CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **California Bridge to Reform Demonstration**

AWARDEE: **California Health and Human Services Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The periods for each Demonstration Year (DY) will consist of 12 months with the exception of DY 6, which will be eight months, and DY 10 which will be 16 months. The periods are:

- DY 6 November 1, 2010 through June 30, 2011
- DY 7 July 1, 2011 through June 30, 2012
- DY 8 July 1, 2012 through June 30, 2013
- DY 9 July 1, 2013 through June 30, 2014
- DY 10 July 1, 2014 through October 31, 2015

The STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date identified in the CMS Demonstration approval letter through October 31, 2015 except for the Low Income Health Program (the Medicaid Coverage Expansion and the Health Care Coverage Initiative) that will be effective through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Historical Context
III. General Program Requirements
IV. General Reporting Requirements
V. General Financial Requirements
   A. Payments for Medicaid-Eligible Patients
   B. Safety Net Care Pool
   C. Funding Limitations on the LIHP - Health Care Coverage Initiative (HCCI)

VI. State Plan and Demonstration Populations Affected by the Demonstration;
VII. Demonstration Delivery Systems
VIII. Operation of Demonstration Programs
    A. Low Income Health Program (LIHP)
    B. Managed Care Delivery Systems for Seniors and Persons with Disabilities (SPD)
    C. Community Based Adult Services and Enhanced Case Management
    D. California Children Services
    E. Healthy Families Program Children Transitioning to Medicaid Expansion Demonstration
    F. 2013 Managed Care Expansion
IX. Other Administrative Requirements
X. General Financial Requirements Under Title XIX
XI. Monitoring Budget Neutrality for the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A.	Critical Path for SPD Enrollment form (reserved)
Attachment B.	SPD Discharge Planning Checklist form (reserved)
Attachment C.	Government Hospitals to be Reimbursed on a Certified Public Expenditure (CPE) Basis
Attachment D.	Additional Cost Elements for Government-Operated Hospitals Using CPE Methodology
Attachment E.	Inpatient Hospital Component
Attachment F.	Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming
Attachment G.	Low Income Health Program
Attachment H.	Accounting Procedures
Attachment I.	Quarterly Report Guidelines
Attachment J.	Administrative Cost Claiming Protocol
Attachment K.	Reserved Budget Neutrality Projections and Allotment Neutrality Requirements
Attachment L.	Managed Care Enrollment Requirements
Attachment M.	Geographic Distribution and Delivery System Model
Attachment N.	Capitated Benefits Provided in Managed Care
Attachment O.	County Listing for SPD Enrollment
Attachment P.	Delivery System Reform Incentive Payments (DSRIP) Program Funding and Mechanics Protocol
Attachment Q.	Delivery System Reform Incentive Payments (DSRIP) Metrics
Attachment R.	(Reserved)
Attachment S.	Healthy Families Transition to MediCal
Attachment T.	2013 Managed Care Expansion Monitoring Elements
Attachment U.	Coordinated Care Initiative (CCI) Enrollment Timeline by Population and County
Attachment V.	Coordinated Care Initiative (CCI) Monitoring Elements

Attachment W.	Community-Based Adult Services (CBAS) Provider Standards of Participation
Attachment X	Drug Medi-Cal Organized Delivery System (DMC-ODS) Operational Protocol
Attachment Y	DMC-ODS Department of Health Care Services (DHCS) Appeals Process
Attachment Z	DMC-ODS County Implementation Plan
Attachment AA	DMC-ODS County Certified Public Expenditures (CPE) Protocol (Reserved)
Attachment BB	DMC-ODS Tribal Delivery System
Attachment CC	DMC-ODS Financing and Availability of Medication Assisted Treatment (MAT) Services
Attachment DD	DMC-ODS University of California, Los Angeles (UCLA) Evaluation

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

With the approval of the State's section 1115(a) Demonstration in September 2005, the State was provided the authority to receive federal matching funding for a Safety Net Care Pool (SNCP) through which the State made total computable payments of up to $1.532 billion per year for 5 years (total of $7,660,000,000) for medical care expenditures for the uninsured and for the expansion of health care coverage to the uninsured. Of this annual $1.532 billion total computable expenditure, $360 million (total computable) per year was defined as "restricted use SNCP funds," and federal matching was conditioned on the State meeting specified milestones. In Demonstration Years 1 and 2 the restricted use funds were tied to goals associated with the expansion of managed care to the Aged, Blind, and Disabled population in the State. The State failed to meet these milestones. In Demonstration Years 3, 4, and 5 the restricted use funds were tied to goals for expansion of health care coverage to uninsured individuals.

In October 2007, the State (for Demonstration Years 3, 4 and 5) amended the Demonstration to meet the milestones for coverage expansion through the development and implementation of a Health Care Coverage Initiative (HCCI) that expanded coverage options for uninsured individuals in the State. The State designed the HCCI to utilize existing relationships between the uninsured and safety net health care systems, hospitals, and clinics and has been constructed to:

- Expand the number of Californians who have health care coverage;
- Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics;
- Improve access to high quality health care and health outcomes for individuals; and.
- Create efficiencies in the delivery of health care services that could lead to savings in health care costs.

During SFY 2009, California reported that it began to experience significant fiscal difficulties that impacted the Medi-Cal program, and the safety net health care system in the State. In July, 2009 the State requested amendments to the STCs in order to: 1) reflect the American Reinvestment and Recovery Act (ARRA) FMAP rates for Safety Net Care Pool (SNCP) expenditures; 2) expand the Health Care Coverage Initiative (HCCI), and 3) include in the

Demonstration certain previously State-only funded health care programs. This amendment was approved by CMS effective February 1, 2010.

The July 2009 amendment request also included a proposal for CMS to recognize a new set of milestones in Demonstration Year (DY) 5. These milestone programs included: disease management pilot programs; and care coordination programs. In exchange for the State achieving various enrollment goals in the stated milestone programs, California proposed that CMS include in the Demonstration an array of Designated State Health Programs (representing $720 million total computable expenditures in Demonstration Year 5).

On June 3, 2010, the State submitted a section 1115 Demonstration proposal as a bridge toward full health care reform implementation in 2014. The States proposal seeks to: phase in coverage in individual counties for adults aged 19-64 with incomes at or below 133 percent of the federal poverty level (FPL), who are eligible under the new Affordable Care Act State option and adults between 133 percent - 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, that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care; 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.

On January 10, 2012, the State submitted an amendment to the Demonstration which was approved on March 31, 2012, to provide an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Medi-Cal beneficiaries enrolled in a managed care organization. The demonstration amendment will research and test whether individuals enrolled in CBAS who have an organic, acquired, or traumatic brain injury and/or chronic mental illness, maintain or improve the status of their health. Some beneficiaries who previously received adult day health care (ADHC) services (which will no longer be offered as an optional benefit under the State Plan) and, because a difference in the level of care criteria, will not qualify for CBAS services will instead receive a more limited "Enhanced Case Management" (ECM) benefit. ECM is a service that provides person centered planning including coordination of medical, social, and education supports.

Effective with the June 28, 2012 approval, the State and CMS revised the demonstration to include the following amendments:

- *A Reallocation of Funds to Safety Net Uncompensated Care Pool* - On July 22, 2011 the State submitted an amendment to the Demonstration to increase authorized funding for the Safety Net Care Uncompensated Care Pool for Demonstration Year in DY 7 by the amount of authorized but unspent funding for the Health Care Coverage Initiative (HCCI) and Designated State Health Programs (DSHP) in DY 6.
- *A Reallocation of Funds to Safety Net Uncompensated Care Pool* - On May 2, 2012 the State submitted an amendment to the Demonstration to reallocate authorized funding for

the Health Care Coverage Initiative (HCCI) to the Safety Net Care Uncompensated Care Pool for Demonstration Year (DY) 7;

- *HIV Transition Program in the Delivery System Reform Incentive Pool (DSRIP)* – On September 12, 2011, the State submitted a concept paper and on June 22, 2012, the State submitted a formal amendment to establish an HIV Transition Incentive Program within the Delivery System Reform Incentive Pool (DSRIP) under the Demonstration to establish "Category 5" HIV Transition projects to develop programs of activity that support efforts to provide continuity of quality care, care coordination, and coverage transition for LIHP enrollees with HIV; and
- Revisions to the budget neutrality agreement to correct errors in Demonstration expenditures.

In addition, on October 30, 2012, the state submitted an amendment request approved on December 31, 2012 to transition the Healthy Families Program beneficiaries to the Medi-Cal program beginning on January 1, 2013. Children enrolled in the HFP will be transitioned into the 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.

On March 1, 2013, the state submitted a request to amend the demonstration to provide that the Department of Health Care Services (DHCS) shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to recognize the burden of uncompensated care costs and support the overall IHS and tribal health care delivery system. Payments will be based on the costs of qualifying uncompensated encounters, using the published Indian Health Service (IHS) encounter rate to determine cost. Qualifying uncompensated encounters will be 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 California County Low Income Health Program (LIHP) and uncompensated costs of furnishing services that had been covered under Medi-Cal as of January 1, 2009 to such uninsured individuals and to Medi-Cal beneficiaries. The purpose of the demonstration would be to determine if these supplemental payments maintain or increase the availability of primary care services for Medicaid beneficiaries in 2014.

On April 29, 2013, the State submitted an amendment to the Demonstration to increase authorized funding for the Safety Net Care Uncompensated Care Pool for DY 8 and DY 9 by the amount of authorized but unspent funding for the Health Care Coverage Initiative (HCCI) in DY 8 and DY 9 respectively. If the available SNCP Uncompensated Care expenditures in DY 8 or DY9 are not sufficient to fully claim the reallocated funds, those funds will be made available for claiming in later demonstration years notwithstanding the total computable annual limits specified in STC 39.

On May 3, 2013, the state submitted a request to amend the demonstration pursuant to Assembly Bill 1467 (Chapter 23, Statutes 2012). The 2012-13 State budget authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 California counties (hereafter referred to as the "2013 managed care expansion"). No earlier than September 1, 2013, approximately 102,000 Medi-Cal beneficiaries will transition from FFS to the COHS model of Medi-Cal managed care in 8 counties, and no earlier than November 1, 2013, approximately

176,000 Medi-Cal beneficiaries will transition from FFS to a non-COHS model of Medi-Cal managed care in the remaining 20 counties (subject to CMS approval of the applicable managed care contracts and the state's compliance with these special terms and conditions). Seniors and persons with disabilities in non-COHS counties will not be required to enroll in managed care, but they will have the option to enroll in managed care on an "opt-in" basis.

On June 18, 2013, California submitted an amendment to implement the Coordinated Care Initiative (CCI). As part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) was adopted to better coordinate Medicare and Medicaid benefits for dual eligibles, mandatorily enroll dual eligibles into managed care plans and to include long term services and supports (LTSS) as managed care benefits. The primary goals and objectives of the CCI are to improve health outcomes and beneficiary satisfaction for Medi-Cal recipients, while achieving savings from rebalancing 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 and is effective no sooner than April 1, 2014 (date dependent on the signing of the Cal MediConnect 3-way contracts and Medicaid managed care contracts).

The three major components of the CCI are:

- ***Cal MediConnect:*** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries that will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan.

  The framework for the Cal MediConnect program was approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in a Financial Alignment Demonstration Memorandum of Understanding (MOU) between CMS and the California Department of Health Care Services (DHCS) signed on March 27, 2013.
- ***Mandatory Enrollment of Dual Eligibles into Medi-Cal Managed Care*:** All dual eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care organization to receive their Medi-Cal benefits. This includes beneficiaries who opt out or are excluded from enrollment in a Cal MediConnect plan.
- ***Inclusion of Long Term Services and Supports (LTSS):*** Beneficiaries enrolled in a Medi-Cal managed care organization, subject to certain exemptions, will receive their long-term services and supports (LTSS) through the plans.

  Long-term services and supports include the following home- and community-based services: In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) as defined in VIII Operation of Demonstration Programs C. Community-Based Adult Services STCs 95-101 Multipurpose Senior Services Program (MSSP), and nursing facility care services.

On October 30, 2013, California submitted an amendment to add the new adult group to the demonstration's delivery system and to carve in additional behavioral health benefits into managed care.

On November 7, 2013, the state submitted an amendment to extend uncompensated care payments for tribal providers for certain optional services until December 31, 2014.

On June 13, 2014, California submitted an amendment to assure continuation of the services being received by approximately 28,000 current CBAS recipients. Enhanced Case Management (ECM) services would be eliminated as of the sunset date of August 31, 2014. The eligibility and definition of ECM is described in the March 19, 2014 version (CCI amendment approval) of the STCs in paragraph 96.

On August 4, 2014, California submitted an amendment to mandatorily enroll Seniors and Persons with Disabilities (SPD) into managed care plans in 19 rural counties, effective December 1, 2014.

On November 24, 2014, the state submitted an amendment to extend uncompensated care payments for tribal providers for certain optional benefits from January 1, 2015 through October 31, 2015.

On September 3, 2014, the State submitted an amendment to the Demonstration which was approved on August 1, 2015, that allows the state to provide full-scope Medi-Cal benefits to low-income pregnant women with incomes above 109 through 138 percent FPL. To the extent permitted by state and federal law, these beneficiaries will be required to enroll in a Medi-Cal managed care health plan in those counties in which a plan is available. Those beneficiaries residing in a county where a Medi-Cal managed care health plan is not available shall be provided services under the Medi-Cal fee-for-service delivery system (FFS).

On November 21, 2014, California submitted an amendment to the Demonstration to create the Drug Medi-Cal Organized Delivery System (DMC-ODS). This amendment authorizes the state to test a pilot program for the organized delivery of health care services for Medicaid eligible individuals with a substance use disorder. The DMC-ODS will be offered as a Medi-Cal benefit and delivery system in counties that choose to opt into and implement the pilot.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that

occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement[s] will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation actually becomes effective, on the first day of the calendar quarter beginning after the legislature has met for six months in regular session after the effective date of the change in federal law, or such other date provided for in the applicable federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, reimbursement methodologies, cost sharing, evaluation design, federal financial participation (FFP), sources of non-federal share funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. The state will not implement changes to these elements without prior approval by CMS. Amendments relating to these elements to the demonstration are not retroactive except as otherwise specified in these STCs and FFP will not be available for changes to the demonstration relating to these elements that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment;

   b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis will include

current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

b. Compliance with Transparency Requirements 42 CFR Section 431.412. Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 14 as well as include the following supporting documentation:

i. *Historical Narrative Summary of the demonstration Project*. The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. *Special Terms and Conditions (STCs).* The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. *Waiver and Expenditure Authorities.* The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. *Quality*. The state must provide summaries of External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state

quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.

v. *Financial Data.* The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical, and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. *Evaluation Report.* The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. *Documentation of Public Notice 42 CFR section 431.408.* The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. Demonstration Phase-Out. The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b. The state must obtain CMS's approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

c. Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures. The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, state Health Official Letter #10-008.

e. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the Demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. **Findings of Non-Compliance or Disallowance.** The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 Demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

    In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal or renewal of this demonstration (42 C.F.R. §431.408(b)(3)).

    The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Post Award Forum:** Within six months of the demonstration's implementation and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medicaid Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of the STC. The state must include a summary in the quarterly report, as specified in STC 23, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required by STC 25.

16. **FFP.** No Federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

17. **Federal Financial Participation (FFP) for Medicaid and Safety Net Care Pool Payments.** Payments for Medicaid, and Safety Net Care Pool (SNCP) payments funded by certified public expenditures (CPEs) are limited to the costs incurred by the certifying entity. No FFP is available for claims of government-operated hospitals designated in Attachment C

in excess of costs as defined in paragraph 37 entitled Certified Public Expenditures or recognized under paragraph 38 entitled Payments to Hospitals. To the extent that the county delivery systems providing services to Medicaid Coverage Expansion and Health Care Coverage Initiative populations utilize CPEs, the payment must be based on cost and in accordance with a CMS approved protocol. This restriction does not preclude Delivery System Reform Incentive Pool (DSRIP) Payments funded through intergovernmental transfers (IGTs) or capitated payments received by county health systems or public hospitals funded through IGTs or general fund payments. Additionally, cost limitations do not apply to risk-based payments for services under the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI) programs, or to payments received by government operated hospitals from Medi-Cal managed care organizations, consistent with Federal law as these payments cannot be funded by CPEs. All DSH costs must be calculated according to the protocols under 42 CFR 447 and 455, however this cost limitation does not preclude IGT funded DSH payments applicable under section 4721(e) of the Balanced Budget Act of 1997.

IV. GENERAL REPORTING REQUIREMENTS

18. General Financial Requirements. The State will comply with all general financial requirements under title XIX and XXI set forth in these STCs.

19. Reporting Requirements Relating to Budget Neutrality and Title XXI Allotment Neutrality. The State will comply with all reporting requirements for monitoring budget neutrality and title XXI allotment neutrality set forth in these STCs. The State must submit corrected budget and/or allotment neutrality data upon request.

20. Accounting Procedure. The State has submitted and CMS has approved accounting procedures for the Medi-Cal Hospital/Uninsured Demonstration to ensure oversight and monitoring of Demonstration claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after Demonstration approval to account for changes and expansions to the waiver as described within these STCs for the California Bridge to Reform Demonstration.

21. Contractor Reviews. The state will forward to CMS summaries of the financial and operational reviews that the state completes on applicants awarded contracts through the demonstration's Low Income Health Program (LIHP) consisting of the MCE and HCCI programs, the Seniors and Persons with Disabilities Program (SPD), the California Children's Services Program (CCS), Healthy Families Program Children Transition to the Medicaid Expansion Demonstration and Managed Care Health Plans operating in the State.

22. Monthly Calls. CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to:

a. The health care delivery system, including the 2013 managed care expansion;
b. The Medicaid Coverage Expansion (MCE) program;
c. The Health Care Coverage Initiative (HCCI) program;
d. The Seniors and Persons with Disabilities (SPD) Program;

e. The Community Based Adult Services (CBAS) Program, including Enhanced Case Management (ECM) Services;
f. California Children's Services (CCS) Program;
g. Healthy Families Children Transition to the Demonstration;
h. Designated State Health Programs (DSHP) receiving federal financial participation. – as defined within these STCs;
i. Enrollment , quality of care, access to care;
j. The benefit package, cost-sharing;
k. Audits, lawsuits;
l. Financial reporting and budget neutrality issues;
m. Progress on evaluations;
n. State legislative developments; and,
o. Any Demonstration amendments, concept papers or State plan amendments the State is considering submitting.

CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

23. Demonstration Quarterly Reports. The state will submit progress reports 60 days following the end of each quarter (Attachment I). The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports will include, but are not limited to:

a. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
b. Action plans for addressing any policy, operational and administrative issues identified.
c. Monthly enrollment data during the quarter and Demonstration Year to Date by:
    i. County of participation, the number of persons in the MCE Program who are applicants, new recipients and existing recipients by FPL;
    ii. County of participation, the number of persons in the HCCI program who are applicants, new recipients and existing recipients by FPL;
    iii. County of participation, the number of persons enrolled in the SPD program;
    iv. County of participation, the number of persons enrolled in the CCS Program based on Medi-Cal eligibility and DSHP;
    v. County of participation, the number of persons enrolled in the CBAS program, and persons receiving ECM through the sunset date of ECM services;
    vi. County of participation, the number of persons enrolled in the 2013 managed care expansion; and
    vii. County of participation, the number of persons participating in any Demonstration programs receiving FFP.
d. Budget and CHIP Allotment neutrality monitoring tables.
e. SPD Advisory Committee Minutes
f. Other items as requested:
    i. Quarterly reports of any Designated State Health Program (DSHP) obtaining Federal

Matching funds through this Demonstration.

ii. By County of participation Demonstration population complaints, grievances and appeals

24. SPD Specific Progress Reports. During the first year of implementation of the mandatory enrollment of SPDs, the State will submit regular progress updates to CMS. After the first year of the waiver, the State will submit quarterly progress reports that are due 60 days after the end of each quarter as described in paragraph 23 entitled "Quarterly Reports." The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. CMS reserves the right to request the annual report in draft. The quarterly and annual reports will address, at a minimum:

a. A discussion of the State's progress in completing enrollments in accordance with approved enrollment strategy in paragraph **Error! Reference source not found.** and ompleting steps outlined in the Quality Assurance and Quality Improvement Plan as described in paragraph **Error! Reference source not found.**;
b. An aggregation and analysis of encounter data for SPD population;
c. A discussion of trends or issues identified through the review of such analysis;
d. A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
e. Aggregated information on all measures utilized to assess the plan performance and outcomes for seniors and persons with disabilities;
f. Notable accomplishments and areas for improvement, including findings from Quality Assurance and Quality Improvement Plan, participant survey and evaluation activities, and review of plan grievance process results and State Fair hearing information;
g. Reports on ongoing data collection and analysis of required measurement elements, including HEDIS and other measurement; and
h. Problems/issues that were identified, steps taken to correct them, how they were solved, and if any progress has occurred in the resolution of the issue.

