interventions. The status of the collaborative, including the MCPs' interventions, will be published in an interim report by the EQRO during the summer of 2013.

Case Management and Coordination of Care Survey

DHCS requires its MCPs to develop and implement processes to ensure the provision of case management (CM), care coordination, and continuity-of-care (COC) services to their members. DHCS monitors the CM and COC services provided by MCPs through an annual electronic survey. DHCS compiled the baseline results for CY 2011. Results for CY 2012 have been compiled and are in the process of being analyzed. CY 2012 results will be compared to CY 2011 baseline results to identify any trends in services

and/or resources related to case management and coordination of care among the managed care health plans.

State Audits

DHCS and DMHC entered into an interagency agreement to conduct financial audits, network adequacy assessments, and medical surveys for the SPD population on behalf of DHCS. The current interagency agreement expires on June 30, 2013; however, DHCS and DMHC are meeting regularly to discuss an extension. The new interagency agreement will be extended at least one year. Ongoing discussions continue regarding coordination efforts between the departments.

Utilization Data (January 2012 – March 2012)

Note: Data were rerun for the previous quarter of October through December 2011, due to a reporting error. Visits were being reported as claims. A visit is a single occurrence of a member seeing a provider on a particular date. One visit can have multiple claims for various services.

During the period January 2012 through March 2012, DHCs enrolled 456,745 unique SPDs into MCPs in Two-Plan and GMC counties, a 21.3% increase in enrollment from the previous quarter. Most areas of service increased for SPDs by approximately the same percentage:

- 25.8% increase in emergency room (ER) claims,
- 27.5% increase in ER visits,
- 20.4% increase in outpatient claims, and
- 24.3% increase in outpatient visits.

The exceptions are:

- 74.6% increase in pharmacy claims,
- 2.5% increase in hospital admissions,
- 18% decrease in inpatient claims, and
- 0.3% increase in inpatient visits (increase 0.3%).

A bar graph depicting these changes and those described below is available in the attachment “DY8 Q3 Utilization Data.”

Regarding ER services for these 456,745 unique SPDs:

- 13% (59,211) visited the ER, a 4.4% increase compared to the ratio to the total population for the previous quarter (46,752).
- 26.6% (12,459) more SPDs visited the ER than during the previous quarter.
- 27.5% (21,202) more ER visits were made compared to the previous quarter.
- Each SPD visited the ER an average of 1.66 times, a 0.7% increase in average visits compared to the previous quarter.
- 25.8% (40,289) more ER claims were generated compared to the previous quarter.

- Each SPD generated an average of 3.32 ER claims, a 0.7% decrease in average claims compared to the previous quarter.

Regarding pharmacy services for these 456,745 unique SPDs:

- 65.6% (299,442) accessed pharmacy services, a 13.3% increase compared to the ratio of the total population for the previous quarter (217,864).
- 37.4% (81,578) more SPDs accessed pharmacy services than during the previous quarter.
- Each SPD generated an average of 12.07 claims for pharmacy services, a 27.1% increase over the previous quarter (9.50 claims).

Regarding outpatient services for these 456,745 unique SPDs:

- 44.3% (202,503) accessed outpatient services, a 0.4% increase compared to the ratio to the total population for the previous quarter (166,271).
- 21.8% (36,232) more SPDs accessed outpatient services, than during the previous quarter.
- 24.3% (217,521) more visits to outpatient medical were made than during the previous quarter (895,220).
- 20.4% (387,103) more outpatient services claims were generated compared to the previous quarter (1,893,801).
- Each SPD generated an average of 5.49 outpatient medical visits, a 2.1% increase over the previous quarter (5.38 visits).
- Each SPD generated an average of 11.26 outpatient claims, a 1.1% decrease from the previous quarter (11.39 claims).