25. Demonstration Annual Report. The state will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. The state will submit the draft annual report no later than 120 days after the end of each demonstration year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the demonstration year to CMS. The annual report will also contain:

a. The previous State fiscal year appropriation detail for those state programs referenced in paragraph 39.b.ii, which are permissible expenditures under the Safety Net Care Pool.
b. The progress and outcome of program activities related to the:
    a. MCE;
    b. HCCI;
    c. SPD program;
    d. CBAS program;
    e. CCS Program;
    f. Healthy Families Children Transitioning to the Demonstration; and
    g. The 2013 managed care expansion;

c. The progress and outcome of activities related to any DSHP obtaining federal matching funds through this demonstration.

26. Transition Plan and Implementation Milestones. This demonstration will not be extended by CMS beyond December 31, 2013 for the LIHP Demonstration populations. The State is required to prepare, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in these Demonstration populations, including details on how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The State must meet the following transition and demonstration implementation milestones.

a. Affordable Care Act Transition Plan. By July 1, 2012, the State must submit to CMS for review and approval an initial transition plan, consistent with the provisions of the Affordable Care Act for all individuals enrolled in the Demonstration, The plan must outline how the State will begin transition activities beginning July 1, 2013, including:
   i. The State shall determine eligibility for coverage for these individuals beginning January 1, 2014 under all eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL. To ensure that eligibility for medical assistance is not disrupted for any individual covered who will be eligible under any such eligibility group as of January 1,2014, prior to December 31, 2013, the State shall obtain any additional information needed from each individual to determine eligibility under such eligibility groups beginning January 1,2014 and shall make and provide notice to the individual of such determination on or before December 31 ,2013. In transitioning these individuals from coverage under the waiver to coverage under the State Plan, the State will not require these individuals to submit a new application.
   ii. A plan to manage the transition to new Medicaid eligibility levels in 2014 by considering, reviewing, and preliminarily determining new applications for Medicaid eligibility beginning as early as July 1, 2013.
   iii. Criteria for provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
   iv. The schedule of implementation activities for the State to operationalize the transition plan.
   v. The process the State will use to assure adequate primary care and specialty provider supply for eligible recipients under the State Plan and Demonstration Populations affected by the Demonstration on December 31, 2013.

b. Access Report and Plan. The State will by January 1, 2013, submit to CMS an assessment of access to care for the populations currently enrolled in Medicaid through the state plan or under this Demonstration. This assessment will measure access to primary care services and specialty care, including access by major type of specialty provider. This assessment will also identify variations in access in the various counties participating in the Demonstration including differences in access to care that exist between urban and rural areas. The assessment shall include the State's

projections for adequacy of access to care for persons who will be eligible on January 1, 2014 through Medicaid or Exchange coverage, along with an evaluation of factors that will affect such access, including but not limited to workforce development and network adequacy. The state will identify policy approaches that it intends to pursue to ensure access to care for these groups as well as for the pre-2014 Medicaid population.

c. Behavioral Health Services Assessment. By March 1, 2012, the State will submit to CMS for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

d. Behavioral Health Services Plan. By October 1, 2012, the State will submit to CMS for approval a detailed plan, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs outlining the steps and infrastructure necessary to meet requirements of a benchmark plan no later than 2014.

e. Implementation. By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees from the Demonstration to Medicaid or the Exchange in 2014 without need for additional determinations of enrollees' eligibility.

f. Delivery System Reform Incentive Payment (DSRIP) Program Evaluation Plan. By no later than October 1, 2013, the state will submit a complete evaluation plan for the DSRIP components of the demonstration to CMS for approval, in accordance with the requirements of STC 28.

g. Interim Evaluation Findings. By no later than October 1, 2014, the state will submit interim evaluation findings for the DSRIP components of the demonstration, in accordance with the requirements of STC 29 and 42 C.F.R. 431.424.

h. Penalty. Failure to implement or operationalize the milestones listed in this paragraph will result in the loss of a percentage of the expenditure cap applicable to Safety Net Care Pool (SNCP) expenditures cap (not including HCCI expenditures) under the expenditure authorities. If the State fails to meet a milestone, the annual expenditure authority cap will be reduced by the amount(s) listed in the table below for SNCP expenditures other than those reserved for the HCCI.

Demonstration Year (DY) Deadline	**Milestone Reference**	**Penalty Amount as a percentage of The Annual Safety Net Care Pool Expenditure (Total Computable)**
DY 8 – July 1, 2012	25.a	0.5%
DY 8 – January 1, 2013	25.b	1.0%
DY 7 – Mar. 1, 2012	25. c.	2.0%
DY 8 – Oct. 1, 2012	25. d	2.0%
DY 9 – July 1, 2013	25. e.	5.0%
DY 9 – Oct. 1, 2013	25.f.	1.0%

DY 10 – Oct. 1, 2014	25.g.	2.0%

i. Application of the Penalty. The State's annual expenditures under the SNCP will be reduced in the proceeding DY to the extent described above. Thirty days after the close of the DY, the State's annual expenditures under the SNCP for that year will be determined. The reduction in expenditure authority shall be applied to sequential DYs, if the State has not met the required milestones. Once a milestone has been met, no further penalties associated with that milestone completion will be imposed. Penalties resulting from failure to implement or operationalize the milestones associated with paragraphs 25.f and 25.g. as referenced in the chart above, shall be reduced from DSHP expenditures only, and shall not be reduced from the DSRIP or any other SNCP expenditures.

27. Final Report. Within 120 days following the end of the Demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

a. Population related Reporting - Within the final Demonstration and evaluation report the State will include:
   i. An assessment using pre-mandatory enrollment as a baseline of the impact on mandatory managed care on the SPD population, including all notable findings;
   ii. An assessment using pre-mandatory enrollment as a baseline of the impact on mandatory managed care on the 2013 managed care expansion, including all notable findings;
   iii. Baseline assessment of populations enrolled who have family incomes at or below 133 percent FPL, and above 133 percent through 200 percent FPL.

28. Evaluation Design. Within 120 days of the effective date of these STCs, the state must submit to CMS for approval a draft evaluation design for the demonstration.

a. At a minimum, the draft design will discuss the outcome measures, which will be used in evaluating the impact of each demonstration related program during the period of approval, particularly among the target populations. The design will also include the specific hypotheses being tested including an evaluation of the effectiveness of using SNCP funding for demonstration related programs. Further, it will discuss the data sources and sampling methodology for assessing these outcomes, including the per capita cost of each demonstration program. Finally, the draft evaluation design will include a detailed analysis plan that describes how the effects of all demonstration programs will be isolated from other initiatives occurring in the state.
b. State shall include an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report. The state will submit its plan for CMS review and approval for this aspect of the evaluation.
c. CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State will submit a final evaluation design within 60 days of receipt of CMS' comments.

29. Implementation of Evaluation Design.

a. The state will implement the evaluation design and submit its progress in each of the quarterly and annual progress reports, including updates on revisions to the evaluation design due to subsequent amendments to the demonstration.
b. CMS shall provide comments within 60 days after receipt of the report. The state will submit the final evaluation report within 60 days after receipt of CMS comments.
c. California must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in STC 39.b.iii and submit interim evaluation findings by January 31, 2015.
    i. The evaluation must test the following specific hypotheses related to the uncompensated care payments:
        1. What is the effect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?
        2. Are the affected facilities able to maintain and/or increase their current staffing levels?
    ii. Methods by which the state can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

30. Revision of the State Quality Strategy. In accordance with federal regulations at Subpart D 438.200 regarding Quality Assessment and Performance Improvement to ensure the delivery of quality health care and establishment of standards, the State must update its Quality Strategy to reflect all managed care plans being proposed through this demonstration and submit to CMS for approval. The state must obtain the input of recipients and other stakeholders in the development of its revised Quality Strategy and make the Strategy available for public comment before adopting it as final, and submitting to CMS for approval. The state must revise the strategy whenever significant changes are made, including changes through this demonstration. The state will also provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy as it impacts the demonstration. This paragraph does not apply to low income health plans as referenced in Section 3, #1 (Expenditure Authority).

31. External Quality Review. The state is required to meet all external quality review (EQR) requirements found in 42 C.F.R. Part 438, subpart E. The state should generally have available its final EQR technical report to CMS and the public by April of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

32. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

V. GENERAL FINANCIAL REQUIREMENTS

A. Payments for Medicaid-Eligible Patients

33. Selective Provider Contracting Program (SPCP). The State will continue the SPCP for payment of certain private hospitals (as described in Attachment E) and non-designated government-operated hospitals as part of the 1115 Demonstration, subject to Attachment H and other applicable STCs. The SPCP component of the Demonstration is now referred to as the "Inpatient Hospital" component. The State may discontinue this program in whole or in part at any time through the submission of a State plan amendment to Attachment 4.19-a.

34. Payments to Contracted Hospitals. With the exception of payments for emergency hospital services, base payments to hospitals that contract with the State under the Inpatient Hospital component will be limited to rates determined through negotiations with California Medical Assistance Commission (CMAC) and shall follow the following principles:

a. The negotiated reimbursement rates to hospitals shall be on a per diem or other basis, and may include supplemental payments, but in no case shall such reimbursement exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations. Should CMS promulgate new regulations governing hospital reimbursement, the reimbursement rates must reflect such new regulations as of the effective date of the new regulations.

b. The non-Federal share of payments to private hospitals may be funded by IGTs from units of local government, at their option, to the State. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any unit of government.

c. The State will inform CMS of the funding of all Medicaid payments to these hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.

35. Payments to Non-Designated Government-Operated Hospitals. With the exception of emergency hospital services, base payments for inpatient services to non-designated government-operated hospitals (government-operated hospitals not identified in Attachment C) will be limited to the Inpatient Hospital component payments. Payments to such hospitals are determined through negotiations with CMAC.

a. The negotiated reimbursement rates to non-designated government-operated hospitals shall be on a per diem or other basis, and may include supplemental payments, but in no case shall aggregate payments to government-operated hospitals exceed the upper payment limit for such hospitals established under CMS regulations. Should CMS promulgate new regulations governing hospital reimbursement, the reimbursement rates must reflect such new regulations as of the effective date of the new regulations.

b. The State will inform CMS of the funding of all Medicaid payments to these non-designated government-operated hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.

36. **Reimbursement to Designated Government-Operated Hospitals.** Reimbursement to those hospitals identified in Attachment C will be based on allowable Medicaid inpatient hospital costs as identified on Medi-Cal 2552-96 cost reports. The methodology for computing such costs and the required procedures for claiming Federal matching funds is detailed in the Funding and Reimbursement Protocol included as Attachment F.

37. **Certified Public Expenditures (CPEs).** Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH or SNCP reimbursement, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include, DSRIP Payments, patient care revenue received as payment for other services rendered under programs such as DSHP, LIHP, Medicare or Medicaid. To ensure that there is no double claiming of federal funding under the DSHP and LIHP, a detailed protocol will be developed outlining the procedures to be followed for claiming under this paragraph.

38. **Payments to Hospitals.** Under this Demonstration, payments to hospitals may include supplemental Medicaid inpatient and outpatient payments to hospitals identified in Attachment C that meet the eligibility requirements for participation in the Construction/Renovation Reimbursement Program, pursuant to California Welfare and Institutions Code section 14085.5 and 14085.57. To the extent that the State continues to make these payments, such payments may be funded by the State general fund, by CPEs and

shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for Disproportionate Share Hospital (DSH) payments. These supplemental payments are in addition to the Medicaid rates described in Attachment F for inpatient Medicaid services, and the non-Federal share must be funded by State or local general funds.

B. **Safety Net Care Pool (SNCP)**

39. Safety Net Care Pool Expenditure. California may claim FFP for expenditures in the defined categories of spending (subparagraphs a, b, and c) subject to the spending limits defined in this paragraph (subparagraphs a, b.iii, and c.v.) for each category and subject to the limitations in Section XI of these STCs entitles "Monitoring Budget Neutrality in the Demonstration."

a. HCCI. California may spend up to $360 million total computable per year in DY 6-8 and $180 million total computable in DY 9 on expenditures associated with defined services and populations under the Health Care Coverage Initiative, which is part of the LIHP, as described in paragraphs 52.a.ii.
   i. Claims for expenditures in the counties participating in the HCCI program as of November 1, 2010 are subject to the funding and claiming protocols described in Attachment G, the coverage limits in paragraphs 67.b, 67.c, and 67.d, except during the transition period (described in 39.a.v.) the HCCI counties may provide health care services in accordance with paragraph 56 of the "Medi-Cal Hospital/Uninsured Care Demonstration," until implementation of the new LIHP, and the eligibility limits in paragraph 52.a.ii.
   ii. Additional counties seeking to participate in the HCCI program must submit funding and claiming protocols to the State. The State must then submit the protocols to CMS and may not claim FFP prior to CMS' approval of the funding and claiming protocols.
   iii. Spending in the HCCI is subject to the limitations described in paragraph 51 describing the HCCI Allocations.
   iv. To the extent counties are unable to utilize the full $360 million per year in DY 6-8 and $180 million in DY 9 on expenditures associated with defined services and populations under the HCCI for a Demonstration year, CA may request that such funds may be available for use in one of the other three categories of SNCP spending described in 39(b)(i), 39(b)(ii) and 39(c). The State must use the process described in paragraph 7. Such redirected SNCP funds may be available for allowable expenditures incurred during the Demonstration year for which the funds were initially reserved, or may be rolled over to subsequent Demonstration years for unrestricted use SNCP expenditures subject to CMS approval.
   v. *Transition Period.* From the period of the effective date identified in the Demonstration approval letter through October 1, 2011 counties currently participating in the HCCI through the prior period "Medi-Cal Hospital/Uninsured Care Demonstration" and in accordance with paragraph 52may claim FFP for qualifying expenditures for enrollees with family incomes from 0-200 percent FPL as the counties implement the new MCE coverage requirements consistent with Attachments G and J of the STCs for the prior

Demonstration until September 30, 2011. Effective October 1, 2011 Attachments F, G and J of the STCs will need to be revised for the continuation of claiming to reflect Demonstration activity after the Transition period.

By January 1, 2011, the State will submit to CMS a plan identifying:

A. Which counties intend to offer MCE;
B. The upper income levels and benefit packages that the county will cover for both MCE and HCCI coverage during DY 6;
C. The counties' plans for implementing the new MCE coverage requirements, including the counties' plans to meet any requirements not enumerated in the Demonstration waiver and expenditure authorities so that MCE requirements are fully achieved by July 1, 2011.

By July 1, 2011, the State will demonstrate to CMS that counties meet the new MCE coverage requirements and that the expenditures related to this coverage can be claimed as FFP under the MCE EG (hypothetical). For those counties meeting this timeframe, FFP claimed from the effective date identified in the Demonstration approval letter will be treated as MCE expenditures for enrollees with family incomes from 0 to 133 percent FPL. For enrollees with family incomes above 133 up to 200 percent FPL, FFP claimed from November 1, 2010 will be subject to the SNCP limits.

For counties that do not elect to participate in the MCE category, FFP will be claimed against the HCCI in the SNCP, subject to the SNCP limits, for all member months or costs from the effective date identified in the Demonstration approval letter.

For DY 7-10, the State must inform CMS of any county that intends to participate in the MCE program 90 days prior to the county enrolling people in that program under the Medicaid Coverage Expansion and must demonstrate that the county meets the new MCE coverage requirements 45 days prior to the county beginning enrollment in the program. All FFP will be treated as MCE for enrollees qualifying for the MCE category from the period that enrollment begins in the MCE.

b. SNCP Uncompensated Care. Expenditures may be made through the SNCP for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received furnished by hospitals or other providers identified by the State. To the extent that uncompensated care expenditures are made for services furnished by entities other the designated public hospitals, the state must identify the provider and the source of the non-federal share of the SNCP Uncompensated Care payment.

i. *Safety Net Care Uncompensated Care Pool.* funds may be used for expenditures for care and services that meet the definition of 'medical assistance' contained in

section 1905(a) of the Act that are incurred by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

ii. *SNCP Designated State Health Programs (DSHP).* The State may claim FFP for the following State programs subject to the annual limits described below and the restrictions described in paragraph 44 "Prohibited Uses of SNCP funds. Expenditures are claimed in accordance with CMS-approved claiming protocols. The State should modify Attachment F to account for any DSHP expenditure claiming in DYs 6 through 10. No FFP is allowed until the year 6-10 DSHP claiming protocol is approved by CMS.

iii. *Supplemental Payments to IHS and 638 Facilities.* The state shall make supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care and support the IHS and tribal 638 service delivery network. Supplemental payments shall be computed based on the uncompensated cost of primary care services furnished by such facilities to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP) and uncompensated costs for services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to such uninsured individuals and individuals enrolled in the Medi-cal program.
Participating tribal facilities shall maintain policies for furnishing services to non-IHS beneficiaries that are in place as of January 1, 2013.Payments shall be based on the approved methodology set forth in Attachment F – Supplement 7.

Supplemental payments for uninsured individuals will end effective December 31, 2013. Supplemental payments will be made to IHS and 638 facilities for uncompensated care payments for services eliminated from the state plan, using the IHS encounter rate through December 31, 2014. Beginning January 1, 2014, the supplemental payments will only be available for services proved to beneficiaries enrolled in the Medi-Cal program.

iv. *SNCP Uncompensated Care Annual Limits.* Taken together, the total computable annual limits for Safety Net Care Uncompensated Care Pool and Designated State Health Programs cannot exceed the following:

1. DY 6 - $1.633 billion
2. DY 7 - $1.672 billion
3. DY 8- $1.572 billion
4. DY 9 - $1.422 billion
5. DY 10 - $1.272 billion

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $176 million and $146 million, from the HCCI component from DY6 and DY7 of those years, respectively, will be added to the total computable annual limit listed above for DY7. If the available SNCP Uncompensated Care expenditures in DY7 are not sufficient to fully claim the reallocated funds, those funds will be made available for claiming in later demonstration years, notwithstanding the total computable annual limits specified above.

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $97 million and $26 million, from the HCCI component from DY8 and DY9 of those years, respectively, will be added to the total computable annual limit listed above for DY8 and DY9, respectively. If the available SNCP Uncompensated Care expenditures in DY8 or DY9 are not sufficient to fully claim the reallocated funds, those funds will be made available for SNCP Uncompensated Care expenditures in later demonstration years notwithstanding the total computable annual limits specified above.

The annual limit the State may claim FFP for DSHP is limited to the programs listed below and shall not exceed $400,000,000 FFP per year for a 5 year total of $2,000,000,000 FFP.

The annual limit for the IHS uncompensated care cost shall be $15,461,000 TC per year (DYs 8 and 9) for a 2 year total of $30,922,000 TC.

The total annual limit for the extension of the IHS uncompensated care cost claiming for the period January 1, 2014 through December 31, 2014 shall be $3,100,000 total computable. This is comprised of a limit of $1,550,000 total computable in the second half of DY 9 (January 1, 2014 through June 30, 2014) and a limit of $1,550,000 total computable in the first half of DY 10 (July 1, 2014 through December 31, 2014).

The total annual limit for the extension of the IHS uncompensated care cost for January 1, 2015 through October 31, 2015 shall be $1,333,800 total computable.

v. *Approved Designated State Health Programs (DSHP)* for which FFP can be claimed subject to the limits in this paragraph are:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIALTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)

County Mental Health Services Program
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Cancer Detection Programs; Every Woman Counts (CDP: EWC)
County Medical Services Program (CMSP) – for the period November 1, 2010 through December 31, 2011 only
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song Brown HealthCare Workforce Training Program • Steven M. Thompson Physician Corp Loan Repayment Program • Mental Health Loan Assumption Program

vi. *SNCP Workforce Development in Low Income/Underserved Communities.* The State may claim FFP for workforce development programs funded by the Universities of California, California State Universities and/or California community colleges to the extent those programs are targeted to benefit low income populations or underserved areas and this justification must be submitted to CMS for its review and approval. The State must then obtain prior CMS approval for the methodology used to capture the workforce development costs eligible for FFP. Once all relevant approvals are obtained, CMS will add this program to the approved DSHP list.

c. SNCP Delivery System Reform Incentive Pool (DSRIP) Payments. Within the SNCP, a Delivery System Reform Incentive Pool (DSRIP) is available for the development of a program of activity that supports California's public hospitals' efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable and directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.

DSRIP Proposals must be consistent with the hospitals' shared mission and quality goals as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care (without any harm whatsoever to individuals, families or communities).

There are 5 areas for which funding are available under the DSRIP, each of which has explicit connection to the achievement of three aims:

i. *Infrastructure Development.* Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and

continuously improve its services. Examples of such initiatives drawn from the hospitals' initial proposals are:

A. Increase in Primary Care Capacity
B. Introduction of Telemedicine
C. Enhanced Interpretation Services
D. Enhanced Improvement Capacity

ii. *Innovation and Redesign.* Investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management. Examples of such initiatives drawn from the hospitals' initial proposals are:

A. Expansion of Medical Homes
B. Expansion of Chronic Disease Management Systems
C. Primary Care Redesign
D. Redesign for Cost Savings

iii. *Population-focused Improvement*. Investments in enhancing care delivery for the 5-10 highest burden (morbidity, cost, prevalence, etc.) conditions in public hospital systems for the population in question. Examples of such initiatives drawn from the hospitals' initial proposals are:

A. Improved Diabetes Care Management and Outcomes
B. Improved Chronic Care Management and Outcomes
C. Reduction of Readmissions
D. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems)

iv. *Urgent Improvement in Care.* Broad dissemination of top-level performance on 2 or 3 interventions (preferably drawn from a superset of interventions) where there is deep evidence, including evidence from within the safety net, that major improvement in care is possible within 5 years, measurable and meaningful for almost all hospital populations such as those served by the California Public Hospitals. These are hospital specific initiatives and will be jointly developed by hospitals, the State and CMS, and need not be uniform across all of the hospitals or the initiative.

v. *HIV Transition Projects.* Establish HIV Transition plans to develop programs of activity that support efforts to provide access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly those LIHP enrollees who previously received services under programs funded by the Ryan White HIV/AIDS Treatment Extension Act of 2009. These plans will support infrastructure, programs, and services to ensure that persons diagnosed with HIV can be cared for in an integrated and coordinated system of care. If a government hospital, as listed in Attachment C, chooses to implement HIV Transition DSRIP, the following two categories of activities must be implemented by the participating hospital system and must be in addition to any other DSRIP projects:

A. Infrastructure and Program Design – These activities will enhance the ability of participating hospital systems to provide care within patient-centered medical homes, an essential building block to ensuring delivery of high-quality medical care for patients diagnosed with HIV. Examples of such activities are:
    1. Establish appropriate medical homes with HIV expertise
    2. Establish electronic consultation systems
    3. Development of retention programs.
B. Clinical and Operational Outcomes – These activities will enable participating hospital systems to pursue patient outcomes across several clinical domains to realize concrete gains in quality and operational effectiveness that will have lasting benefits for individuals. Examples of such activities are:
    1. Viral load monitoring
    2. Medical visits
    3. T-Cell count.

vi. *General Overview of Payments*. Payments for the Infrastructure Development, Innovation and Redesign and HIV Transition Infrastructure and Program Redesign shall be tied to process measures (e.g., successful initiation of an enhanced interpretation program, enrollment of a majority of patients into a Medical Home model). Payments related to Innovation and Redesign shall recognize that the initiatives do not guarantee outcomes, but that the milestones will result in learning, adaptation and progress. Payments for HIV Transition Clinical and Operational Outcomes must be tied to the Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) performance measures. The total Demonstration funding for DSRIP shall not exceed total computable expenditures of $6.671 billion over five years. Annual limits on this SNCP category of spending are:
    1. DY 6 - $1.006 billion
    2. DY 7 - $1.3 billion
    3. DY 8- $1.51 billion
    4. DY 9 - $1.455 billion
    5. DY 10 - $1.4 billion

The total annual limits of DY 8 and DY 9 include sublimits of $110 million for DY 8 and $55 million for DY 9, with respect to HIV Transition incentive payments. The total Demonstration funding for HIV Transition activities must not exceed total computable expenditures of $165 million over DY 8 and DY 9. For DY 9, HIV Transition activities will end on December 31, 2013. The parameters for obtaining an HIV Transition activity payment shall be detailed in forthcoming supplements to Attachments P and Q.

vi. Payment for both the Population-Focused Improvement and Urgent Improvement in Care shall be tied chiefly to an organization's absolute progress from the time it initiates its improvement activities with recognition of demonstrated advancement

from each facility's starting point. In some cases, it may also be tied to outcome measures (e.g., an infection rate, the rate of reliable delivery of an evidenced-based care protocol). Payments for metrics may be graduated or based on making meaningful and significant progress rather than full achievement of a particular metric. Organizations will have the opportunity to recapture a DSRIP payment in subsequent Demonstration years upon metric/milestone achievement if the Organization does not meet a milestone /metric in the specified or targeted Demonstration year for achievement. The parameters for such recapture shall be detailed in Attachment P. For all categories of payment, metrics should, whenever possible,: (1) reference a nationally or statewide accepted measurement, including but not limited to CHART, HEDIS, CMS, NQF, and the U.S. Task Force on Prevention; and (2) an individual plan must include the measurement specifications for each initiative.

vii. Total payment amounts available for each of the public hospital system proposal will be determined prior to submission for final approval by CMS. Each public hospital system will be responsible for developing proposals that include proposed payment mechanisms based on the metrics guidelines as stipulated in Attachment P for categories I-IV and a forthcoming supplement to Attachment P or Attachment Q for category V.

Each public hospital system will provide the non-federal share of its DSRIP payments through an IGT. Available funding under the initial four defined areas of focus may be weighted more heavily toward Infrastructure Investment and Innovation and Redesign initiatives in the first two years of the Demonstration and inversely weighted toward Population-focused Improvement and Urgent Improvement in Care initiatives in the last two years of the Demonstration.

In consultation with the designated public hospitals and to the degree it does not impede the ability of the designated public hospitals to meet the requirements and conditions contained for DSRIP payments set forth in this section, the State may provide for milestone incentive payments to private disproportionate share hospitals and/or non-designated public disproportionate share hospitals to incentivize improvement activities towards, and achievement of, delivery system transformation. Such milestone incentive payments to private disproportionate share hospitals and/or non-designated public disproportionate share hospitals must be structured in accordance with the requirements and conditions for DSRIP Payments set forth in this section. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and/or non-designated public hospitals. All incentive pool funding, including any potential private and/or non-designated public hospital sub-pools, will be limited to the total amount of incentive pool funding allowed for DSRIP payments as set forth in this section.

viii. *Finalize DSRIP Protocol.* Within the 60 days following the acceptance of the terms and conditions, CMS, the State and the California Association of Public

Hospitals will, through a collaborative process, develop a blueprint to move quickly forward to develop more specific standards, measures and evaluation protocols with the intention of clarifying requirements and expediting the approval of the plans. Specifically, the deliverable will be future Attachment Q and will:

A. Develop standard metrics for both process measures and absolute improvement measures;
B. Finalization of scorecard process and metric grouping to measure project progress;
C. Finalization of payment mechanisms for projects based the agreed upon metrics;
D. Finalize a State review process that will assure action on the proposal within 30 days of submission by the hospitals. Approval results in submission to CMS by the State for approval of DSRIP funding.
E. Finalize a review and approval process for proposals received by CMS that assures action on the proposal with 30 days from submission by the State; finalize a process for ongoing support and collaboration, annual reporting process and project coordination.

ix. *DSRIP Payments are Not Direct Reimbursement for Expenditures or Payments for Services.* Payments from the DSRIP are intended to support and reward hospital systems for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by hospitals in implementing reforms. The DSRIP payments are not reimbursement for health care services that are recognized under these Special Terms and Conditions or under the State plan. DSRIP fund payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated hospital systems and their affiliated government entity providers for health care services, DSH or administrative activities as defined under these Special Terms and Conditions and/or under the State plan.

x. The State must submit a revised Attachment P and Attachment Q, or supplements thereto, to incorporate Category V, HIV Transition Projects, within 30 days of the amendment approval. Consistent with the STCs related to the SNCP, CMS approval of the revised Attachment P and Attachment Q, or supplements, is required before FFP for Category V, HIV Transition Projects will be dispersed.

40. General Funding and Reimbursement Protocol for SNCP Expenditures. The State must maintain an approved funding and reimbursement protocol (Attachment F) to document the procedures and methodologies the State will use to determine those costs eligible for Federal matching through the Safety Net Care Pool (SNCP) through the Certified Public Expenditure (CPE) process. The Federal government will only match SNCP expenditures, under the Demonstration, that the State makes with State and/or Local funds.

The funding and reimbursement protocol must specify the definitions, methodologies and cost-reporting formats for documenting expenditures made by the State and non-hospital based providers in order to claim Safety Net Care Pool (SNCP) Federal matching funds. The funding and reimbursement protocol must be approved by CMS before the State may claim FFP against the SNCP for all medical services. The funding and reimbursement protocol must also include methodologies for reimbursing for the following:

a. Safety Net Care Uncompensated Care Pool furnished by designated public hospitals and other governmental providers that is not otherwise funded through Medicaid, claimed for DSH or reimbursed by other payers. The reimbursement methodologies for designated public hospitals and other governmental providers participating in the Demonstration that are not described in Section 4.19-A of the Medicaid State Plan are described in Attachment F and includes a description of any use of estimates or adjustment factors that will be used to modify actual cost findings;

b. Supplemental Payments to IHS and 638 Facilities. Attachment F describes the methodology to compute supplemental payments to IHS and tribal facilities using the published IHS encounter rate for qualifying uncompensated encounters.

c. Designated State Health Programs (DSHP). The State must revise and amend Attachment F to document the procedures for DSHP interim claiming and the payment reconciliation process the State will use to determine those costs eligible for Federal matching through the Safety Net Care Pool for DSHP in paragraph 398.b., iv. The State will submit a final proposed revised Attachment F to CMS. Failure of the State to submit the final proposed revised Attachment F to CMS will result in a loss of Federal matching for DSHP expenditures; and

d. Workforce Development in Low Income/Underserved Communities as described in paragraph 38.b.vi.

41. Restricted Use of SNCP Funds. Safety Net Care Pool funds are available annually at the levels defined in paragraph 39. Annual limits are further subject to reductions associated with paragraph 26.h., as determined by the State meeting its projected budget neutrality savings. To the extent any of the funds associated with a SNCP category are not fully expended in a given year, they may be available for subsequent years for the purposes for which the funds were initially reserved. However, consistent with paragraph 39, funds spent in a given year cannot exceed the cumulative DY expenditure limits for the individual SNCP category. Funds may also be rolled over to subsequent Demonstration years for use in other SNCP categories subject to CMS approval.

42. Entities Eligible to Receive SNCP Funds. The government operated hospitals listed in Attachment C, the State, a county or a city and IHS or 638 tribal facilities are eligible to receive Safety Net Care Pool funds based upon CPEs determined through an approved cost reimbursement methodology. With prior approval of CMS, the State may add other governmental entities (and may include providers established under State statutes authorizing

hospital authorities, hospital districts, or similar entities) to this list. The State must notify CMS when an entity on Attachment C is removed.

43. **Permissible non-Federal Share Funding Mechanisms for SNCP.** The State must have permissible sources for the non-Federal share of payments from the Safety Net Care Pool, which may include CPEs or permissible IGTs from government-operated entities. Sources of non-Federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from SNCP providers, or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

    In the event that the use of CPEs or permissible IGTs by the State and government-operated entities is insufficient to fully utilize the SNCP allowance, the State may propose alternate legitimate funding mechanisms. However, CMS must review and approve any such alternate funding prior to its use as the non-Federal share of a payment under Title XIX.

44. **Prohibited Uses of SNCP funds.** Safety Net Care Pool expenditures do not include expenditures associated with the provision of non-emergency care to non-qualified aliens.

    a. To implement this limitation, 13.95 percent of total provider expenditures or claims through SNCP for uncompensated care will be treated as expended for non-emergency care to non-qualified aliens.

    b. To implement this limitation with respect to DSHP:
        i. Expenditures for the Medically Indigent Long Term Care (MI/LTC) program will not be reduced by 13.95 percent because there are no non-qualified aliens receiving services under this program.
        ii. Expenditures for the Breast and Cervical Cancer Treatment Program (BCCTP) will be reduced by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens; however, the 13.95 percent reduction will not be applied otherwise.
        iii. Expenditures for the California Children Services (CCS) program will be reduced by 13.95 percent as specified in subparagraph (a).
        iv. Expenditures for the Genetically Handicapped Persons Program (GHPP) will be reduced by 13.95 percent as specified in subparagraph (a).
        v. Expenditures for the Expanded Access to Primary Care (EAPC) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
        vi. Expenditures for the AIDS Drug Assistance Program (ADAP) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
        vii. Expenditures for the California Department of Developmental Services will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the

costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.

viii. Expenditures for the California County Mental Health Services Program will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.

ix. Expenditures for the Prostate Cancer Treatment Program (PCTP) will be reduced by 13.95 percent as specified in subparagraph (a).

x. Expenditures for the Cancer Detection Programs; Every Woman Counts (CDP: EWC) program will be reduced by 13.95 percent as specified in subparagraph (a).

xi. Expenditures for the County Medical Services Program (CMSP) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.

A. Expenditures for the CMSP are only allowable for DSHP for the period November 1, 2010 through December 31, 2011,

B. Implementation of the CMSP LIHP prior to December 31, 2011 will terminate the eligibility of provider expenditures or claims through SNCP for uncompensated care.

45. Redistribution of SNCP Funds. The State may redistribute, among designated public hospitals, Federal matching funds drawn against Safety Net Care Pool claims it receives which are based on providers' CPEs, provided that providers receiving Federal funds in excess of their certified costs cannot return any portion of the payment received to any unit of government and providers not receiving the total Federal matching funds for a documented cost cannot utilize those costs as CPEs to claim Federal funds. No Federal matching funding is available for such redistributions. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable. Any redistribution cannot increase local contributions towards the non-Federal share that would violate maintenance of effort provisions regarding political subdivisions contributions under the Recovery Act of the Affordable Care Act.

46. Low Income Health Program (LIHP). The LIHP is a county[1]-based elective program that consists of two components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). The MCE is not subject to a cap on federal funding, and provides a broader range of medical assistance than the HCCI, which is subject to a cap on federal funding within the limited amounts available for the SNCP.

47. LIHP Cost Claiming Protocols. The State must maintain a CMS approved funding and reimbursement protocol (Attachment G) which explains the process the State will use to determine costs incurred by the LIHP under this Demonstration.

a. Requirements of the funding and reimbursement protocol must:

i. Indicate how the LIHP will document costs; how interim payments will be made; and how reconciliations will be performed.

[1] In the LIHP program ONLY a "county" will be defined as a county, a city and county, a consortium of counties serving a region consisting of more than one county, a tribal government, or a health authority.

ii. Document how the CPE process will interact with the CPE process currently outlined in Attachment F, and used by the hospitals listed in Attachment C to document costs eligible for Federal matching. This process should only address the provision of medical services under the LIHP; the administrative cost claiming protocol is separately described in Attachment J.

iii. The State must submit funding and claiming protocols to CMS with respect to each county participating in the LIHP program. The State may not claim FFP prior to the approval of the funding and claiming protocols. Once the funding and claiming protocol is approved, payment may be rendered as of the date that the LIHP met all requirements.

b. For any Demonstration program paid based on actuarially sound per capita rates, the requirements of the funding and reimbursement protocol must address:

i. How the rates will be determined

ii. Whether the nonfederal share will be provided through intergovernmental transfers or certified public expenditures, and

iii. The procedures that will apply to payment.

c. Provide for methodologies to determine the separate costs of HCCI services and MCE services incurred by the LIHP.

48. LIHP Maintenance of Effort (MOE). The State must demonstrate that the annual amount of non-Federal funds expended for the LIHP in effect under the prior demonstration as HCCI programs will be maintained or increased above the State Fiscal Year (SFY) 2006-07 level and for any new LIHP will be maintained or increased above the SFY 2009-10 level for the Demonstration period through December 31, 2013, i.e., the State must demonstrate that total non-Federal expenditures for LIHP in any Demonstration year is equal to or exceeds the total amount that would have been expended by either the State or local governments in SFY 2006-07 or SFY 2009-10, as applicable, in the absence of the Demonstration. If the State cannot meet the MOE requirement, CMS will reduce Federal funding for LIHP expenditures by the amount of the deficiency.

49. Prior Approval of Claiming Mechanism. The State must maintain a CMS approved Administrative Cost Claiming Protocol (Attachment J) which explains the process the State will use to determine administrative costs incurred by the LIHP which must be compliant with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." CMS will provide Federal financial participation (FFP) to the State at the regular 50 percent match rate for administrative costs including, start up, implementation and close out costs associated with the approved LIHP and incurred and subject to the limitations outlined in Attachment J during the Demonstration approval period within these STCs. The claiming protocol should be modified for Demonstration years 6-9 for the new LIHP time periods and also to account for the allocation of administrative costs between the MCE and the HCCI populations. No FFP for administrative costs is allowed until a claiming protocol is approved by CMS.

C. **<u>Funding Limitations on the LIHP - Health Care Coverage Initiative (HCCI)</u>**

50. Federal Financial Participation for the HCCI Population. A reserved amount of restricted use SNCP funds as described in paragraph 39.a may only be used to fund expenditures for the HCCI population that will expand coverage options for individuals who meet the criteria in paragraph 52.a. ii. The HCCI population program may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics.

51. HCCI Allocations. The State with CMS approval will determine HCCI allocations for expenditures in each county for each year of the Demonstration. The allocations will be the maximum levels of SNCP funding that will be available to pay for expenditures for HCCI recipients in each county during the Demonstration year. If FFP is to be provided based on county certified public expenditures, the expenditures for health care coverage service costs for county HCCI recipients must be documented by each county and. must be compliant with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." Expenditures will be claimed in accordance with the CMS-approved HCCI claiming protocol in Attachment G. Attachment G must be modified for DY's 6 through 9 to accommodate any new/changes to HCCI programs as well as the allocation of expenditures between the MCE and the HCCI medical services.

VI. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

The Special Terms and Conditions, waivers and authorities separately enumerated for the State Plan and Demonstration Populations affected by the California Bridge to Reform Demonstration, and the corresponding Demonstration programs affected by the Demonstration are effective from the effective date identified in the CMS Demonstration approval letter through October 31, 2015 except for the LIHP that will be effective through December 31, 2013 and will not be extended by CMS beyond December 31, 2013.

52. Eligibility. Certain state plan eligibles and Demonstration populations authorized under the expenditure authorities are affected by the Demonstration, as described below.

State plan eligibles derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are affected by the demonstration by being required to use the managed care network and gaining access to additional benefits not described in the state plan.

The Medicaid Coverage Expansion (MCE) population, described below in 52.a.i., and CCS with special health care needs population, described below in 52.b., are subject to all applicable Medicaid laws and regulations except as expressly waived or described herein. The Health Care Coverage Initiative (HCCI) population, described below in52.a.ii., are subject to Medicaid laws or regulations except as specified in the expenditure authorities or described herein for these Demonstration populations.

The following population groups are affected by the Demonstration:

a. Demonstration Low Income Health Program – Eligible individuals who meet county residency requirements of a participating county, are a U.S. citizens, nationals or otherwise have satisfactory immigration status: are not eligible for Medicaid or CHIP; are not pregnant, and are within the following populations:

i. *Medicaid Coverage Expansion (MCE) Population.* Adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL (or less as applicable based on participating county income eligibility standards). Eligibility for the MCE population expires December 31, 2013, at which time MCE beneficiaries will be administratively transferred to the new adult group.

1. New MCE Recipients. Adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL and who have been determined to be eligible for enrollment into a participating county program after the Demonstration approval date including individuals determined eligible for enrollment during the Transition Period pursuant to paragraph 39.a.v; and
2. Existing MCE Recipients**.** Includes certain adults who have family income at or below 133 percent FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," HCCI in their county of residence on the effective date identified in the CMS Demonstration approval letter.

ii. *Health Care Coverage Initiative (HCCI) Population.* Adults between 19 and 64 years of age who have family incomes above 133 percent through 200 percent FPL (or less as applicable based on participating county income eligibility standards). Eligibility for the HCCI population expires December 31, 2013, at which time HCCI beneficiaries will be referred to health coverage options available on the California Health Benefit Exchange (Covered California) in accordance with the state's LIHP transition plan and transition plan addendum.

1. New HCCI Recipients. Adults between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL and who have been determined to be eligible for enrollment into a participating county program after the Demonstration approval date including individuals determined eligible for enrollment during the Transition Period pursuant to paragraph 39.a.v; and
2. Existing HCCI Recipients. Includes certain adults who have family income above 133 through 200 percent of the FPL, who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," in their county of residence on the effective date identified in the CMS Demonstration approval letter.

b. State Plan California Children's Services (CCS) Affected by the Demonstration are those children with Special Health Care Needs who are:

i. Under 21 years of age; and

ii. Meet the medical eligibility criteria as defined in the California Code of Regulations such as congenital anomalies, cerebral palsy, hearing loss, cancer and diabetes; and

iii. Meet financial eligibility criteria for CCS if they are:
   1. Enrolled in Medi-Cal (per the Medicaid State Plan);
   2. Enrolled in Healthy Families (California's Child Health Insurance Program);
   3. Persons in families with an adjusted gross income of $40,000 or less in the most recent tax year, as calculated for California state income tax purposes; or
   4. Projected to expend more than 20 percent of their annual, adjusted gross family income for treatment of the CCS-eligible condition.