Regarding inpatient services for these 456,745 unique SPDs:

- 4.6% (20,818) accessed inpatient services, a 2.8% decrease compared to the ratio to the total population from the previous quarter (17,646).
- 18% (3,172) more SPDs accessed inpatient services compared to the previous quarter.
- 0.3% (138) more visits to inpatient services were made compared to the previous quarter (46,072).
- 18% (14,802) fewer claims for inpatient services were generated compared to the previous quarter (82,332).
- Each SPD generated an average of 2.22 medical visits, a 15% decrease from the previous quarter (2.61 visits).
- Each SPD generated an average of 3.24 claims, a 30.5% decrease from the previous quarter (4.67 claims).

Regarding hospital admissions for these 456,745 unique SPDs:

- 5.3% (24,075) were admitted to a hospital, a 2.9% decrease compared to the ratio to the total population from the previous quarter (20,448).
- 17.7% (3,627) more SPDs were admitted to a hospital than during the previous quarter (20,448).

- Each SPD generated an average of 1.62 claims for hospital admissions, a 13% decrease from the previous quarter (1.86 claims).

For the top ten services accessed, MCPs submitted 8,887,069 total claims, a 16.6% increase over the previous quarter. As shown in the table below, the number of claims for services increased in most categories, except in “Other Clinics,” which decreased, and two categories were new while two dropped off the list. “Prescribed Drugs” remained the most-accessed service, followed by “Lab/X-Ray” and “Physicians,” respectively, in reverse order from the previous quarter. “Outpatient Hospital” remained fourth. “Other Services” rose to fifth from sixth. “Rural Health Clinics” rose to sixth from seventh. “Hospital: Inpatient Other” jumped from ninth to seventh. “Other Clinics” dropped from fifth to eighth. “Personal Care Services” and “Targeted Case Management” dropped off the list. Transportation and Rehab Services were new to the list in ninth and tenth positions respectively. A bar chart showing the changes between the two quarters is available in the attachment “DY8 Q3 Utilization Data.”

Change in Ranking of Top Ten Services Accessed by Newly Enrolled SPDs

	Quarter 2: Oct 2011 – Dec 2011	Quarter 3: Jan 2012 – March 2012
1	Prescribed Drugs	Prescribed Drugs
2	Physicians	Lab/X-Ray
3	Lab/X-Ray	Physicians
4	Outpatient Hospital	Outpatient Hospital
5	Other Clinics	Other Services
6	Other Services	Rural Health Clinics
7	Rural Health Clinics	Hospital: Inpatient Other
8	Personal Care Services	Other Clinics
9	Hospital: Inpatient Other	Transportation
10	Targeted Case Management	Rehab Services

For the top ten diagnosis categories, MCPs submitted data for a total of 1,981,181 encounters. Mental Illness was in the top rank with 32.4% of the encounters. “Symptoms; signs; and ill-defined conditions and factors influencing health status” accounted for 16.6%. In the third position, “Diseases of the circulatory system” was 9.8%. The remaining seven categories ranged from 7.8% to 3.1% of the encounters.

Quarterly aggregate and MCP-level data can be found in the attachment “DY8 Q3 Utilization Data.”

Enclosures/Attachments:

- “DY8 Q3 Defaults Transfers 2Plan GMC”

- “DY8 Q3 Ombudsman Data”
- “Q3 2012 Risk Data”
- “Q4 2012 Continuity of Care”
- “Q4 2012 SPD Grievance”
- “Q4 2012 MERs Data”
- “Q4 2012 Network Adequacy”
- “DY8 Q3 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 will focus on improving care provided to children in the CCS program through better and more efficient care coordination, with the goals of improved health outcomes, increased consumer satisfaction and greater cost effectiveness, by integrating care for the whole child under one accountable entity. Existing state and federal funding will be used for the pilot projects, which are expected to serve 15,000 to 20,000 CCS eligible children. The positive results of these projects could lead to improved care for all 185,000 children enrolled in CCS.