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

d. 1915(b) Waiver Populations are individuals enrolled in the: (1) California Health Insuring Organizations; (2) Health Plan of San Mateo (3) Santa Barbara San Luis Obispo Regional Health Authority; (4) Two Plan Geographic Managed Care delivery systems

i. *Section 1931 Children and Related Populations* are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children
ii. *Section 1931 Adults and Related Populations* are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
iii. *Foster Care Children* are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

e. Community Based Adult Services (CBAS) Populations are persons who are age 18 or older and meet CBAS eligibilityunder STC 95(a) and (d).

f. Healthy Families Children Transitioning to the Demonstration are uninsured children with family income up to 250 percent of the FPL not otherwise eligible under the state plan who are either: a) transition children previously enrolled in the state's separate CHIP who meet the conditions for phased-in enrollment in the demonstration population described in Section 105of the STCs; or b) new enrollees who would otherwise meet the eligibility criteria for enrollment in the state's approved separate CHIP program.

g. 2013 Managed Care Expansion Populations**.** This population consists of persons residing in 28 California counties transitioning from Medi-Cal FFS to Medi-Cal managed care, beginning no earlier than September 1, 2013. Attachment L specifies the 28 counties, the anticipated start date (subject to CMS approval of the managed care contracts and the state's compliance with these STCs), and which populations are required to enroll in managed care and which are voluntary (by county).

h. New Adult Group. Effective January 1, 2014, the new adult group, described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR 435.119, pursuant to the approved state plan will be required to obtain services through this demonstration's managed care delivery system as described in these STCs. Benefits

for the new adult group are described in the state's approved alternative benefit plan state plan amendment.

i. **Cal MediConnect eligible beneficiaries** are defined in the California-CMS Financial Alignment Memorandum of Understanding signed March 27, 2013.

j. **Coordinated Care Initiative (CCI) Eligible Beneficiaries**: are individuals age 21 and older and includes dual eligible beneficiaries who opt out or are excluded from the Cal MediConnect program, Medi-Cal only Seniors and Persons with Disabilities (SPDs) who were previously excluded from the mandatory managed care SPD transition program, and Medi-Cal managed care enrollees who reside in one of the following 8 counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara, excluding:Beneficiaries enrolled in PACE;Beneficiaries enrolled in the AIDS Healthcare Foundation;Medi-Cal-only beneficiaries excluded due to an approved Medical Exemption Request, and;Beneficiaries enrolled in SCAN.

k. As of August 1, 2015, low-income Pregnant Women, defined as pregnant women with incomes up to and including 138 percent of the FPL will be required to obtain services through this demonstration's managed care delivery system. Beneficiaries who are pregnant women in fee-for-service prior to August 1, 2015 may remain in fee-for-service for the duration of their pregnancy and post-partum period to ensure continuity of care. Any pregnant women voluntarily moving from FFS to managed care will be provided appropriate care coordination.

VII. DEMONSTRATION DELIVERY SYSTEMS

If the State chooses to use a managed care delivery system to provide benefits to the Demonstration populations (defined in STC 52), any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438.

53. Transition of existing 1915(b) waiver programs into the Demonstration. Prior to this Demonstration, the State operated managed care programs under the authority of 1915(b) through four separate 1915(b) waivers:

a. Health Plan of San Mateo (HPSM);
b. Santa Barbara San Luis Obispo Regional Health Authority (SBSLORHA);
c. Health Insuring Organizations (HIO)-OBRA County-Organized Health Systems (COHS); and
d. Two Plan/Geographic Managed Care (GMC).

Health Insuring Organizations are managed care delivery systems unique to California and operate under the authority of section 9517(c) of COBRA 1985, which was subsequently amended by section 4734 of OBRA 1990 and MIPAA 2008. HIOs are exempt from the

managed care requirements of section 1932 of the Act (implemented through 42 CFR Part 438) because they are not subject to the requirements under 1903(m)(2)(A) that apply to MCOs and contracts with MCOs. 42 CFR 438.2 identifies these as county-operated entities and California state law that passed simultaneously with OBRA 1990 identifies these as county-organized health systems (COHS). The entities covered by the 1915(b) waivers in subparagraph b. and c. operate under the HIO authority to deliver benefits to State plan populations; the HPSM is considered a COHS, but is not considered an HIO by Federal standards because it became operational after January 1, 1986.

COHS plans must enroll all Medicaid beneficiaries residing in the county in which it operates. In Humboldt County, beneficiaries may be subsequently disenrolled from COHS to be enrolled in the Program of All Inclusive Care for the Elderly (PACE), if eligible. Medicaid beneficiaries residing in COHS counties may not be enrolled in any other alternative delivery system without prior approval from CMS and an amendment to this demonstration.

The counties participating in the Two Plan offer a choice of two types of MCOs – a local initiative plan (a county-organized plan which includes local safety net providers and clinics) and a commercial plan. The counties participating in the GMC offer a choice of two or more MCOs.

54. **Managed Care Expansions.** The State has been granted the authority to operate managed care programs in the counties in Attachment M. Therefore, a Demonstration amendment is not required to implement expansions in these counties. However, any new service area expansions, proposed changes in Demonstration authorities, or changes in the populations included or excluded in the authorized counties will require an amendment to the Demonstration as outlined in STC 7, including updated Attachments L and M.

55. **Encounter Data Validation Study for New Health Plans.** When a managed care entity begins serving the populations in STC 52. b., c., d., or g, in the Demonstration, the State will be responsible for conducting a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study will include validation through a sample of medical records of Demonstration enrollees.

56. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law, policy and regulation. The State must assure that encounter data maintained at managed care entities can be linked with eligibility files maintained at the State.

57. **Standard Transaction Formats for Transmission of Payment and Enrollment to Managed Care Entities.** The State must ensure that regular capitation payments and plan enrollment rosters provided to the managed care entities serving Demonstration populations are generated through an automated process that is compliant with the appropriate standard HIPAA ANSI X12 transaction file format. The State must transition to utilizing Version 5010 of the 820 standard for capitation payments, and the 834 standard for enrollment rosters

by the January 1, 2012. FFP under this Demonstration may be at risk if these electronic standards are not implemented by the HIPAA-mandated compliance date.

58. **Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State will provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the contract compliance requirement is met.

59. **Capitation Payments.** The State must ensure that regular capitation payments made to the Medicaid health plans that are covered under this Demonstration are done through an automated process that is compliant with the standard HIPAA ANSI X12 820 electronic transaction format. The State must transition to utilizing Version 5010 of the 820 standard transaction by the compliance date of January 1, 2012. Likewise, the State must ensure that regular plan enrollment rosters are provided to the Medicaid health plans covered under this Demonstration through an automated process that is compliant with the standard HIPAA ANSI X12 834 electronic transaction format. The State must transition to utilizing Version 5010 of the 834 standard transaction by the compliance date of January 1, 2012. FFP under this Demonstration may be at risk if these electronic standards are not implemented by the HIPAA-mandated compliance date.

60. **Network Adequacy.** The State must ensure that each managed care entity has a provider network that is sufficient to provide access to all covered services in the contract.

    a. For the Demonstration populations identified in STC 52. b., c., d., g, and h, no later than 30 days prior to enrollment of these populations and annually thereafter, the State must provide to CMS for review and approval the following:
        i. The anticipated Demonstration population enrollment;
        ii. Expected service utilization based on the Demonstration population's characteristics and health care needs;
        iii. The anticipated number and types of primary care and specialty providers needed to provide covered services to the Demonstration population;
        iv. The number of network providers accepting the new Demonstration population; and
        v. The geographic location of providers and Demonstration population, considering distance, travel time, transportation, and disability access (Not applicable to demonstration populations identified in STC 52 h).

    b. To the extent that the state applies an exception to its time and distance access standards for a particular region that is part of the 2013 managed care expansion population described in STC 52.g the state shall provide the CMS the following information no later than 30 days prior to enrollment:
        i. The geographic zip codes where the exception is applied;

ii. The reason(s) for applying this exception, and;
iii. A description of how the health plan network being certified for network adequacy compares to the number of FFS provider in the region where the exception is applied.

And annually thereafter:

i. The geographic zip codes where the exception is applied; and
ii. The reason(s) for applying this exception.

61. Network Requirements. The State must through its health plans deliver adequate primary care, including care that is delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population, and coordinate health care services for Demonstration populations.

a. **Special Health Care Needs -** Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual's health care condition.
b. **Out of Network Requirements -** The State through its health plans must provide Demonstration populations with the corresponding Demonstration program benefits described within these STCs and must adequately cover these benefits and services out of network in a timely fashion, for as long as it is necessary to provide them, at no additional cost to the enrollee.
c. **Timeliness -** The State through its health plans must comply with timely access requirements and ensure their providers comply with these requirements. Providers must meet State standards for timely access to care and services, considering the urgency of the service needed. Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week when medically necessary. The State, through the health plan contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
d. **Credentialing -** The State through its health plans must demonstrate that the health plan providers are credentialed. The State must also require these health plans to participate in efforts to promote culturally competent service delivery.
e. **Demonstrating Network Adequacy -** Annually the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.
    i. The State must provide supporting documentation that must show that the health plan offers an adequate range of preventive, primary, and specialty services care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees.
    ii. The State through its health plans must submit this documentation when it enters into a contract.

A. The State must submit this documentation any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services.
B. Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.

f. **Certification** – Prior to enrollment and annually, the State is required to certify to CMS that each health plan has complied with State standards for service availability and must make all documentation available to CMS upon request.

62. **Concurrent Operation of the Multipurpose Senior Services Program (MSSP) 1915 (c) Home and Community Based Services (HCBS) program (CA 0141).** Payment for the MSSP 1915 (c) waiver services will be included in the plan capitation payments from the State starting July 1, 2014. Eligible beneficiaries in the eight CCI counties who are participating in the MSSP waiver will be allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in a plan. The Cal MediConnect plans and Medi-Cal only managed care plans will be required to contract with MSSP providers to ensure on-going access to MSSP waiver services for enrolled beneficiaries through January 31, 2016. MSSP waiver providers will continue to provide the same services to MSSP Waiver participants/clients; however, they will receive payment for Medi-Cal managed care members from the plans. These requirements shall be outlined in the plan and MSSP Waiver provider contracts.

VIII. OPERATION OF DEMONSTRATION PROGRAMS

A. Low Income Health Program (LIHP)

Note: As described in STC 52 and in the demonstration's expenditure authorities, eligibility for the Low Income Health Program expires December 31, 2013, when these beneficiaries will be transitioned to other coverage options.

62. Eligibility and Enrollment Processes. For both the MCE and HCCI programs, eligible individuals may not be otherwise eligible for Medicaid or CHIP, must be non-pregnant, and must meet, income eligibility standards that are determined on a county-by-county basis, with variation in the income eligibility standards between counties within ranges established under this Demonstration. No asset test will be imposed upon LIHP enrollees. An individual determined eligible in one participating county who moves to another participating county will be disenrolled by the county in which the individual is no longer a resident, and may apply in the county to which the individual becomes a resident.

a. Definitions.
   i. *MCE Applicants* are non-pregnant individuals between 19 and 64 years of age who are not enrolled in Medicaid or CHIP and who appear to have family incomes at or below 133 percent of the FPL (or less as applicable based on participating county standards) who have completed an application in a participating county and who have not had an eligibility determination.
   ii. *MCE Recipients*

1. New MCE Recipients are individuals between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL, are not eligible for Medicaid or CHIP and who have been determined to be otherwise eligible (including individuals determined eligible for enrollment during the Transition Period pursuant to paragraph 38.a.v) and are U.S. citizens, nationals or pending documentation of citizenship consistent with 1902(a)(46)(B) of the Act; or have satisfactory immigration status consistent with 1137 of the Act; and
2. Existing MCE Recipients includes certain individuals whose income is at or below 133 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Demonstration, in their county of residence at the effective date identified in the CMS approval letter of the California Bridge to Reform Demonstration. These individuals are entitled to continued MCE eligibility even though they may not meet the current income eligibility standards imposed by the participating county program.

iii. *HCCI Applicants* are non-pregnant individuals between 19 and 64 years of age who appear to have family incomes above 133 through 200 percent of the FPL (or less as applicable based on participating county income standards), are not enrolled in Medicaid or CHIP, do not have third party coverage, who have completed an application for HCCI in a participating county and who have not had an eligibility determination.

iv. *HCCI Recipients*

1. New HCCI Recipients are individuals between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL, are not enrolled in Medicaid or CHIP, do not have third party coverage, and who have been determined to be otherwise eligible (including individuals determined eligible for enrollment during the Transition Period pursuant to paragraph 38.a.v) and are U.S. citizens, nationals or pending documentation of citizenship consistent with 1902(a)(46)(B) of the Act; or have satisfactory immigration status consistent with 1137 of the Act and
2. New HCCI Recipient Enrollment Limitation. Within 60 days of Demonstration approval the State must provide to CMS for review and approval reasonable procedures and monitoring plans for assuring that MCE applicants are enrolled prior to HCCI applicants. No FFP will be available for county plans that enroll new HCCI applicants at the exclusion of MCE applicants.
3. Existing HCCI Recipients includes certain individuals whose income is above 133 through 200 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Demonstration, in their county of residence at the effective date identified in the CMS approval letter of the California Bridge to Reform Demonstration. These individuals are entitled to continued HCCI eligibility even though they may not meet the current HCCI income eligibility standards imposed by the participating county program.

v. *Initial Eligibility Determination* – the determination by a participating county as to whether an applicant meets the eligibility standards for the MCE or HCCI programs, using applicable methodologies or procedures in effect in the county under this Demonstration. As set forth below, a county may determine an individual eligible

subject to a waiting list.

b. Income Range for Eligibility

i. *Baseline Income Limit Notice.* The State will provide to CMS within 60 days after Demonstration approval and with each newly participating county the following:

1. The actual upper income limit elected by the county for recipient eligibility for the:
   A. MCE population - which must be at or below 133 percent of the FPL; and
   B. HCCI population - which must be above 133 through 200 percent of the FPL.
2. Actual/projected enrollment for the county by:
   A. MCE population; and
   B. HCCI population.
3. The projected expenditure limit for the county's
   A. MCE population: and
   B. HCCI population.
4. Any county-specific eligibility standards, methodologies, or procedures in effect in determining how MCE and HCCI applicants become recipients.

ii. *Adjustments to the Income Limit.* In the event that, based on advance budget projections made by the county, funding will not be sufficient to continue to enroll applicants under the levels the county establishes in paragraph 62.b.i., the county may reduce the income limit for new applicants. Any reduction in income limits must ensure that lower income applicants remain eligible unless applicants with higher incomes are ineligible (as a result, upper income limits may not be reduced for MCE applicants unless the county no longer extends eligibility to HCCI applicants). As described in paragraph 64, eligibility levels for recipients will be maintained. In such cases, The State must submit a 90 day written notice to CMS describing the nature of the adjustment to the income limit, the start date of the adjustment(s), and the County's actual and projected enrollment.

c. *Enrollment Caps.* In cases where a county determines, based on advance budget projections that it cannot continue to enroll applicants without exceeding the funding available for the county program, the county can establish enrollment caps for the HCCI program. If, notwithstanding enrollment caps that totally close new enrollment in the HCCI program, the county estimates that it will still exceed available funding, the county can establish enrollment caps for the MCE population.

d. *Wait Lists for MCE and HCCI Applicants*. The State may employ county based wait lists when a county has established enrollment caps pursuant to the preceding paragraph, as a method of managing individual applicant enrollment into a county based HCCI or MCE program.

e. *Outreach for those on the Wait Lists*. The State will ensure that county based outreach is conducted for those individuals on a wait list, for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are still seeking coverage. Outreach materials will remind individuals they can apply for Medicaid and CHIP programs at any time.

63. Eligibility Determinations.

a. Eligibility determinations for the MCE and HCCI populations will be made by individuals who are employed under merit system principles by the State or local governments, including local health departments. These employees will refer any applicant who may be eligible for either Medicaid or CHIP to the State or local government social services office for an eligibility determination. Any individual eligible for either Medicaid or CHIP is not eligible for enrollment into the MCE or HCCI program.

b. Counties will develop eligibility income standards, methodologies and procedures for the MCE and HCCI populations. Such income standards, methodologies and procedures must comply with the requirements of section 42 USC 1396b(x) [Social Security Act section 1903b(x)] and 42 USC 1396a(a)(46)(B) [1902(a)(46)(B)] regarding documentation of immigration status.

64. Eligibility Redeterminations. Recipients enrolled in a MCE or HCCI program must have an eligibility redetermination at least once every 12 months unless the county elects the delayed renewal option described in paragraph (d) below.

a. These eligibility redeterminations cannot be more restrictive during the redetermination period than those "in effect" during the period of the MCE or HCCI recipient's initial eligibility determination.

b. Each redetermination must include a reassessment of the recipient's eligibility for Medicaid and CHIP. If upon a redetermination, a recipient is determined ineligible the recipient shall be disenrolled and if appropriate referred to the county Medi-Cal office.

c. A MCE or HCCI enrollee may apply for eligibility under Medicaid or CHIP at any time for any reason. The State or local governments, including local health departments will determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible.

d. Between September 1, 2013 and December 31, 2013, counties may elect to delay renewals for MCE or HCCI beneficiaries for a one year period.

65. Retroactive Eligibility. Retroactive eligibility up to 3 months prior to the date of application may be extended to the LIHP population, at county option, similar to the retroactive eligibility under the State plan.

66. Disenrollment of Recipients.

a. MCE population**.** Recipients will be disenrolled:
   i. In accordance with Medicaid law and policy; or
   ii. If they no longer reside in the county participating in the MCE program.

b. HCCI population. Recipients will be disenrolled if they:
   i. Have been determined to be unable to provide documentation of citizenship;
   ii. Does not provide or no longer meets program eligibility requirements;
   iii. Exceed income limits allowed for the program;
   iv. Voluntarily withdraw from the program
   v. No longer reside in the County participating in the HCCI

vi. Become incarcerated or are institutionalized in an IMD;
vii. Attain age 65;
viii. Are no longer living; or
ix. Obtain other health coverage.

67. Standard Low Income Health Program Benefits consists of a core set of services listed below in 67.a., and b. and other add-on services allowable under Section 1905(a) of the Social Security Act, which are reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR 440.230). FFP is available for such services through the authority granted in this Demonstration.

a. MCE population core benefits to the extent available under the California State Plan.
   i. Medical equipment and supplies;
   ii. Emergency Care Services (including transportation);
   iii. Acute Inpatient Hospital Services;
   iv. Laboratory Services;
   v. Mental health benefits as described in paragraphs 68 and 69;
   vi. Prior-authorized Non-Emergency Medical Transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available);
   vii. Outpatient Hospital Services;
   viii. Physical Therapy;
   ix. Physician services (including specialty care);
   x. Podiatry;
   xi. Prescription and limited non-prescription medications;
   xii. Prosthetic and orthotic appliances and devices; and
   xiii. Radiology.

b. HCCI population core benefits.
   i. Medical equipment and supplies;
   ii. Emergency Care Services;
   iii. Acute Inpatient Hospital Services;
   iv. Laboratory Services;
   v. Outpatient Hospital Services;
   vi. Physical Therapy;
   vii. Physician services(including specialty care);
   viii. Prescription and limited non-prescription medications;
   ix. Prosthetic and orthotic appliances and devices; and
   x. Radiology.

c. Excluded or Non Covered Benefits. Services and Benefits excluded from the MCE and HCCI core benefit plans include:

i. Organ Transplants;
ii. Bariatric surgery; and
iii. Infertility related services

d. Enhancements to Core Benefits. Counties may provide other add-on services and benefits allowable under Section 1905(a) of the Social Security Act that include additional Medicaid eligible services above the minimum core benefits and receive Federal funding. The State will submit such proposals to CMS for approval.

e. Denial of Services. Except for those medically necessary emergency care services for MCE recipients described in 67.f., the LIHP may exclude those services listed above in paragraph 67.a.b, and d, that are rendered by providers that are not in the provider network for the LIHP.

f. Coverage of Out-of-Network Emergency Services. Participating counties under the LIHP must provide coverage of emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the LIHP network consistent with paragraph 67.e.
   i. *Payment.* LIHP may pay for emergency services and post-stabilization services provided by out-of-network providers at 30 percent of the applicable regulatory fee-for-service rate under the State plan (less any supplemental payments), except that, with respect to inpatient hospital services, LIHP programs may pay 30% of the applicable regional un-weighted average of per diem rates paid to SPCP-contracted hospitals. The out-of-network provider must accept LIHP program payments made in accordance with these STCs as payment in full for the services rendered, and the LIHP recipient may not be held liable for payment.
   ii. *Out-of-network providers* must, as a condition for receiving payment for emergency services, notify the LIHP program within 24 hours of admitting the patient into the emergency room, and, with respect to post-stabilization care, meet the approval protocols established by the LIHP.
   iii. *Definitions.*
      1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
         A. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
         B. Serious impairment to bodily functions.
         C. Serious dysfunction of any bodily organ or part.
      2. Emergency services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title, and needed to evaluate or stabilize an emergency medical condition.
      3. Post-stabilization care services means covered services related to an emergency medical condition that, subject to approval protocols, are provided after an enrollee

is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

g. *Funding of Out-of-Network Emergency Services.* In addition to the funding mechanisms described in paragraph 43 [CPE and IGT], the State may fund the nonfederal share of LIHP program payments for out-of-network emergency services with provider fee revenues that comply with section 1903(w).
h. *LIHP Materials*. LIHP will include in materials information about their ability to receive emergency and/or post-stabilization services in out-of-network hospitals as well as their right to not be liable for payment for these services. LIHP programs will ensure that beneficiary id cards indicate to emergency providers that the LIHP program should be contacted for reimbursement and approval for post-stabilization services.
i. *Provider Bulletin.* The State will issue a provider bulletin indicating the requirement that providers must accept the LIHP out of network emergency service rates as reimbursement in full and are not permitted to balance bill patients.

68. MCE Mental Health Benefit Criteria. The MCE enrollee as described in paragraph 52entitled "Eligibility" must be diagnosed by a MCE participating provider, within their scope of practice, with a mental health diagnosis specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

a. The enrollee must also have at least one of the following impairments as a result of the diagnosed mental disorder:
   i. A significant impairment in an important area of life functioning.
   ii. A probability of significant deterioration in an important area of life functioning.
b. The intervention recommended by the enrolled provider, within their scope of practice, must be reasonably calculated to:
   i. Significantly diminish the impairment; or
   ii. Prevent significant deterioration in an important area of life functioning.
c. In addition to the criteria listed above, for an inpatient admission for treatment of a diagnosed mental disorder, one or more of the following criteria may also apply:
   i. The impairment, symptoms or behavior:
      A. Represent a current danger to self, others or property;
      B. Prevent the enrollee from providing for, or utilizing food, shelter or clothing;
      C. Present a severe risk to the enrollee's health and safety;
      D. Require further psychiatric evaluation or medication treatment that cannot be provided on an outpatient basis.

69. Mental Health Benefits for MCE enrollees. The State must offer a minimum evidence-based benefits package for mental health services under the Demonstration, to promote services in community-based settings with an emphasis on prevention and early intervention.

a. <u>Minimum Benefits Package.</u> Each county will provide the minimum level of mental health benefits to enrollees:
   i. Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
   ii. Psychiatric pharmaceuticals.

iii. Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan will optionally expand the service(s).

b. Benefits beyond the Minimum. Counties may provide other add-on services allowable under Section 1905(a) of the Social Security Act that include additional Medicaid eligible services above the minimum core benefits and receive Federal funding. The State will submit such proposals to CMS for approval.

c. Option to carve out Mental Health Benefits. Counties may opt to provide mental health services through a delivery system that is separate from the LIHP.

70. Design of Behavioral Health Needs Assessment - Upon Demonstration approval, the State shall work with CMS, Substance Abuse and Mental Health Services Administration (SAMSHA), State Departments of Mental Health and Alcohol and Drug Programs to design an approach for a systems assessment to identify the services (including amount, duration, and scope) available throughout the State. This assessment design shall also include information on available service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

71. Initial Behavioral Health Services Needs Assessment. No later than March 1, 2012, The State will submit to CMS a comprehensive assessment, developed collaboratively with the State Departments of Mental Health and Alcohol and Drug Programs, of its current behavioral health system, anticipated growth needs to meet all Medicaid needs by 2014, including mental health and substance use services system. This assessment shall include an accounting of the services (including amount, duration, and scope) available throughout the State as of the assessment. This assessment shall also include information on available service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization) current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

72. Behavioral Health Services. By October 1, 2012, the State will submit a detailed plan, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs, to CMS outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and ensure strong availability of behavioral health services statewide no later than 2014. This plan must be approved by CMS.

73. Technical Assistance for Assessment and Plan. CMS, in partnership with other Agencies of the Department of Health and Human Services, including the SAMSHA, will provide technical assistance in the development and conduct of the assessment(s), and the plan to ensure service delivery capacity sufficient to meet Federal requirements effective in 2014.

74. Cost Sharing Parameters for the LIHP Population.

a. MCE related enrollment fees and premiums must be discontinued for enrollees with family income at or below133 percent of the FPL and newly participating MCE program counties must comply with Medicaid cost sharing limits for MCE and HCCI populations.
b. Effective July 1, 2011. All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all HCCI enrollees must be limited to a 5% aggregate cost sharing limit per family.

75. Delivery Systems for the LIHP Population. If the State chooses to use a managed care delivery system to provide benefits to the LIHP population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. A county based delivery system with a closed network of providers will be considered a managed care delivery system.

76. Network Adequacy and Access Requirements for the LIHP Population. The State must ensure that any managed care entity or managed care delivery system (Plan) complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

a. Accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each enrollee's place of residence. Primary care appointments will be made available within 30 business days of request during the period of the Demonstration term through June 30, 2012 and within 20 business days during the Demonstration term from July 1, 2012 through December 31, 2013. Urgent primary care appointments will be provided within 48 hours (or 96 hours if prior authorization is required) of request.
b. Specialty care access will be provided at a minimum within 30 business days of request.
c. Network providers must offer office hours at least equal to those offered to a Plan's commercial line of business enrollees or Medicaid fee-for-service participants. Services under the contract must be made available 24 hours per day, seven days per week when medically necessary. The State, through managed care entity contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
d. The State will establish alternative primary and specialty access standards for rural areas, service areas within a county with a population of 500,000 or fewer, other areas within a county that are sparsely populated, or other circumstances in which the standards are unreasonably restrictive.
e. In an area of Los Angeles County where an uneven distribution of population resides across a large geographic area, the County shall, in instances where there is no network participation by other designated public hospitals or non-designated public hospitals,

include coverage of inpatient hospital services at the nearest network hospital through the provision of appropriate transportation that is commensurate with patient need, is required for obtaining medical care and is provided at the lowest cost mode available.

f. A Plan will not be found to be in violation of 1902(a)(10)(A) with respect to the provision of federally-qualified health center (FQHC) services as long as it contracts with or otherwise offers services through at least one FQHC if such a health center exists in the county or geographic service area of the Plan.

g. Penalty Provisions Related to Network and Access Requirements. Failure to implement or operationalize the provisions listed in this paragraph will result in the loss of a percentage of the expenditure cap applicable to Safety Net Care Pool (SNCP) expenditures cap (not including HCCI expenditures) under the expenditure authorities. If the State fails to meet a provision, related to Network Adequacy and Access Requirements for the LIHP Population, the annual expenditure authority cap will be reduced by the amount(s) listed in the table below for SNCP expenditures other than those reserved for the HCCI.

Deadline	**Penalty Amount as a percentage of The Annual Safety Net Care Pool Expenditure (Total Computable)**
Prior to Demonstration Enrollment	5.0 %
Nov. 1, 2011 and annually	5. 0%

h. Application of the Penalty. The State's annual expenditures under the SNCP will be reduced in the proceeding DY to the extent described above. Thirty days after the close of the DY, the State's annual expenditures under the SNCP for that year will be determined. The reduction in expenditure authority shall be applied to sequential DYs, if the State has not met the required provisions. Once a requirement has been met, no further penalties associated with that requirement will be imposed.

77. LIHP Credentialing and Cultural Competence. The State must ensure that providers of all managed care entities or managed care delivery systems are appropriately credentialed for the services furnished, and must ensure that the managed care entities participate in efforts to promote culturally competent service delivery.

78. Encounter Data. Each county LIHP managed care delivery system in the Demonstration will be responsible for the collection and reporting of data on services furnished to Demonstration enrollees through encounter data or other methods as specified by the State. The State will, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all outpatient, inpatient and physician services.

79. Federal Financial Participation for the Medicaid Coverage Expansion (MCE) Population. There will be no limit to the FFP in expenditures for the provision of services to MCE populations.

80. Due Process. By May 1, 2011, the State must implement standards and procedures for hearings and appeals by LIHP applicants and recipients. These standards and procedures shall not go into effect until approved by CMS. The State's proposed standards and procedures shall be submitted to CMS for review by January 1, 2011.

a. Scope. The State must describe the standards and procedures for hearings and appeals from the following determinations under the LIHP:
   i. Denial, reduction or termination of eligibility;
   ii. Denial of enrollment and denial of placement on a waiting list; or
   iii. Denial, reduction or termination of specific benefits.

b. Standards and Procedures must include, but are not limited to:
   i. Notices provided to individual applicant or recipient prior to an adverse action taking place, include content of the notice and timeframes the notice will be issued;
   ii. Requirement to maintain and reinstate services in appropriate circumstances per 42 CFR 431.230 and 231.
   iii. Hearing rights - To include, but not be limited to, right to a "de novo hearing," neutral arbiter, right to review case record, present evidence, and question or refute evidence (including to cross-examine witnesses)
   iv. Hearing decision and informing the applicant or recipient of the decision.

c. Expedited Process. Any process the state may use to expedite hearings or appeals.

d. Recoupment**.** The procedure the State may employ to recoup payments made pending an appeal that upholds a denial or termination of eligibility or benefits.

e. Federal Financial Participation (FFP). Once the State's unique hearings and appeals standards and procedures go into effect, FFP will be available in administrative costs to the State for operating the hearings and appeals system, and for medical assistance costs for benefits within the scope of the Demonstration to carry out the hearing decision. But no FFP will be available to the State for the administrative or medical assistance costs relating to judicial appeals challenging the adequacy of the hearing system (including remanded cases). Since the State will be exercising flexibility to deviate from the federal standards and procedures, the State will be at risk for defending its hearing and appeals system procedures and related substantive outcomes.

B. Managed Care Delivery Systems for Seniors and People with Disabilities (SPD) Populations Affected by the Demonstration

If the State chooses to use a managed care delivery system to provide benefits to the SPD population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities) is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. Each of these STCs is in addition to standards established under other provisions of the STCs for this Demonstration, and nothing in this section waives any provision of Part 438 of Title 42 to the Code of Federal Regulations (CFR) and Section 1903(m) of the Social Security Act.

Requirements related to tribal members apply to this section. These STCs apply to the counties indicated in Attachment O – County Listing for SPD Enrollment.

81. **Mandatory Enrollment of SPDs**

a. Enrollment. The State may mandatorily enroll SPDs into Medi-Cal managed care programs to receive benefits in the counties specified in Attachment O on or after December 1, 2014 in the Regional and Imperial Model Counties, herein called RIMC. This does not include individuals who are eligible for full benefits in both the Medicare and Medicaid programs, or dual-eligible individuals, who are excluded from mandatory enrollment in a Medi-Cal managed care plan unless the same plan operates as a Medi-Cal and Medicare Advantage plan in the county that the dual eligible resides in. The mandatory enrollment of SPD individuals will apply to new or existing Medi-Cal in the counties specified in Attachment O when the plan or plans in the geographic area have been determined by the State to 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 State will provide updates through its regular meetings with CMS and submit regular documentation requested of its Readiness Review status.

    i. SPDs residing in Sacramento County will not be mandatorily enrolled into the Sacramento County dental program. SPDs will have the option to voluntarily enroll into the dental program.

b. Choice. For RIMC and for counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 plans meeting all readiness requirements from which to choose. For counties that operate a COHS, the State need not ensure any choice of plans.

c. Notice Requirement for a Change in Network. The State will provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State may not mandatorily enroll the SPD population into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

d. Enrollment and Contracting. The State must not begin mandatory enrollment of the SPD population into a managed care plan prior to obtaining contract approval from CMS. The State will utilize appropriate risk adjustment in the development of its capitation payments and will set forth expectations for plans to ensure sufficient access, quality of care, and care coordination for beneficiaries.

e. Advisory Committee. The State will maintain for the duration of the Demonstration a managed care advisory group comprised of individuals and interested parties impacted by Medi-Cal managed care, regarding the impact, effective implementation, and quality of

care provided to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of newly mandatorily enrolled individuals. The Advisory Committee will meet at least quarterly during the Demonstration's implementation and minutes related to the Advisory Committee's activity will be submitted to CMS with the State's quarterly report as per STC 23.

f. The specific geographic areas where SPDs may be mandatorily enrolled in managed care are detailed in Attachment O. For RIMC, SPDs will become mandatory effective on December 1, 2014, or following contract approval.

82. **SPD Benefit Package**

a. SPDs mandatorily enrolled in any managed care program within the State will receive from the managed care program the benefits as identified in Attachment N – Capitated Services List/Managed Care Benefit Package. The attachment must also indicate the services excluded from the benefit package; those services will be available outside of the managed care program. As noted in plan readiness and contract requirements, the State will assure that enrolled individuals shall have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee-for-service delivery system, and will also assure referral and coordination with services not included in the established benefit package.

b. Any addition or subtraction in Medicaid program benefits not reflected in the state plan, such as home and community-based services (HCBS), for any specific population added to the established benefit package will require an amendment to the Demonstration. The state may submit technical updates to Attachment N without submitting an amendment for benefit changes that are reflected in the state plan as a result of an approved state plan amendment.

83. **Consumer Assistance**

a. Initial Outreach and Communication Strategy. The state must demonstrate to CMS through documentation that it has an outreach and communications strategy prior to implementation for RIMC to explain the changes to individuals to be impacted by mandatory enrollment. The state must also publish on its website current, future and past outreach events. The state will provide details including the date, time, location, and agendas. The state will update this information as needed. The strategy shall describe the State's planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific population. The strategy will further articulate the State's efforts to ensure that the individuals have access to information and human assistance to understand the new system and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for implementation. All updates or modifications to the outreach and communication strategy shall be submitted to CMS for review throughout the Demonstration.

b. CMS Review of Enrollee Communication. The State will submit to CMS any written communication from the State to enrollees for review 10 days in advance of being sent to beneficiaries.

c. Stakeholder Review of Enrollee Communication. The State will submit to stakeholders any written communication to enrollees for review before they are sent to beneficiaries.

d. Ongoing Outreach and Communication Strategy. The state must demonstrate to CMS through documentation that it has an ongoing outreach and communications strategy prior to implementation for RIMC to reiterate the options and articulate the rights of individuals impacted by mandatory enrollment as required by 42 CFR 438. This strategy must describe the State's methodology for advising individuals utilizing an array of outreach techniques to meet the wide spectrum of needs identified within the population. The strategy will further articulate the State's efforts to ensure that the individuals have access to human assistance to understand the new system and their choices, their opportunities to select a health plan or particular provider and to achieve continuity of care and care coordination. On an ongoing basis the State will assure that enrollees be notified of changes that will have a major impact on their benefits or access no less than 30 days prior to the change.

e. Sensitivity Training. The state must demonstrate to CMS through documentation that it has a SPD Sensitivity Training curriculum, including an anticipated target audience prior to implementation for RIMC. Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.
   i. All appropriate plan and State staff shall be trained using the *SPD Sensitivity Training Curriculum* prior to implementation.

f. Informing/Education Materials. The state must demonstrate to CMS through documentation that it has informational and educational materials that meet the requirements of 42 CFR 438 prior to implementation for RIMC to explain the changes in service delivery. Such materials must comport with 42 CFR 438., and be developed in collaboration with stakeholders. These materials must be sent to the CMS Regional Office for review 10 days in advance of mailings to beneficiaries. Information should include information on timeframes, enrollment choice options and types and availability of assistance.

   The State shall submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents. Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.

g. Offers of individual assistance should be prevalent in documentation developed by the State and the plans including information on how to obtain in-person individual

assistance through various means in an effort to minimize default assignments (e.g., assistance through enrollment broker, availability of a toll-free number, etc.).

i. *CMS Review.* The State will submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents. Updates or modifications to the curriculum will be submitted to CMS throughout the Demonstration.

ii. *Communication Follow-up.* Offers of individual assistance should be prevalent in documentation developed by the State and the plans.

h. Readability and Accessibility. All education materials, mail or electronic, should be available in languages, in formats, and at reading levels that will substantially meet the needs of the individuals impacted by the mandatory enrollment.

i. Community Presentation. The state must demonstrate to CMS through documentation that it has developed a "Community Presentation" and completed all "Community Presentations" prior to implementation for RIMC. Community presentations can consist of in-person meetings, teleconferences, webinar, or other appropriate forums. Forums or locations for these Presentations will be determined in collaboration with stakeholder groups.

j. Collaboration with Community Organizations. Since transition of a large number of high needs beneficiaries will impact the organizational structure and resources of health plans, clinics and community-based organizations that serve SPD, the State will ensure health plans are partnering with community organizations in an ongoing effort to improve resource utilization, training, communication for members, and information on the completion of health risk assessment process. The state will provide CMS with updates on the completion of health risk assessments quarterly, during monthly monitoring calls.

84. **Transition into Mandatory Managed Care and Enrollment Strategies**

a. Approaches to Affirmative Choices. The State will implement mandatory managed care for all SPD populations affected by the Demonstration:

i. Any non- County Organized Health System (COHS) participating county once at least two contracts have been approved by CMS

ii. Any new non-COHS county cannot implement mandatory managed care for SPDs until the designated plan meets the same readiness requirements as described in paragraph 85

iii. For RIMC, all SPDs will transition on the same day.

iv. Through the outreach, enrollment and education strategy the State will articulate and establish clear methods for affirmative choice for individuals (e.g., online, in person, in writing, verbal with signature confirmation, by

proxy or surrogate decision-maker, etc.). These methods will be available for review by CMS prior to implementation for RIMC.

b. Approaches to Default

i. For individuals who do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data to make a default selection into a plan based on usual and known sources of care, including previous providers, and utilization history, including use of particular specialty providers data. Default enrollees will have the opportunity to see their existing providers for a period of 12 months after enrollment as described in paragraph 81.f. iii. The default shall not occur until education and outreach efforts are conducted (in person as needed) as noted above. The State must submit its default process rationale and design to CMS prior to initial enrollment. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.

ii. The State will provide documentation and assurances for CMS review, that the infrastructure will be in place at the State level, and across the plans, to effectively manage the default selection process prior to implementation for RIMC.

iii. The State must have a CMS-approved enrollment broker protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to SPD default prior to implementation. Such protocol should, in circumstances where available data and utilization is insufficient to provide a clear, reasonable default selection, provide for pre-default assessment to determine individual needs.

iv. The State shall inform individuals of their opportunity to change plans at any time.

c. Efforts to Ensure Seamless Transitions

i. The State will provide CMS with its methodology for providing plans with a maximum of available data on Medi-Cal service utilization and provider utilization for SPD enrollee. This includes Medi-Cal administered services that are administered through sister agencies and takes into account the use of electronic health records (EHR) and Health Information Exchange as a source of clinical data on SPD enrollees as it becomes available. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

ii. The State must document prior to implementation that information technology systems and infrastructure are in place to effectively manage the data exchange expectations set forth in this section to support smooth transition of SPDs in RIMC to managed care.

iii. The State must provide plans with up to one year of utilization and Treatment Authorization Request data sufficiently in advance of implementation to assist plans in identifying enrollees with complex, multiple, chronic or extensive

health care needs or high risk enrollees upon assignment or enrollment. CMS recommends that plans be provided these data at least 30 days prior to mandatory enrollment.

iv. In order to minimize possible care disruption, the state will require health plans to honor active Fee-For Service Treatment Authorization Requests for up to 60 days or until a new authorization is completed by the plan.

v. The State will work with CMS to establish a mechanism within its Money Follows the Person (MFP) Demonstration, "California Community Transitions," to increase opportunities for eligible individuals to access HCBS upon discharge from hospitals and nursing facilities as an alternative to institutional services.

85. **Plan Readiness and Contracts**

a. Plan Readiness – Initial and Ongoing

i. The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the mandatorily enrolled SPDs that ensures compliance with 42 CFR 438 and the Knox Keene Act prior to implementation. The final methodology will be developed in consultation with CMS and will include such items as specialist to beneficiary ratios based on data from the COHS, geo-mapping of FFS providers versus network providers, minimum standards regarding access to specialty providers and their capacity to serve individuals, physical and programmatic accessibility of the plan (including completion of facility site reviews before readiness) or other strategies to ensure adequate network resources to meet the needs of the individuals to be served by managed care in RIMC.

ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation.

iii. The State will complete network certifications for each county prior to implementation. Each county network certification will be done across the geographic area covered by the county.

iv. The State will submit any updates to the network adequacy procedures upon changes.

b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets as defined in the methodology are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply.

c. The State will submit to CMS for review and approval a list of deliverables/submissions for readiness that is being requested from plans (presently and on regular intervals), and a description of State approach to analysis and verification prior to implementation.

d. The State shall submit to CMS its plan for ongoing monitoring of plans, which must include the necessary elements in the network adequacy methodology. Beginning in year one of mandatory enrollment, monitoring must occur quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter until the quarter ending , December 31, 2015 for RIMC.

e. The State will submit to CMS for review the State's contingency plan for addressing insufficient network issues prior to implementation.

f. Items Necessary for Plan Readiness:

i. Care Coordination. The State shall submit to CMS their procedures for ensuring that each plan has sufficient resources and training available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging prior to implementation. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SPD population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

ii. Standardized Assessments. The State shall provide detailed information regarding the process to conduct health risk assessments for individuals at risk based on FFS data prior to implementation.

The State shall direct the plans to engage in a preliminary assessment/screen of needs of enrolled individuals within 44 days of enrollment.

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments.

iii. Care Continuity. Initial and Ongoing - The State shall ensure that the plans have mechanisms to provide continuity of care to SPD enrolled individuals in order to furnish seamless care with existing providers for a period of up to 12 months after enrollment and established procedures to bring providers into network.