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

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

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

Enrollment information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

The Department of Health Care Services (DHCS) continues to collaborate with all five Demonstration entities relative to issues and challenges specific to each of the model locations. A challenge that impacts four of the five Demonstrations is access to cost utilization data required by these entities to adequately determine financial risk. Other challenges are issues that are specific to each location such as covered populations and health conditions, general organizational structure, reporting requirements, etc.

Health Plan San Mateo (HPSM) Demonstration Project

The California Children's Services (CCS) Demonstration for Health Plan San Mateo (HPSM) became operational on April 1, 2013.

DHCS Communications with CMS

DHCS participates in pre-scheduled reoccurring meetings with Centers for Medicare & Medicaid Services (CMS) which includes CMS Region IX staff, CMS Central Office staff, and other DHCS organizations who are participating in other components of the 1115 Bridge to Reform Waiver. DHCS's Systems of Care Division (SCD) also maintains separate communications with CMS Regional IX staff relative to issues such as review of Demonstration contracts, development and review of Special Terms and Conditions protocols, readiness review documents, preparation and review of member notices, and review and approval of other CMS requirements.

Readiness Review Deliverables

On March 5, 2013 the top 10 Readiness Review policies and procedures (P&Ps) deliverables were sent to CMS for their review and approval. These Readiness Review P&P deliverables included: Provider Network of CCS approved health care providers and health care facilities; Provider to Member Ratios; Specialists by type within the Contractor's network; Federally Qualified Health Centers and Indian Health Services Facilities; Geographic/Physical access and Geo Access report; Excluded services for Drug and Alcohol services; Care Coordination; Mental Health including Memorandum of Understanding (MOU) for Local Mental Health Plan and Local Regional Centers; Targeted Case Management; Member Identification Card, and Member Services Guide.

CMS approved the HPSM Contract on March 27, 2013 and informed DHCS that HPSM could begin operations for this Demonstration Project.

DHCS Communications with HPSM

Final Contract Package was sent to HPSM for signature on February 27, 2013 and was returned back to the Department on March 28, 2013 from HPSM signed.

Capitated Reimbursement Rates

The capitation rates were accepted by HPSM on February 11, 2013, amended on March 12, 2013, and was amended and finalized on March 26, 2013 for the HPSM contract.

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

Department Communications with RADY

DHCS has provided two contract versions with RADY and has exchanged contract language changes. DHCS has also engaged in numerous discussions and conference calls with RADY regarding issues associated with access to cost utilization data, clarification of the CCS population to be covered, organizational structure, staffing etc.

Department Communications with other state agencies

DHCS has been in communication with the Department of Managed Health Care (DMHC) and submitted a request for exemption to Knox-Keene licensure under the Accountable Care Organization model in San Diego County: Rady Children's Hospital. DHCS received a response back from DMHC approving the Knox-Keene Waiver request on March 4, 2013. Exemption to Knox-Keene licensure will not waive conformance with Knox-Keene performance requirements, the request recognizes the large financial burden associated with pursuing licensure as well as acknowledging the nature of this project as a demonstration with specific time frames.

Children's Hospital Orange County (CHOC) Demonstration Project

DHCS Communications with CHOC and Cal Optima

DHCS has provided a contract version to Cal Optima on February 15, 2013. Cal Optima requested 10 health conditions be included in the next contract version. DHCS has also engaged in numerous discussions and conference calls with CHOC and Cal Optima regarding issues associated with access to cost utilization data, confirmation of 10 health conditions, resolving the Knox-Keene issue, etc.

Pilot Schedule

DHCS is projecting that the five pilot models will be phased in according to the general time table provided below.