The State shall submit to CMS the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended

period of care continuity for individuals with significant, complex or chronic medical conditions prior to implementation.

iv. Person-Centered Planning and Service Design. The State ensures that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee by the end of the first year of the Demonstration. While definitions and models of person-centered planning vary, the protocols shall at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

Specialty Healthcare Sufficient Provider Pool. The State shall ensure that each plan has a sufficient supply and continuum of providers to meet the unique needs of the population to be served as required by 42 CFR 438.206-207, the Knox Keene Act and other applicable state law and regulation. Such adequacy analysis can be based upon COHS plans data. For RIMC, the State will utilize current Fee-for-Service utilization data for matching against each health plan's network to assure an adequate network is in place to continue to provide all medically necessary care.

v. Geographic Accessibility. The State shall ensure that each plan has an accessible network (including specialty providers) with reasonable geographic proximity to the individuals enrolled as required by State statute and regulations, including the Knox Keene Act, taking into account the location of FFS providers, means of transportation ordinarily used by SPD enrollees, and taking into consideration community standards as necessary, including time and distance standards.

vi. Physical Accessibility. The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

vii. Interpreter Services - Information Technology. The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology

including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.

viii. Transportation – Specialized. The State will ensure that each plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.

ix. Fiscal Solvency (SPD-specific considerations). The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis.

x. The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c).

xi. Transparency. The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to SPDs.

The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.

xii. Timing. The State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

xiii. Access to non-network specialty providers. The State shall ensure that plans provide enrolled members timely access to non-network specialty providers as required by 42 CFR 438, State statute and regulations and the Knox Keene Act.

86. **Contract Requirements**. Each of the elements noted in 85 above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains:

a. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:

i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and
ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution. The State will encourage statewide use of a uniform discharge planning checklist (see Attachment B).

b. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using claims data and/or other available data sources, such as electronic health records (EHRs) and Health Information Exchange (HIE) as a source of clinical data on SPD enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements (including mechanisms for regular monitoring).

c. Expectations regarding plan obligation to link individuals to services outside of plan benefit packages.

d. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.

e. Requirements for each plan to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012.

f. Standardized notices to beneficiaries that meet all Federal and State legal requirements.

g. The State must ensure that a uniform Grievance System is in place and monitored by the State for enrolled individuals in each plan that includes a grievance process, an appeal process and access to the State's Fair hearing process as defined in the Medicaid statutory and regulatory requirements per 42 CFR 438 subpart F. This includes, but is not limited to the following:
i. Protocols for receiving, tracking and resolving grievances (complaints)
ii. Protocols for what to include in a Notice of Action when a service request is denied or reduced
iii. Protocols for receiving tracking and responding to Member Appeals including Notice of Decision including State Fair Hearing Request instructions

h. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable.

i. SPDs will be substantially involved in plan advisory groups and committees.

j. Provisions outlining when out-of-network care be provided.

k. Comprehensive health assessments for SPDs.

l. Coordination of carved out services based on FFS data.

m. A requirement for the plan to provide provider directories.

n. A requirement for the plan to provide a member services department that is available by toll-free call.

o. A requirement for the plan to provide information on 24-hour access to care.

87. **Information Technology.** The State will demonstrate to CMS that information technology is available and operational to meet all requirements set forth in these SPD STCs prior to implementation.

88. **Health Home Service Delivery Model.** The State will ensure that any health home delivery model developed through the Demonstration will comport with Section 1945 of the Social Security Act (the Act), and any applicable Federal future regulation or guidance on its implementation.

    Enhanced FMAP for health home services will only be available through the Demonstration, including for the Low Income Health Program, if the program design meets all applicable requirements of Section 1945 of the Act.

    The State will assure a mechanism for tracking appropriate health home services to receive the enhanced FMAP.

    The State will submit detailed information on health home program design in a manner specified by CMS for approval prior to the State's implementation of the design.

89. **Participant Rights and Safeguards**

    a. Information - All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

    b. Disenrollment - Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities regularly and in a manner consistent with 42 CFR 438 and other requirements set forth in the Demonstration terms and conditions.

90. **Quality Oversight and Monitoring.** In addition to all quality requirements set forth in 42 CFR 438, the State will ensure the following:

a. Encounter Data - The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by seniors and persons with disabilities, in a manner that enables the State to assess performance by plan, by county, and Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data on SPDs from each plan is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the Demonstration. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

b. Measurement Activities - The State will collect data and information on the following measures to ensure ongoing monitoring of individual wellbeing and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

   The State will comply with the plan approved by CMS on October 2, 2014 for developing and implementing additional HEDIS and QIP measures specific to the SPD population (as opposed to the general HEDIS and QIP measures).

c. In addition to HEDIS and Existing CAHPS tools currently utilized, the State will consider the use of OASIS measures or other measures. The State shall also require the mandatory utilization of measures related to:
   i. Avoidable Hospitalizations
   ii. Hospital Readmissions
   iii. Emergency Room Utilization
   iv. Outcome measures related to person-centered care planning and delivery

   The State will continue to collect and report performance measurement results for all managed care plan members and begin reporting statistically significant stratified results for mandatory SPDs once these members have had one year of continuous enrollment in managed care.

d. Stratification and Analysis by County and Plan - For all data collected from MCOs, and COHS the State will be able to stratify information by population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the counties and the plans.

91. **Notice of Change in Implementation Timeline**. The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified above.

92. **Withholding Approval.** At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

93. **Applicability to Existing COHS Plans.** The State will ensure that COHS Plans formerly operating under 1915(b) authority prior to approval of this Demonstration or those COHS plans expanding in 2011 (Ventura, Marin and Mendocino counties) will meet the requirements in these STCs within a 2-year period after approval of this Demonstration or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

94. **Applicability to Future COHS Expansions.** The State will ensure that the 2013 managed care COHS expansion and any new COHS expansions that are implemented subsequent to this Demonstration with the exception of those COHS plans (Ventura, Marin and Mendocino counties) will meet the terms in this Section (B), or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

D. Community-Based Adult Services (CBAS) and Enhanced Case Management (ECM) for Medi-Cal State Plan Populations

95. Community-Based Adult Services (CBAS) Eligibility and Delivery System. "Community Based Adult Services" is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, care coordination, and transportation to eligible State Plan beneficiaries.

a. CBAS Recipients are those persons who:
   i. Are age 18 years and older;
   ii. Derive their Medicaid eligibility from the State Plan and are either aged, blind, or disabled; including those who are recipients of Medicare.
   iii. Are Medi-Cal managed care plan members or are exempt from enrollment in Medi-Cal managed care.
   iv. Reside within a geographic services area in which the CBAS benefit was available as of April 1, 2012, as more fully described in STC 95(b), or are determined eligible for the CBAS benefit by managed care plans that contract with CBAS providers pursuant to STC 95(b) and STC 98(a)(ii).

b. Delivery System.
   i. CBAS is a Medi-Cal managed care benefit in counties where CBAS existed on April 1, 2012. To the extent that the provision of CBAS is determined by DHCS to

be both cost-effective and necessary to prevent avoidable institutionalization of plan enrollees within a plan's service area in which CBAS was not available as of April 1, 2012, CBAS may be a Medi-Cal managed care benefit pursuant to STC 98(a)(ii) available to that plan's enrollees at the discretion of the plan when it contracts with a CBAS provider that has been certified as such by DHCS. The State must ensure that plans have mechanisms to provide care coordination, person-centered planning continuity-of-care, out-of-network care, and other provisions related to newly enrolled managed care beneficiaries as described in STC 85.f.

ii. CBAS shall be available as a Medi-Cal fee-for-service benefit for individuals who do not qualify for, or are exempt from enrollment in, Medi-Cal managed care as long as the individual resides within the geographic service area where CBAS is provided.

iii. If there is insufficient CBAS Center capacity due to Center closure(s) to satisfy demand in counties where CBAS centers existed as of April 1, 2012, the State Medicaid Agency must assure that eligible CBAS beneficiaries that had received CBAS at the closed Center(s) have access to unbundled CBAS as needed for continuity of care and subject to the following general procedures:

1. Managed care beneficiaries: For managed care beneficiaries who are eligible for CBAS and there is a 5% change from County capacity as of April 1, 2012, in the area, the MCO will authorize unbundled services and facilitate utilization through care coordination.
2. Fee-for-Service beneficiaries: For FFS beneficiaries who are eligible for CBAS and there a 5% change from County capacity as of April 1, 2012, in the area, the following procedures will apply:
    - DHCS will work with the local CBAS Center network and beneficiary's physician to identify other available CBAS Centers, and the type, scope and duration of the CBAS the beneficiary needs.
    - DHCS will work with the beneficiary's physician to arrange for
        - needed nursing services,
        - referral to, or reassessment of, In-Home Supportive Services as needed for personal care services (or authorization of waiver personal care services needed in excess of the IHSS cap).
    - If the beneficiary needs therapeutic services, DHCS will work with the beneficiary's physician to coordinate the authorization of needed services.
    - If the beneficiary needs mental health services, DHCS will work with the beneficiary's physician to refer the beneficiary to the local mental health services program.

iv. In the event of a negative change in capacity of 5% or greater in any county for any reason, DHCS shall identify in the quarterly report for the same quarter as the negative change the provider capacity in that county for providing all core and additional CBAS services (as listed in STCs 96(a) and 96(b)) on an unbundled basis.

c. Home and Community-Based Settings. The state must ensure that home and community-based settings have all of the qualities required by 42 CFR 441.301(c)(4), and other such qualities as the secretary determines to be appropriate based on the needs of the individual as indicated in their person-centered plan. In a provider owned or controlled setting, the additional qualities required by CFR 441.301(c)(4)(vi) must be met. The state will engage in a CBAS stakeholder process to amend the HCB settings statewide transition plan to ensure that all home and community-based settings found in the 1115 Demonstration have all of the qualities required by 42 CFR 441.301(c)(4). The state will amend the statewide transition plan to include all HCBS settings used by individuals in the 1115 Demonstration and submit to CMS no later than September 1, 2015, to ensure complete compliance with HCB Settings by March 17, 2019.

d. CBAS Program Eligibility Criteria. The CBAS benefit shall be available to all beneficiaries who meet the requirements of STC 95(a) and for whom CBAS is available based on STC 95(b), who meet medical necessity criteria as established in state law and who qualify based on at least one of the medical criteria in (i) through (v):
   i. Meet or exceed the "Nursing Facility Level of Care A" (NF-A) criteria as set forth in the California Code of Regulations; OR
   ii. Have a diagnosed organic, acquired or traumatic brain injury, and/or chronic mental disorder. "Chronic mental disorder" means the enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilia, (m) Eating Disorders, (n) Impulse Control Disorders Not Elsewhere Classified (o) Adjustment Disorders, (p) Personality Disorders, or (q) Medication-Induced Movement Disorders. In addition to the presence of a chronic mental disorder or acquired, organic, or traumatic brain injury, the enrollee shall need assistance or supervision with either:
      A. Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or
      B. One need from the above list and one of the following: money management; accessing community and health resources; meal preparation, or transportation; OR.
   iii. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 of the Alzheimer's Type; OR
   iv. Have a mild cognitive disorder such as dementia, including Dementia of the Alzheimer's Type, AND need assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; OR
   v. Have a developmental disability. "Developmental disability" means a disability, which originates before the individual attains age 18, continues, or can be expected

to continue indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

e. CBAS Eligibility Determination.
Eligibility determination for the CBAS benefit will be performed as follows:
   i. The initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by the State Medicaid Agency unless criteria under 95 (e)(ii) are met. The eligibility determination will be conducted by the beneficiary's managed care plan, or by the State Medicaid Agency or its contractor(s) for beneficiaries exempt from managed care.
   ii. An 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.
   iii. 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.
   iv. Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by a managed care plan requires a face-to-face review.

f. Grievances and Appeals
   i. A beneficiary who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
   ii. A CBAS participant may file a grievance with their Managed Care Organization as a written or oral complaint. The participant or their authorized representative may file a grievance with the participant's Managed Care Organization at any time they experience dissatisfaction with the services or quality of care provided to them, and as further instructed by the MCO.

96. CBAS Benefit and Individual Plan of Care (IPC).
CBAS benefits include the following:

a. Core Services: Professional nursing care, personal care and/or social services, therapeutic activities, and a meal shall be provided to all eligible CBAS beneficiaries on each day of service as follows.
   i. Professional nursing services provided by an RN or LVN, which includes one or more of the following, consistent with scope of practice: observation, assessment, and monitoring of the beneficiary's general health status; monitoring and assessment of the participant's medication regimen; communication with the beneficiary's personal health care provider; supervision of personal care services; and provision of skilled nursing care and interventions.
   ii. Personal care services provided primarily by program aides which include one or more of the following: supervision or assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs); protective group supervision and interventions to assure participant safety and to minimize risk of injury, accident, inappropriate behavior, or wandering.

iii. Social services provided by social work staff, which include one or more of the following: observation, assessment, and monitoring of the participant's psychosocial status; group work to address psychosocial issues; care coordination.
iv. Therapeutic activities organized by the CBAS center activity coordinator, which include group or individual activities to enhance social, physical, or cognitive functioning; facilitated participation in group or individual activities for CBAS beneficiaries whose physical frailty or cognitive function precludes them from independent participation in activities.
v. A meal offered each day of attendance that is balanced, safe, and appetizing, and meets the nutritional needs of the individual, including a beverage and/or other hydration. Special meals will be provided when prescribed by the participant's personal health care provider.

b. Additional Services. The following additional services shall be provided to all eligible CBAS beneficiaries as needed and as specified on the person's IPC:
   i. Physical therapy provided by a licensed, certified, or recognized physical therapist within his/her scope of practice.
   ii. Occupational therapy provided by a licensed, certified, or recognized occupational therapist within his/her scope of practice.
   iii. Speech therapy provided by a licensed, certified, or recognized speech therapist within his/her scope of practice.
   iv. Behavioral health services for treatment or stabilization of a diagnosed mental disorder provided by a licensed, certified, or recognized mental health professional within his/her scope of practice. Individuals experiencing symptoms that are particularly severe or whose symptoms result in marked impairment in social functioning shall be referred by CBAS staff to the identified managed care plan, County Mental Health programs, or appropriate behavioral health professionals or services.
   v. Registered dietician services provided by a registered dietician for the purpose of assisting the CBAS beneficiary and caregivers with proper nutrition and good nutritional habits.
   vi. Transportation, provided or arranged, to and from the CBAS beneficiary's place of residence and the CBAS center, when needed.

c. Individual Plan of Care (IPC).
   The IPC is a written plan designed to provide the CBAS beneficiary with appropriate treatment in accordance with the assessed needs of the individual, as determined by the CBAS center and as specified in State law. The IPC is submitted as supporting documentation for level of service determination with the treatment authorization request.

   The person-centered planning process will, with further development in the CBAS stakeholder process, be completed no later than September 1, 2015, comply with the requirements at 42 CFR 441.301(c)(1) through (3) including specifying: 1) How the IPC will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the IPC will allow the enrollee to participate fully in any treatment or service planning discussion or meeting,

including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the IPC will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the IPC process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

The IPC is prepared by the CBAS center's multidisciplinary team based on the team's assessment of the beneficiary's medical, functional, and psychosocial status, and includes standardized components approved by the State Medicaid Agency. Development of the IPC is based on principles of Person-Centered Planning, which is an individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences for the delivery of services and supports. Person-Centered Planning includes consideration of the current and unique bio-psycho-social-cultural and medical needs and history of the individual, as well as the person's functional level, support systems, and continuum of care needs. CBAS center staff, the beneficiary, and his/her support team shall review and update the beneficiary's IPC at least every six months or when there is a change in circumstance that may require a change in benefits. Such review and updates must include an evaluation of progress toward treatment goals and objectives, and reflect changes in the beneficiary's status or needs. The IPC shall include at a minimum:

i. Medical diagnoses.
ii. Prescribed medications.
iii. Scheduled days at the CBAS center.
iv. Specific type, number of service units, and frequency of individual services to be rendered on a monthly basis.
v. Elements of the services that` need to be linked to individual objectives, therapeutic goals, and duration of service(s).
vi. An individualized activity plan designed to meet the needs of the enrollee for social and therapeutic recreational activities.
vii. Participation in specific group activities.
viii. Transportation needs, including special transportation.
ix. Special diet requirements, dietary counseling and education, if needed.
x. A plan for any other necessary services that the CBAS center will coordinate.
xi. IPCs will be reviewed and updated no less than every six months by the CBAS staff, the enrollee, and his/her support team. Such review must include a review of the participant's progress, goals, and objectives, as well as the IPC itself.

97. CBAS Provider Specifications.

CBAS center staff shall include licensed and registered nurses; licensed physical, occupational, and speech therapists; licensed behavioral health specialists; registered dieticians; social workers; activity coordinators; and a variety of other non-licensed staff such as program aides who assist in providing services.

a. Licensed, registered, certified, or recognized staff under California State scope of practice statutes shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.
b. All staff shall have necessary experience and receive appropriate on-site orientation and training prior to performing assigned duties. All staff will be supervised by CBAS center or administrative staff.

c. The State Medicaid Agency maintains Standards of Participation for all CBAS providers are found in Attachment W to these STCs. These Standards of Participation are hereby incorporated by reference and can be found on the Department of Health Care Services and California Department of Aging (CDA) websites. Any changes in the CBAS Provider Standards of Participation must be approved by CMS.

98. Responsibilities of Managed Care Plans for CBAS Benefits

The responsibilities of managed care plans for the CBAS benefit shall be consistent with each individual managed care plan's contract with DHCS and with these STCs and shall include that plans do the following.

a. Contract Requirements for Managed Care Plans:
   i. Contract with sufficient available CBAS providers in the managed care plans' covered geographic areas to address in a timely way the needs of their members who meet the CBAS eligibility criteria in 95(d). Sufficient means: providers that are adequate in number to meet the expected utilization of the enrolled population without a waitlist; geographically located within one hour's transportation time and appropriate for and proficient in addressing enrollees' specialized health needs and acuity, communication, cultural and language needs and preferences.
   ii. Plans may, but are not obligated to, contract for CBAS with providers licensed as ADHCs and authorized by the Department to provide CBAS on or after April 1, 2012. Plans are not obligated to develop new CBAS networks or capacity in geographical areas where CBAS capacity is limited or where ADHC was not available prior to April 1, 2012;
   iii. Where there is insufficient or non-existent CBAS capacity in the plan's covered geographic area and ADHC had been available prior to April 1, 2012, the plan shall arrange for the delivery of appropriate plan-covered benefits and coordinate with community resources to assist members, who have similar clinical conditions as CBAS recipients, to remain in the community.
   iv. Confirm that every contracted CBAS provider is licensed, certified, operating, and meets the managed care plan's credentialing and quality standards.
      A. The managed care plan may exclude any CBAS provider, to the extent that the managed care plan and CBAS provider cannot agree to terms, the CBAS provider does not meet the plan's credentialing or quality standards, is terminated pursuant to the terms of the CBAS provider's contract with the managed care plan, or otherwise ceases its operations as a CBAS provider.
      B. The managed care plan shall provide the State Medicaid Agency a list of its contracted CBAS providers and its CBAS accessibility standards on an annual basis.

b. Eligibility and Authorization: Develop and implement policies and procedures for CBAS eligibility determination and authorization that address the eligibility criteria set forth in STC 95, the processes and timelines in State law, and all of the following:
   i. Face-to-face eligibility determination (F2F) review requirements: the minimum standard is that the managed care plan will conduct an F2F eligibility determination for those beneficiaries who have not previously received CBAS through the plan, provided that the managed care plan has not already determined through another

process that the member is clinically eligible for CBAS and in need for the start of CBAS to be expedited.

ii. Timeline for eligibility determination: the plan shall complete the F2F eligibility determination using the standard State-approved tool, as soon as feasible but no more than 30 calendar days from the initial eligibility inquiry request. The plan shall send approval or denial of eligibility for CBAS to the CBAS provider within one business day of the decision and notify the member in writing of his/her CBAS eligibility determination within two business days of the decision.

iii. Timeline for service authorization: After the CBAS eligibility determination and upon receipt of the CBAS treatment authorization request and individual plan of care (IPC), the plan shall:

A. Approve, modify or deny the authorization request within five business days of receipt of the authorization request, in accordance with State law.

B. Determine level of service authorization (i.e., days per week authorized) based on the plan's review of the IPC submitted by the CBAS provider, consideration of the days per week recommended by the CBAS multidisciplinary team, and the medical necessity of the member.

C. Notify the provider within one business day of the authorization decision. Notify the member within two business days of the authorization decision, including informing the member of his/her right to appeal and grievance processes in accordance with 95(f).

iv. Timeline, process, and criteria for expedited eligibility determination and authorization for CBAS such that an F2F will not be performed. At a minimum, expedited authorization shall occur within 72 hours of receipt of a CBAS authorization request for individuals in a hospital or nursing facility whose discharge plan includes CBAS, or when the individual faces imminent and serious threat to his or her health.

v. Written notices to the beneficiary shall include procedures and contacts for grievances and appeals.

vi. Guidelines for level of service authorization, including for the number of days per week and duration of authorization up to 12 months.

vii. Continuity of care: The managed care plan shall ensure continuity of care when members switch health plans and/or transfer from one CBAS center to another.

c. Coordination with CBAS Providers: Coordinate member care with CBAS providers to ensure the following:

i. CBAS IPCs are consistent with members' overall care plans and goals developed by the managed care plan.

ii. Exchange of participant discharge plan information, reports of incidents that threaten the welfare, health and safety of the participant, and significant changes in participant condition are conducted in a timely manner and facilitate care coordination.

iii. Clear communication pathways to appropriate plan personnel having responsibility for member eligibility determination, authorization, care planning, including identification of the lead care coordinator for members who have a care team, and utilization management.

iv. Written notification of plan policy and procedure changes, and a process to provide education and training for providers regarding any substantive changes that may be implemented, prior to the policy and procedure changes taking effect.