- Health Plan San Mateo County (HPSM) – April 1, 2013 Operational
- Rady Children's Hospital of San Diego County (RADY) – 3rd Quarter 2013 (April to June)
- Los Angeles Care Health Plan (LA Care) – 4th Quarter 2013 (July to September)
- Children's Hospital of Orange County (CHOC) – 4th Quarter 2013 (July to September)
- Alameda County Health Care (Alameda) – 4th Quarter 2013 (July to September)

It should be noted that the projected implementation time table for each of the Demonstration Projects (DP) is contingent on a number of factors including acceptance

of reimbursement rates by the contracting entity, the ability of the contractor to demonstrate readiness to begin operations, and approval of the contract by CMS.

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

- RADY - Providing claims data to RADY consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and confidentiality requirements; completion and agreement of capitated reimbursement rates; confirmation of health conditions; possibility of additional health conditions for the future; and member and health plan notification.
- CHOC – Providing claims data to CHOC consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; and confirmation of 10 health conditions, which may be reduced.
- LA Care - Status of the Knox-Keene Waiver amendment approval with DMHC; providing claims data to LA Care consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; infrastructure challenges associated with three individual provider networks; coordination with other initiatives (coordinated care initiative, dual population, healthy family transition, Affordable Care Act); coordination with local CCS Program / eligibility and enrollment.
- Alameda – Providing claims data to Alameda consistent with the HIPAA security and confidentiality requirements; completion and agreement of capitated reimbursement rates; confirmation of population (high acuity focus vs. entire population); and confirmation of administrative infrastructure.

Consumer Issues:

On February 22, 2013, DHCS convened an 1115 Waiver Stakeholder Advisory Committee (SAC) meeting in Sacramento. The meeting included a CCS Demonstration briefing document of the CCS pilots and is available at:

<http://www.dhcs.ca.gov/Documents/CCSDemonstrationUpdateFeb.pdf>

Meeting agenda and materials can be found at:

<http://www.dhcs.ca.gov/Documents/Feb2213SACMtgAgendaFinal.pdf>

<http://www.dhcs.ca.gov/Pages/February22,2013SACMeeting.aspx>

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

Nothing to report.

Evaluations:

The Department received from University of California Los Angeles (UCLA) Health Policy Research a draft Scope of Work (SOW) for the CCS Evaluation. As of May 7, 2013 a contract is being drafted by SCD, which addresses both the SOW and Budget detail items for UCLA Health Policy Research's participation in doing the CCS Evaluation. Once SCD has finished reviewing the CCS Evaluation contract, it will be forwarded on to CMS for review and comment.

Enclosures/Attachments:

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

LOW INCOME HEALTH PROGRAM (LIHP)

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

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

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

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

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

Enrollment Information:

Quarterly LIHP enrollment and applicant reports, and the grievances and appeals report will be submitted to CMS in a separate note.

Outreach/Innovative Activities:

The University of California Los Angeles Center for Health Policy Research (UCLA) released the report “*Successful Strategies for Increasing Enrollment in California’s Low Income Health Program (LIHP)*.” This report highlights strategies for outreach issues,

enrollment, redetermination and retention activities. It may be accessed at the following address:

<http://healthpolicy.ucla.edu/publications/Documents/PDF/lihppolicynotesep2012.pdf>

Operational/Policy Issues:

The Centers for Medicare & Medicaid Services (CMS) approved the Monterey County LIHP (ViaCare Monterey County) to implement effective March 1, 2013, and also approved the Tulare County LIHP (TulareCare) to implement March 15, 2013. DHCS continued to work with CMS and local LIHPs toward approval of county specific cost claiming protocols for Los Angeles and County Medical Services Program (CMSP), to claim health care service reimbursements.

DHCS continues to monitor Santa Barbara and Stanislaus counties regarding their possible implementation of the program, however due to time constraints an implementation of a local LIHP in these counties is not likely.