99. CBAS Center Provider Oversight, Monitoring, and Reporting.

The State shall maintain a plan for oversight and monitoring of CBAS providers to ensure compliance and corrective action with provider standards, access, and delivery of quality care and services. Reporting of activity associated with the plan must be consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements and reported to CMS on a quarterly basis. Such oversight, monitoring and reporting shall include all of the following:

a. Enrollment Information: to include the number of CBAS FFS and MCO beneficiaries in each county the capacity of each county -, total determined eligible and ineligible beneficiaries per county quarterly, and explanation of probable cause of any negative change from quarter to quarter of more than five percent and description of any steps taken to address such variances.
b. The monthly CBAS provider-reported data submitted to the CDA, identifying participant statistics, average daily attendance utilization at Centers, and capacity data.
c. Summary of operational/policy development/issues, including complaints, grievances and appeals. The State shall also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.
d. Summary of all quality assurance/monitoring activity undertaken in compliance with STC 100, inclusive of all amendments.
e. CBAS FFS and Managed Care Access Monitoring. The State Medicaid Agency will assure sufficient CBAS access/capacity, through the mechanisms listed below, in every county where CBAS existed as of April 1, 2012.
   i. Review the total number of individuals receiving a new assessment for CBAS vs. the total number of individuals obtaining ongoing CBAS and the number of participants obtaining unbundled services. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.
   ii. Review of overall utilization of CBAS, including newly opened or closed Centers. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.
   iii. Review of FFS and MCO grievances and appeals by CBAS enrollees for areas including but not limited to: appeals related to requesting services and not able to receive services or receiving more limited services than requested, excessive drive/ride times to access CBAS, grievances around CBAS providers, grievances around FFS or MCO staff in assessment, any reports pertaining to health and welfare of individuals utilizing CBAS, and any reports pertaining to requesting a particular CBAS provider and unable to access that provider. CMS requires the State to report and review these metrics quarterly and upon a negative change from

quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.

iv. A review of any other beneficiary or provider call center/line for complaints surrounding the provision of CBAS benefits through FFS or the MCOs. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as a corrective action plans that addresses such variances.

v. Review the CBAS provider capacity per county vs. the total number of beneficiaries enrolled for CBAS each quarter. CMS requires the State to report and review these metrics quarterly and upon a negative change from quarter to quarter of more than 5%, the State must provide a probable cause for the negative change as well as an analysis that addresses such variances.

vi. Evidence of sufficient access monitoring and corrective action plans must be provided to the regional office annually and at any other time a significant impact to the MCO's operations are administered

vii. If it is found that the State did not meet the monitoring mechanisms listed above, CMS reserves the right to withhold a portion or all of FFP related to CBAS until which time the State provides adequate documentation assuring sufficient access.

100. CBAS Quality Assurance and Improvement Strategy.

Quality assurance and monitoring of CBAS shall be consistent with the managed care Quality Strategy required by 42 CFR Part 438 Subpart D which is integrated into the DHCS contracts with managed care plans statewide. Such a Quality Assurance and Improvement strategy shall assure the health and safety of Medi-Cal beneficiaries receiving CBAS and shall address, at a minimum, all of the following:

a. The quality and implementation of the CBAS beneficiary's person-centered IPC.
b. The provider's adherence to State licensure and certification requirements.
c. Financial oversight by the State Medicaid Agency, and
d. Administrative oversight of the managed care plans by the State Medicaid Agency.

101. CBAS Provider Reimbursement.

a. DHCS shall reimburse CBAS providers serving eligible Medi-Cal beneficiaries who are exempt from enrollment in Medi-Cal managed care at an all-inclusive rate per day of attendance per beneficiary. DHCS shall publish such rates.
b. Managed care plans shall reimburse contracted CBAS providers pursuant to a rate structure that shall include an all-inclusive rate per day of attendance per plan beneficiary, or be otherwise reflective of the acuity and/or level of care of the plan beneficiary population served by the CBAS providers. Plan payments must be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services were available to the respective Medi-Cal population as of April 1, 2012. Managed care plans may include incentive payment adjustments and performance and/or quality standards in their rate structure in paying CBAS providers.

E. **California Children's Services (CCS)**

102. CCS Pilot Programs Approval. With at least 180 days-notice and after CMS approval the State may submit a plan to test up to four health care delivery models for children enrolled in the California Children's Services (CCS) Program. The plan shall include provisions to ensure adequate protections for the population served, including a sufficient network of appropriate providers and timely access to out of network care. The plan shall also include specific criteria for evaluating the models. These CCS pilot models shall be eligible for FFP from the Date of CMS approval through December 31, 2015.

103. CCS Pilot Program Protocol. The overarching goal of the CCS pilot project is for the State to identify the model or models of health care delivery for the CCS population that results in achieving the 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. CMS will evaluate the submitted pilot projects based on the criteria included in the plans and the following:

a. A Program Description – inclusive of eligibility, benefits, cost sharing;
b. Demonstration Program Requirements - inclusive of eligibility, enrollment, benefits, and cost-sharing;
c. Budget/Allotment Neutrality projections
d. Outcomes for -
    i. Ensuring that the CCS population has access to timely and appropriate, high quality and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.
    ii. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
    iii. Increasing satisfaction with both the delivery of and the reimbursement of services among providers who serve the CCS population.
    iv. Improving the State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
    v. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
    vi. Reducing the annual rate of growth of expenditures for the CCS population.
e. Use up to four models of care for care delivery:
    i. An Enhanced Primary Care Case Management (EPCCM) Program;
    ii. A Provider-based Accountable Care Organization (ACO);
    iii. A Specialty Health Care Plan (SHCP); and
    iv. Utilization of existing Medi-Cal Managed Care Plans.

F. **Healthy Families Program Children Transitioning to Medicaid Expansion Demonstration (HFPCTD)**

The objective of this amendment is to provide California with time-limited Section 1115 expenditure authority in order to phase-in a population of approximately 850,000 children from a separate program to a Medicaid expansion. Beginning no sooner than January 1, 2013, California will begin to transition children from its separate CHIP (Healthy Families Program/HFP) that covers children with incomes up to and including 250 percent of the Federal poverty level (FPL) to a demonstration Medicaid expansion population. For individuals in the demonstration Medicaid expansion population, coverage is otherwise identical to Medi-Cal. The demonstration authority will allow California to include in the demonstration Medicaid expansion population only those children who it can operationally shift to the Medi-Cal healthcare delivery system. In addition to the children transitioning from the HFP, the demonstration Medicaid expansion population will also include all new enrollees as of January 1, 2013. Once the transition period is complete, the children enrolled in this demonstration Medicaid expansion population will be made eligible under the Medicaid state plan, and the demonstration authority will expire. This transition, subject to CMS' approval of each phase, is proposed to occur over approximately a 9 month period, but no later than December 31, 2013, when the authority for this demonstration amendment will expire.

104. Definitions

a**.** Demonstration Medicaid expansion population. Children qualifying as transition children as defined in STC 103(b) or new enrollees as defined in STC 103(d).

b. Transition children. Uninsured children ages 0 through 18 with incomes up to and including 250 percent of the Federal poverty level (FPL), who have met the title XXI definition of a targeted low-income child at §457.310 (based on a previous HFP eligibility determination) and are eligible for one of the transition phases defined below.

c. Transition phases.
   i. *Phase 1 - Part A:* Children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence.
   ii. *Phase 1 - Part B:* Additional children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence.
   iii. *Phase 1 – Part C:* Remaining children enrolled in a HFP health plan that is also a Medi-Cal managed care health plan in their county of residence.
   iv. *Phase 2:* Children enrolled in a HFP health plan that is a subcontractor of a Medi-Cal managed care health plan, in their county of residence.
   v. *Phase 3:* Children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan.
   vi. *Phase 4:* Children enrolled in the HFP residing in a county that is not currently a Medi-Cal managed care county.

d. New enrollees. Uninsured children ages 0 through 18 with incomes up to and including 250 percent of the FPL, applying for coverage on or after January 1, 2013, who meet the title XXI definition of a targeted low-income child at §457.310 and would have previously been determined to be eligible for coverage in the HFP.

105. Implementation of Transition Children Enrollment Phase-in

a. Implementation of Phase 1a-Phase 4: Transition children will be phased into the Medicaid expansion demonstration in four phases and the anticipated schedule for this phase-in is described below in 104(b-g). However, the state must demonstrate the successful provision of coverage to children in previous phases, as well as provider network adequacy (including geographic access) and appropriate plans for maintaining continuity of care, prior to implementing each subsequent phase, and prior to receiving CMS approval to implement each subsequent phase. To the extent an unanticipated problem(s) be identified by CMS or the state during the implementation process, CMS may request additional information prior to approval of any subsequent phase. In the absence of sufficient evidence from the state demonstrating that identified problem(s) with previous or pending phases have been resolved, CMS may delay implementation of any phase. Written approval from CMS is necessary prior to the implementation of each phase.
b. Phase 1a: Beginning no sooner than January 1, 2013, approximately 197,000 transition children in phase 1a will be made eligible under the demonstration Medicaid expansion population and, to the extent possible, remain enrolled in the same health plan as they were in the HFP.
c. Phase 1b: Beginning no sooner than March 1, 2013, approximately 95,000 transition children in phase 1b will be made eligible under the demonstration Medicaid expansion population and, to the extent possible, remain enrolled in the same health plan as they were in the HFP.
d. Phase 1c: Beginning no sooner than April 1, 2013, approximately 87,000 transition children in phase 1c will be made eligible under the demonstration Medicaid expansion population and, to the extent possible, remain enrolled in the same health plan as they were in the HFP
e. Phase 2: Beginning no sooner than April 1, 2013, approximately 269,000 transition children in phase 2 will be made eligible under the demonstration Medicaid expansion population and enrolled into a Medi-Cal health plan in their county. To the extent possible, transition children in Phase 2 will be enrolled in a health plan operated by the Medi-Cal managed care plan that contracted with the child's HFP health plan.
f. Phase 3: Beginning no sooner than August 1, 2013, approximately 200,000 transition children in phase 3 will be made eligible under the demonstration Medicaid expansion population and will be enrolled in a Medi-Cal health plan in their county.
g. Phase 4: Beginning no sooner than September 1, 2013, approximately 50,000 transition children in phase 4 will be made eligible under the demonstration Medicaid expansion population and will receive services through the Medi-Cal fee-for-service system. To the extent the department is successful in its efforts to create managed care delivery systems in these counties, the children will be enrolled into the managed care health plans.

106. Eligibility and Enrollment Process

a. Eligibility criteria.

i. *Transition children.* In order to be enrolled in the demonstration Medicaid expansion population, transition children must meet the definition of STC104.b.above and must be in a phase described in STC 104.c. that the state has been authorized to implement

in accordance with STC 105. Transition children that do not meet this definition will remain enrolled in HFP under the title XXI separate program.

ii. *New enrollees.* Children applying for coverage after January 1, 2013 will be determined eligible for the demonstration Medicaid expansion population based on the same eligibility criteria previously employed by the HFP. Children that would have been found eligible for the HFP in December 2012 will, in the aggregate, be found eligible for the demonstration Medicaid expansion population beginning January 1, 2013. Individuals will be able to apply at either the County human services department, via in person, mail, phone, online or through the existing Single Point of Entry (SPE), which is operated by the state's administrative vendor. Applications received directly at the county will continue to be screened for Medi-Cal eligibility. Applications received at the SPE will be provided with an initial eligibility screen, including a determination as to whether individuals qualify for presumptive eligibility (referred to as "accelerated enrollment," in California). Subsequent to this initial screen, applications will be transferred to the individual counties (and their Statewide Automated Welfare System Consortia (SAWS) systems). Detailed information on how applications will be processed for transition children can be found at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf

1. Once determined eligible for the demonstration Medicaid expansion population, new enrollees will be promptly enrolled in a Medi-Cal managed care plan serving their county, following existing state enrollment process, unless they reside in a county with no participating Medi-Cal managed care plan, in which case, they will receive services through the Medi-Cal fee-for-service delivery system.

b. Application of Medicaid rules – With the exception of the limited enrollment to implement a phase-in of transition children in accordance with STC 105.a., all Medicaid rules (including eligibility, benefits, cost sharing, grievances and appeals, and managed care) will apply to this demonstration Medicaid expansion population.

c. "Automatic" enrollment. The state will rely on the eligibility determinations previously made by the HFP for all transition children being made eligible for the demonstration Medicaid expansion population. A new application, or further documentation, will not be required, or requested, at the time transition children are made eligible under the demonstration Medicaid expansion population. California will inform all families with children made eligible for the demonstration Medicaid expansion population that, if they experience a change in circumstances, they may request a new eligibility determination and they may also request a review of income used to determine premium levels.

d. Annual renewal. The annual review of the case will not be due until one year after the HFP last reviewed the case (the HFP renewal date). The state must ensure that all information that has been previously collected for transition children in the HFP is successfully transferred to Medi-Cal and that upon renewal families are not required to provide the same information that has already been collected by the state. The state must also ensure that if a child's annual renewal is delayed due to workload or system

limitations, the child will remain enrolled until such time as the renewal can be appropriately conducted without undue burden placed on the family. The state will monitor, by county, the timely renewal of transitioned children and report to CMS if renewals are not being conducted in a timely manner.

107. Public Engagement. The state must continue to provide easily accessible and up-to-date information to stakeholders, including information provided on its existing HFP website, and contact information for questions regarding the transition. In addition, the state must continue to regularly convene meetings with counties, consortia, and other stakeholders to discuss transition issues, identify any problems or concerns and develop solutions.

108. Notices to Children and their Families

a. CMS Review of Enrollee Communication. The state will submit to CMS, 10 days in advance of finalizing the notice for production, any written communication from the state to enrollees to be used to explain the transition, for CMS review and comment. Offers of individual assistance should be clearly set forth in materials developed by both the state and the health plans. The state will also submit to CMS for review and comment any directional memoranda or guidance documents to the counties, plans, and providers.

b. Readability and Accessibility**.** All informing and educational materials should be clear, easy to read, and provide the information families need to help them navigate the transition, be reviewed by a health literacy expert, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

c. Content and Timing. The state must provide written notice to transitioning children at least 60 days prior to the start of Phase 1, and at least 90 days prior to the start of Phases 2 through 4. The state must also provide a personalized reminder notice 30 days prior to each phase, starting with Phase 1B, of the transition. The notices must explain that all children will have coverage throughout the transition, and provide detailed information on how to access physical, dental, mental health, substance use disorder, and vision services, continuity-of-care rights, and what to do if a family has a problem accessing care.

109. Consumer Assistance. Consumer assistance will be available to families both during and after the transition.

a. Call Centers: The state will use the HFP, Medi-Cal and Medi-Cal Managed Care, and Mental Health Ombudsman and Health Care Options call centers to provide information and assistance to families during and after the transition of children from HFP to Medi-Cal. It will ensure that all of these entities are trained to assist families and will coordinate educational material to provide accurate and consistent responses to questions from families.

b. Community-based assistance groups: The state will ensure that community-based assistance groups (e.g., certified application assisters) are adequately informed to

help families of transitioning children continue to maintain enrollment and access to care.

c. State Review of Beneficiary Complaints, Grievances, and Appeals to Managed Care Organizations: The state must review quantity and type of complaints, grievances, and appeals for each MCO and data from the state or MCO call centers, to understand what issues beneficiaries and providers are having with the transition. The state will use this information to implement any immediate corrective actions necessary. The state must review these statistics at least weekly for the first 90 days, and monthly, thereafter. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS.

110. Beneficiary Surveys. Beneficiary surveys will be conducted on a statistically significant sample of transition children. The surveys will determine beneficiary perceptions related to access to care in Medi-Cal (including primary care, medical and dental specialty care, dental, mental health and substance use disorder services). Additionally, the survey will ask questions about families' overall experiences during and after the transition. The first survey will be conducted within the first 60 days of the transition of Phase 1a, and will be repeated quarterly. Survey populations will include families of children in each phase of transition and families accessing the range of services described above (primary care, medical and dental specialty care, dental, mental health and substance use disorder services). The state will submit survey questions to CMS for review and feedback prior to distribution, and survey findings will be submitted to CMS upon completion of each survey.

111. Delivery System. Individuals eligible under the demonstration Medicaid expansion population will receive health care through a Medi-Cal managed care health plan where available. Children living in counties where Medi-Cal managed care is available will be required to be enrolled in a health plan, and will receive default assignments as indicated in STC 104 or, if not indicated there, under the state's normal default assignment rules. Nothing in these STCs exempts the state from managed care requirements at 42 CFR 438.

112. Benefits. The benefits provided to the demonstration Medicaid expansion population are the same as those specified in California's Medicaid state plan for categorically needy children through 18, including all services the state is required to cover under §440.210(a)(1) (including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) at §441 subpart B), and all services it has opted to cover under §440.225. The state must provide a written description to CMS of how it will ensure continuity of care in each transition phase for children receiving all types of services, including primary and specialty medical care, dental treatment, and mental health and substance use disorder services.

a. Dental Services. Dental services for the demonstration Medicaid expansion population will be covered under the Medi-Cal fee-for-service program, known as Denti-Cal, with the following exceptions. Children in Los Angeles County will choose between Denti-Cal and a dental managed care plan. Children in Sacramento County will be required to enroll into a dental managed care plan (unless qualified for the beneficiary exception process). In Sacramento, if a child's HFP dental plan is *not* a Medi-Cal

dental managed care plan then the child will be automatically enrolled into a plan. In Los Angeles, if a child's HFP plan is *not* a Medi-Cal dental managed care plan the child will be automatically enrolled into Denti-Cal fee-for-service if they have not already made an active choice of a dental managed care plan.

i. *Consumer Assistance for Dental Services.* The state must employ strategies to ease the transition for children who will have to change plans and/or providers, as well as assess outcomes in this area.

1. Denti-Cal Beneficiary Customer Service Line – The state will improve its current Denti-Cal Beneficiary Customer Service line referral process by having a customer service representative remain on the line while transferring a family member to a dental provider who has actively indicated that he or she is accepting new patients. The customer service representative will also help the family member secure an appointment for the child (if requested). The state must collect information on a monthly basis on the number of provider referral calls. The report should also list outcomes, including requests unresolved, and resolved, on locating providers to provide the necessary services to the beneficiary, and number of beneficiaries referred out of county. In addition, the state must ensure that a process is in place to identify providers listed on the referral list who are not actively accepting new patients and to document and outreach to those geographical areas that are lacking sufficient providers willing to accept new patients. This information will be reported to CMS on a monthly basis.
2. Denti-Cal Website - The state must maintain on its website a current and accurate list of dentists providing care to children enrolled in Denti-Cal, including dentists who treat children with special health care needs, and must submit data to the Insure Kids Now website, as required by Section 2108(f) of the Act, on a quarterly basis. CMS will provide technical assistance to the state on strategies to enhance the quality and accuracy of the data.
3. Dental Informing Materials – The state must ensure that dental-specific informing materials are mailed to all children as they transition to Medi-Cal.

ii. *Dental Provider Recruitment and Simplification of Administrative Requirements***.** In partnership with the dental community, the state must establish new incentives to increase provider participation in Denti-Cal, and identify and eliminate existing administrative barriers.

1. Provider Survey - A survey must be sent to providers to assess provider capacity, ability to accept new clients, and identify barriers to enrollment, prior to implementation of each phase.
2. Streamlined Provider Application and Enrollment Process - The state must streamline its process for provider enrollment in Denti-Cal, including elimination of the requirement for a hard copy provider signature on the application in order to be added to the online Denti-Cal provider directory. Dentists may request Preferred Provisional Provider status, which enables providers credentialed with a Knox Keene plan to begin treating and billing for Medicaid patients while

Denti-Cal credentialing is pending, for up to 18 months. PPP applicants submit a cover letter and DHCS 6204 or 6203 with supporting documentation. In addition, providers must be allowed to request inclusion, removal, or updating of information, on the Denti-Cal provider directory by phone, email, fax, or mail. The state must also contact providers for any additional information needed to complete the provider application, and notify the provider once he/she has been added to the provider directory.