DHCS, in conjunction with the California Association of Public Hospitals and Health Systems (CAPH), developed and submitted a concept paper to CMS on February 1, 2013 regarding the administrative activities claiming protocol, or Attachment J, pursuant to Special Terms and Conditions Paragraph 45. DHCS simultaneously began the development of the Attachment J claiming protocol and Attachment J implementation plan. DHCS formed a LIHP Attachment J work group comprised of LIHPs that represented legacy LIHPs (LIHPs implemented before January 1, 2012); LIHPs implemented after January 1, 2012, stakeholders and associated DHCS divisions. DHCS-LIHP and CMS had a conference call, February 13, 2013 to discuss the Attachment J concept paper. On the call, CMS requested DHCS-LIHP submit the Attachment J claiming protocol and the Attachment J implementation plan for their review.

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

- LIHP Eligibility Redetermination
- LIHP Local Appeal Process and State Fair Hearings Process

Currently 13 of 19 operational local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state and county populations determined eligible for Medi-Cal or LIHP by DHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

UCLA began posting LIHP demographic data by county on its website. DHCS continues to collaborate with UCLA in drafting and reviewing reports and publications required as deliverables under the Interagency Agreement (IA) for the LIHP evaluation. DHCS also reviewed the final Health Care Coverage Initiative evaluation report during this quarter.

DHCS and UCLA continue collaboration on developing and testing the LIHP program progress report. The format, instructions, and reporting portal were reviewed and tested by a sample of local LIHPs. When finalized and utilized (DY8 Q4), these quarterly reports will provide data for DHCS to monitor program compliance and effectiveness in program areas such as provider networks and health care services utilization and access. UCLA continues to make progress on the implementation of the LIHP Evaluation Design, as detailed in the attached UCLA quarterly progress report.

DHCS executed amendments to the LIHP contracts for Alameda, Kern, Los Angeles, Riverside, San Mateo, Santa Clara, and San Francisco counties to incorporate the new BAA addendum. The BAA addendum amendment for the San Bernardino County LIHP contract will be executed next quarter.

The amendment to the LIHP contract for these counties to change the financing methodology to capitation rates, and the related draft Attachment G, Supplement 2 for the capitation rate claiming protocol continue to be under review by CMS and DHCS.

DHCS continues to work with the State Office of AIDS (OA) to develop program requirements and policies to transition eligible Ryan White clients to LIHP. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- Eleven proposed DSRIP Plan modifications were submitted to CMS for review in the prior quarter. During January and February, DHCS worked intensively with individual designated public hospitals (DPHs) and the county workgroup to revise and resubmit each proposed plan in accordance with CMS's review comments.
- Beginning in February 2013, DHCS participated in bi-weekly division DSRIP Category 5 meetings to develop the review framework and assignments for DSRIP reports, resolve policy and operational issues regarding the Category 5 review process, and update management on Category 5 status.
- Worked with the county workgroup and other department divisions to identify and coordinate DSRIP reporting and payment process questions, including those prepared for submittal to CMS.
- DHCS received semi-annual reports from all DPHs March 31.

DHCS has established a project team to develop the process and policies for implementing the LIHP transition phase of the Medicaid expansion under ACA. The team is working through many critical issues such as:

- The interaction of LIHP redeterminations and LIHP enrollments with the transition.
- The process for completing Medi-Cal redeterminations for former LIHP enrollees who transitioned to the Medi-Cal program.

- The outreach process for those LIHP enrollees who are eligible for health care coverage products through Covered California.
- The primary care provider linkage process for Medi-Cal plan enrollment.

The project team is also working with a Transition Stakeholder Workgroup to solicit input on various aspects of the transition, such as LIHP enrollee notices, communications and outreach strategies, continuity of care issues, and refinement of the LIHP Transition Plan submitted to CMS last year.

Consumer Issues:

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

- Weekly teleconferences with the local LIHP counties to address important questions relating to the LIHP program and transition activities.
- Quarterly teleconferences with advocacy groups to address questions and concerns regarding the LIHP program.
- Bi-weekly LIHP/OA Stakeholder Advisory Committee and the Healthcare Reform Communications Workgroup to discuss issues related to the transition of individuals diagnosed with HIV and receiving health care services through the Ryan White programs, to health care coverage under LIHP and Medi-Cal.
- Weekly LIHP/Medi-Cal Eligibility Division/Safety Net Financing Division/California Department of Corrections and Rehabilitation (CDCR) CCHCS, for discussion on populations determined eligible for Medi-Cal and LIHP by DHCS.

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

Financial/Budget Neutrality:

Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
(Qtr 3) CDCR	10,800,162	\$0.00	\$21,600,324	DY 7	\$9,187,935
				DY 8	\$1,612,227
(Qtr 3) Health Care	169,132,157	\$0.00	\$338,264,314	DY 7	\$32,874,672
				DY 8	136,257,485
(Qtr 3) Administrative	\$5,923,118	\$0.00	\$11,846,236	DY 6	\$5,777,196
				DY 7	\$145,022
Total	<u>\$185,855,437</u>	<u>\$0.00</u>	<u>\$371,710,874</u>		<u>\$185,855,437</u>

Quality Assurance/Monitoring Activities:

DHCS collaborated with UCLA in developing reporting procedures and correcting data for reports to monitor and measure the effectiveness of the local LIHPs. UCLA developed new reporting tool designed to help resolve minor reporting issues that LIHPs were experiencing in reporting monthly enrollment data. The new tool has the capability to track data submitted and provides the ability to thoroughly review the data prior to submission to reduce data entry errors in reports.

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

Enclosures/Attachments:

UCLA quarterly progress report for DY8 Q3 regarding the implementation of the LIHP Evaluation Design.

FINANCIAL/BUDGET NEUTRALITY

Payment Type	FFP Payment FFP Payment	Other Payment (IGT)	(CPE) (CPE)	Service Period	Total Funds Payment Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	\$ 96,500,000		\$ 96,500,000	DY 8 (July –Sept.)	\$ 193,000,000
(Qtr 2)	\$ 96,500,000		\$ 96,500,000	DY 8 (Oct. – Dec.)	\$ 193,000,000
(Qtr 3)	\$ 96,500,000		\$ 96,500,000	DY 8 (Jan. – Mar)	\$ 193,000,000
Total:	\$ 289,500,000		\$ 289,500,000		\$ 579,000,000
DSRIP					
(Qtr 1)	\$ -	\$ -			\$ -
(Qtr 2)	\$ 188,438,148	\$ 188,438,148		DY 7	\$ 376,786,297
(Qtr 3)	\$ -	\$ -			\$ -
Total:	\$ 188,438,148	\$ 188,438,148			\$ 376,786,297
Designated State Health Program (DSHP)					
Payment Type	FFP Claim FFP Claim		(CPE) (CPE)	Service Period	Total Claim Total Claim
State of California					
(Qtr1)	\$ 23,709,051		\$ 47,418,102	DY 8 (Jul-Sept)	\$ 23,709,051
(Qtr 2)	\$ 92,010,154		\$ 171,911,397	DY 8 (Oct-Dec)	\$ 92,010,154
(Qtr 3)	\$ 194,096,551		\$ 382,481,377	DY 8 (Jan-Mar)	\$ 194,096,551
Total:	\$ 309,815,756		\$ 601,810,876		\$ 309,815,756

I. DESIGNATED STATE HEALTH PROGRAM (DSHP) UPDATE

Program costs for each of the Designated State Health Programs (DSHP) are expenditures made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, Designated State Health Programs claimed \$194,096,551 in federal fund payments for SNCP eligible services.

II. SAFETY NET CARE POOL UNCOMPENSATED CARE UPDATE

Expenditures may be made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received, furnished by the hospitals or other providers identified by the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

This quarter, designated public hospitals received \$96,500,000 in federal fund payments for SNCP eligible services.

California Children Services (CCS) Member Months and Expenditures

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

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

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