3. Provider Outreach –Based on provider survey results, the state will perform provider outreach to encourage current providers to accept new children enrolled in Medi-Cal and to encourage HFP dental providers to enroll in Medi-Cal dental managed care plans and fee-for-service. In addition, the state will oversee Medi-Cal dental managed care plans' outreach to their enrolled providers to ensure continuity of care.
4. Provider training – Denti-Cal will hold a series of webinars and in person workshops to educate providers on how to enroll in Denti-Cal, how to bill for services, and other frequently asked questions.

iii. *Efforts to Ensure a Seamless Transition and Continuity of Care.* The state must provide a written description to CMS of how it will ensure continuity of care for children receiving dental services. If a transition child previously received a prior authorization from a HFP dental plan provider, the new Denti-Cal provider of the transition child will be able to utilize the approved prior authorization when claiming for dental services with Denti-Cal. Neither the provider nor the family will be required to obtain another prior authorization from Denti-Cal as long as the existing prior authorization has not expired.

b. Mental Health Services. Basic mental health services for the demonstration Medicaid expansion population will be covered primarily through managed care health plans. More specialized mental health services are provided by local County Mental Health plans as "carve-outs" for both programs. Under Medi-Cal, Specialty Mental Health Services (SMHS) are provided through a 1915b waiver.

i. *Continuity of Care for basic mental health services.* When a transition child receiving "basic" mental health services is enrolled into a Medi-Cal managed care health plan, his/her basic mental health services will continue and will be provided by the Medi-Cal managed care health plan, usually by the primary care doctor. If the service is not covered by the plan, the plan will ensure that the child is referred to a Medi-Cal fee-for-service provider or the county mental health plan (if the child meets specialty mental health services criteria). Children receiving basic mental health services previously authorized through a HFP health plan provider must be transitioned to a Medi-Cal health plan provider with no disruption in coverage.

ii. *Continuity of care for SMHS.* If a transition child is receiving specialized mental health services through the County Mental Health plan prior to the transition, the

County Mental Health plan will continue to provide services to these children after the transition with no disruption in coverage. Under select circumstances (e.g., a child is near the end of his or her treatment plan or experiences a significant change in mental health status), a child may need to be reassessed for specialty mental health services, and will be reassessed based on Medi-Cal medical necessity criteria rather than HFP serious emotional disturbance (SED) criteria. If the child does not meet the medical necessity criteria, the County Mental Health plan will continue to provide services until the Medi-Cal managed care plan has identified a provider in its network or in the fee-for-service network, and the child is able to receive services from that provider. In such a transfer, the County Mental Health plan and Medi-Cal managed care plan will follow the protocols outlined in their memorandums of understanding, and the County Mental Health plan will follow discharge planning procedures appropriate for the client. All children have the right to appeal the outcome of a reassessment and will continue to receive services pending a Medicaid fair hearing.

iii. *Coverage of mental health services furnished by County Mental Health Plans.* Mental Health services provided by the County Mental Health plans are covered as described by the California §1915(b) Specialty Mental Health Services waiver.

iv. *Consumer assistance for mental health services.* The state must employ strategies to ease the transition for children who will have to change plans and/or providers, as well as assess its efforts in this area. If a child is receiving basic mental health services through his/her Medi-Cal managed care health plan or Medi-Cal SMHS through the county mental health plan, and services are reduced, changed, or terminated, families will have access to the county's Beneficiary Problem Resolution system and managed care grievance process, which manages grievances, appeals, and state fair hearings. The Medi-Cal Mental Health Services Ombudsman Unit will also be available as a resource to families.

c. Substance Use Disorder Services. Substance use disorder services will be covered through a contracted system that is primarily county-administered. DHCS also has a small number of direct contracts with Drug Medi-Cal fee-for-service providers.

d. Continuity of Care. The state must ensure that transition children eligible in the demonstration Medicaid expansion population who have been receiving substance use disorder services authorized by their health plan continue to receive such services under the demonstration. For new enrollees, health plans must appropriately refer children to county alcohol and drug programs. The county alcohol and drug programs may receive self-referrals of former HFP children.

112. **Cost Sharing.** The premiums/cost sharing for the demonstration Medicaid expansion population must be consistent with Medicaid requirements for state plan populations that are set forth in statute, regulation and policies and must be limited to a 5 percent aggregate cost sharing limit per family as specified at 1916 and 1916A of the Act.

a. Premiums. Consistent with section 1916A of the Act and Medicaid regulations at 447.71 and 447.72, California will not impose premiums for children with family income below 150 percent of the FPL. For children who have family income above 150 percent and up to and including 250 percent of the FPL, the state will impose the following monthly premiums: $13 for one child, $26 for two children, and $39 for three or more children.

b. Premium Policies**.** Families that pay three months of premiums in advance will receive the fourth consecutive month of coverage with no premium required. Families that pay their premium by means of electronic funds transfer including credit card payment will receive a 25 percent discount on their premium. Eligibility will be terminated for failure to pay after a grace period of 90 days after the premium due date.

c. Cost Sharing – The state will not apply any other type of cost sharing, such as co-payments, for children through age 18.

113. Information Technology. The state will need to provide an assurance to CMS, prior to the implementation of each phase, that the state has information technology available, tested and operational that are ready to ensure a smooth and timely transition of electronic data and files for transition children and ongoing interface of necessary systems to correctly and expeditiously enroll new eligible applicants into the demonstration,

114. Oversight of Administrative Contractors. The state must actively oversee and ensure the accuracy, and completeness of information in contracts, and other related documents, and ensure that there are administrative and management arrangements, and procedures, designed to safeguard against contractor errors in the implementation and operation of all business rules for the transition. In addition, the state must periodically monitor contractor services on site, as well as conduct random samples of cases to ensure that all business rules are implemented as intended by the state. The state must notify CMS immediately upon detection of any type of potential or identified problem with contractor administration of the Medicaid expansion demonstration program.

115. Submission and Effective Dates of Medicaid State Plan Amendment (SPA). To ensure the transition of these children to full Medicaid state plan authority, California must submit a Medicaid SPA to expand coverage to optional targeted low-income children under the Medicaid state plan 90 days prior to implementation of Phase 4. The SPA must be approved by CMS prior to implementation of Phase 4.

116. Provider Network Adequacy. The state must demonstrate provider network adequacy prior to each phase, and prior to receiving written authority and approval to implement subsequent phases. CMS reserves the right to delay implementation of any phase in the absence of sufficient evidence of provider network adequacy. Pre-implementation of each phase, the state must estimate the percentage of beneficiaries the state anticipates will be able to keep their current HFP PCPs, and dentists, in managed care and Denti-Cal arrangements (by county and taking into consideration community standards as necessary.

a. Managed Care Network Adequacy. This transition involves enrollment of a new Medicaid expansion population in the Medi-Cal delivery system. Consistent with Medicaid requirements related to availability of services at §438.206, assurances of adequate capacity and services at §438.207, and coordination and continuity of care at §438.208, the state must ensure, through oversight of its contracts, at a minimum, that each managed care plan provides the state with supporting documentation to demonstrate that it:

i. Has the capacity to serve the expected enrollment in its service area in accordance with the state's standards for access to care. This must include the percentage of primary and specialist providers accepting new patients.

ii. Offers an appropriate range of primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.

iii. Will ensure that if the plan network is unable to provide necessary services covered under the contract, to a particular enrollee, the plan will adequately and timely cover these services

iv. Maintains and monitors a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees.

v. Will ensure that if the plan network is unable to provide necessary services, covered under the contract, to a particular enrollee, the plan will adequately and timely cover these services out of network for the enrollee, for as long as the plan is unable to provide them.

b. FFS Network Adequacy. This transition will involve the enrollment of a new Medicaid expansion population into the Medi-Cal fee-for-service delivery system in some counties. The state must monitor the availability of sufficient access to services using "A Plan to Monitor Healthcare Access for Medi-Cal Beneficiaries," as approved by CMS. The plan is available at http://www.dhcs.ca.gov The state must ensure that their fee-for-service network meets the requirements at 1902(a)(30)(A).

c. Dental Network Adequacy and Certification signed by the state Medicaid Director. In order to provide timely access to quality dental services, the state will track adherence to the 1/2000 provider adequacy ratio. This includes a 1/2000 ratio of providers to eligible children in each county. The state must provide documentation that the number of general dentists accepting new patients is sufficient to absorb the number of new enrollees and transition children who will be required to change dental providers. If certain geographic areas do not meet this threshold, the state must recruit sufficient new dentists or already-enrolled HFP dentists to accept new patients. The state must have a sufficient number, mix, and geographic distribution of providers of services. In addition, the state must certify to CMS that there is network adequacy for Denti-Cal fee-for-service providers.

i. The state will continue to improve the accuracy of the dental provider data reported to InsureKidsNow.gov, and will develop a plan to use these data to determine the number of dentists available to treat young children and children with special health care needs. The state will work with CMS to determine a target date for reporting these data.

d. Items necessary for network adequacy readiness for all phases:

i. *Network certification signed by the state Medicaid Director***.** After the state reviews the documentation submitted by managed care plans, the state must certify to CMS that the plans have complied with the state's requirements for availability of services, as set forth in §438.206. The state must make available to CMS, upon request, all documentation collected by the state from the managed care plans.

ii. *Demonstration of Geographic Accessibility (e.g., GeoAccess analysis)***.** The state shall ensure that each plan has an accessible network with reasonable geographic proximity to the individuals enrolled as required by state statute and regulations, including the Knox Keene Act, and taking into account community standards as necessary. Based upon a showing of geographic access concerns, revealed through monitoring Phase 1 and 2, the state shall provide a GeoAccess report to CMS for subsequent phases 60 days prior.

iii. *Continuity of care plans.* The state must provide a document describing continuity of care in the following areas: medical care, mental health, substance abuse and dental services in both managed care and fee-for-service delivery systems. This written description must be submitted to CMS 60 days prior to implementation of Phase 1A and updated, as necessary, prior to each subsequent phase.

iv. *Contingency plans.* Should an unanticipated problem(s) be identified by the state or CMS during the implementation process, the state must provide corrective actions plans for those health plans that are currently underperforming or appear to have prospective network adequacy concerns based on previous phases implemented.

117. Monitoring and Reporting on Medicaid Expansion Demonstration Population. The state will collect data on the implementation of each phase of the demonstration in order to monitor, measure and report to CMS on the results of each phase prior to implementation of subsequent phases. CMS will review this data and evaluate the success of each phase before granting approval of the subsequent phase. The state's monitoring plan and monitoring report template, presented in Attachment S, are incorporated in this demonstration.

a. Monitoring Plan and Monitoring Report Template. The plan provides a narrative description of the objectives of the transition and the monitoring report template presents the metrics that will be reported relevant to the accomplishment of those objectives, sources of data to be reported and anticipated outcomes. The data reported through this plan will assist the state, CMS and stakeholders in assessing the ongoing success of the transition and the impact on children and families with regard to, maintaining coverage for transition children, the appropriate enrollment of new enrollees, timely access to care, continuity of care, provider capacity, and consumer satisfaction under each phase, consistent with Medicaid requirements (at §438.206, §438.207, and §438.208).

b. Monthly Submission of Data on Monitoring Report Template. Beginning one month following implementation of Phase 1a, and monthly thereafter, the state will submit

within 15 days of the end of each calendar month, a monitoring report template, which must be made publically available and must display data collected over time for the cohort of children transitioned in each phase as well as provide ongoing information on new enrollees and changes in provider capacity. The monitoring report template will be used by the state to quickly identify concerns and develop solutions and by CMS to help determine if previous transition phases have been successful and if subsequent phases will be approved for implementation.

c. Analytical summary reports. The state must submit to CMS a monthly summary report that includes a discussion and analysis of events occurring during implementation of each phase and the state's analysis of the data presented in the monitoring report template and other relevant information available to the state. The summary report will also include proposals for addressing any problems identified during implementation of each phase. The intent of the report is to present the state's analysis of the success of the transition to date with an emphasis on children maintaining coverage, continuity of care and provider access for children receiving dental or mental health services.

d. Reporting timeframe. Results of monitoring and corrective action plans (as appropriate) must be provided on a monthly basis during the course of this transition and after the transition to ensure access after Phase 4.

e. Modification. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward. CMS may request that certain data be reported earlier than the normal reporting timeframe in order to support approval or disapproval of subsequent phases. The state will work with CMS to determine which data elements are most relevant and available to facilitate such approval. It is also acknowledged that some data elements in the report template may require development of new systems and processes for collection and may not be available for the first monthly monitoring report due on February 15, 2013. The state and CMS will work together to determine if the reporting of any metrics may be delayed.

118. Evaluation: Within 30 days of the effective date of these STCs, the state must submit to CMS for approval a draft evaluation design for the Demonstration.

a. At a minimum, the evaluation will determine the extent to which CHIP eligible children successfully transition from HFP to MediCal without loss of coverage, and maintain access to primary, specialty, and oral health care. The draft design will rely primarily on the findings from the data reported in the monthly monitoring template, which will be used in evaluating the impact of this amendment, during the period of approval, for the Medicaid expansion population. Finally, the draft evaluation design will include a detailed analysis plan that describes how the effects of all Demonstration programs will be isolated from other initiatives occurring in the state.

b. State shall include an assessment, using pre-transition enrollment and utilization data as a baseline, of the impact on the Medicaid expansion population, including all significant and notable findings based on all of the data accumulated through the monitoring report template and summary reports as well as utilization data made available during the transition.

c. CMS will provide comments on the draft evaluation design within 30 days of receipt, and

the state will submit a final evaluation design within 30 days of receipt of CMS' comments.

G. **2013 Managed Care Expansion**

This section describes additional requirements related to the operation of the state's planned 2013 expansion of the demonstration's COHS and non-COHS managed care models to 28 counties. Unless otherwise specified, managed care entities in these counties are subject to all other delivery system requirements described in these STCs, particularly section VII.

119. General. No earlier than September 1, 2013 (and not prior to CMS approval of the applicable managed care contracts) the State may enroll beneficiaries in the 8 COHS counties into Medi-Cal managed care consistent with Attachment L. No earlier than November 1, 2013 (and not prior to CMS approval of the applicable managed care contracts) the state may enroll beneficiaries in 20 non-COHS counties into Medi-Cal managed care, consistent with Attachment L. The state shall not enroll beneficiaries into Medi-Cal managed care in any particular region (without delaying enrollment in other regions) in the event that the applicable contracts have not been approved by CMS by the date specified. The state may submit technical updates to Attachment L and M without submitting an amendment.

Beneficiaries residing in counties where managed care enrollment is voluntary may be assigned to a health plan according to a passive enrollment process. Notices provided by the State to the beneficiary shall clearly indicate the beneficiary's ability to opt out of an MCO and return to the fee-for-service delivery system at any time. Seniors and persons with disabilities in non-COHS counties that are part of the 2013 managed care expansion, however, will be voluntarily enrolled through an "opt-in" process.

120. Transitional Beneficiary and Provider Notices and Information Sharing

a. CMS Review of Enrollee Communication. The state will submit to CMS, 10 days in advance of finalizing the notice for production, any written communication from the state to enrollees to be used to explain the transition for CMS review and comment. The availability of resources for individual assistance should be clearly set forth in materials developed by both the state and the health plans.
b. Readability and Accessibility. All transitional informing and educational materials should be clear and easy to read, provide information beneficiaries need to help them navigate the transition, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.
c. Timing. The state must provide at least two written notices to transitioning beneficiaries for non-COHS counties at least 60 days and 30 days prior to the transition. The state must attempt to contact the beneficiaries who have not made a plan selection by phone, at least three times, prior to 15 days before the transition.
d. Validation of Beneficiary Addresses. The state will ensure mailings will be sent to the most appropriate beneficiary by using appropriate beneficiary address verification software and other means as necessary. The state will report to CMS on the effectiveness of the validation of beneficiary addresses for the COHS transition and will incorporate lessons learned into a plan for validation of beneficiary address for the non-

COHS transition, to be submitted to CMS 45 days in advance of the transition.

e. Provider and Community Based Organization (CBO) Notice. The state shall develop and distribute written information to providers and CBOs prior to transition via provider bulletins. For the non-COHS transition, the state will provide this information no later than 45 days prior to the transition and will submit these materials to CMS at least10 days prior to finalizing the notice for production.

f. Beneficiary notices should include information regarding dental benefits for applicable populations.

121. Eligibility and Enrollment Process

a. Eligibility criteria. The counties and the beneficiaries subject to managed care enrollment as part of the 2013 managed care expansion are defined in Attachment L. The geographic distribution and delivery model for each county is defined in Attachment M.

b. Enrollment Process
   i. *COHS expansion counties*. Eligible Medi-Cal beneficiaries residing in COHS expansion counties will be required to enroll in the COHS health plan (in Accordance with Attachment L)
   ii. *Non-COHS expansion counties*
      1. Beneficiaries residing in non-COHS expansion counties that are in mandatory MEGs (in accordance with Attachment L) will be required to choose a Medi-Cal managed care health plan. If the beneficiary fails to choose, they will receive default assignments. Nothing in these STCs exempts the State from managed care requirements at 42 CFR 438.
      2. Beneficiaries residing in non-COHS expansion counties that are in voluntary MEGs (in accordance with Attachment L) will be given the choice of enrolling in FFS or managed care. If the beneficiary fails to choose, they will remain in FFS.
      3. Beneficiaries residing in non-COHS expansion counties with one plan that are in voluntary MEGs (in accordance with Attachment L) will be given the choice of enrolling in FFS or managed care. If the beneficiary fails to choose, they will be passively enrolled into the managed care health plan with an opportunity to opt-out.

c. Default Process. State will use FFS data to link non-choosing beneficiaries to health plans. State should, at a minimum, consider highest utilized provider over the last 12 months when matching beneficiaries to health plans.

d. Non-choosing families living in the same household and enrolled in Medi-Cal with mandatory MEG codes (in accordance with Attachment L) should be defaulted into the same health plan.

e. Application of Medicaid rules. All Medicaid rules (including eligibility, benefits, cost sharing, grievances and appeals, and managed care) will apply to this expansion population.

122. Consumer Assistance. Consumer assistance will be available to beneficiaries during the transition through the following:

a. The State will use the Medi-Cal Managed Care Office of the Ombudsman and Health Care Options call centers to provide information and assistance, including enrollment assistance, to beneficiaries during the transition.

b. The state will make informative resources available to interested CBOs on how to provide information and assistance to beneficiaries affected by the transition.

123. Delivery System. The managed care delivery system models, their geographic distribution, and participating health plans are identified in Attachment M.

124. Benefits. Transitioned beneficiaries will receive benefits as identified in Attachment N.

125. Managed Care Network Adequacy. Consistent with Medicaid requirements related to availability of services at §438.206, assurances of adequate capacity and services at §438.207, and coordination and continuity of care at §438.208, the State must ensure, through oversight of its contracts, at a minimum, that each managed care plan provides the State with supporting documentation to demonstrate network adequacy in accordance with STC 59.

126. Monitoring and Reporting. The State will collect data and information, consistent with Attachment T, on the Medi-Cal managed care expansion in order to monitor, measure and report on this expansion. The State will utilize existing monitoring tools to ensure efficiency and consistency across the Medi-Cal managed care program.

H. Managed Care Delivery Systems for the Coordination Care Initiative Eligible Beneficiaries

127. CCI Enrollment Processes

a. Cal MediConnect Enrollment. Effective no sooner than April 1, 2014, according to the schedule described in Attachment U, dependent on the effective date of the 3-way contract, the State may begin enrollment of beneficiaries eligible for the Cal MediConnect program. Enrollment is described in the plan-specific three-way contracts signed by CMS, the State, and the Cal MediConnect plan. Beneficiaries who opt out of Cal MediConnect, will remain in their existing Medicare program and be enrolled in a Medi-Cal managed care plan for coverage of their Medi-Cal benefits, including LTSS. Beneficiaries may opt out of the Cal MediConnect program at any time.

b. CCI Eligible Beneficiary Enrollment. Dual eligibles who opt out or are excluded from the Cal MediConnect program, and Medi-Cal only SPDs who were previously excluded from the SPD mandatory enrollment program will be mandatorily enrolled into a Medi-Cal managed care plan beginning no sooner than April 1, 2014, according to the schedule described in Attachment U and contingent on an approved amendment to the Medicaid managed care contract. The enrollment may be tailored for each county as appropriate to address the specific demographics and population of each county.

Notwithstanding the provisions under this STC 100, for Two-Plan and GMC counties dual eligibles enrolled in a Medicare Advantage plan shall be mandatorily enrolled in a

Medi-Cal managed care plan that is not operated by the same parent organization for their Medi-Cal and Medicare wrap around benefits. The State shall ensure dual eligibles enrolled in a Medicare Advantage plan will be provided coordination of benefits based off current practice. This is applicable only in the eight authorized CCI counties.

c. CCI Eligible Beneficiary Enrollment Choice. For counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of enrollment, the individuals will have an opportunity to choose from the managed care health plans and providers, if applicable, available to the specific population groups. If the beneficiary does not choose a health plan, they will receive a default plan assignment as described below. For counties that operate a COHS, the State will ensure individuals have a choice of providers, upon enrollment.

d. Noticing - Beneficiary and Provider Notices and Information Sharing

i. Noticing for Cal MediConnect eligible beneficiaries is described in the MOU, the Cal MediConnect three-way contracts, and the enrollment guidance. For beneficiaries that are not a part of the MOU transition, the noticing requirements are described below:

A. *Initial and On-going Outreach and Communication Strategy*. The State shall develop an outreach and education strategy to explain the changes to individuals who are impacted by the Coordinated Care Initiative. The State will establish a stakeholder process to solicit input and recommendations from a broad array of advocates, providers, plans, beneficiaries, and families for the development of a CCI Eligible Beneficiary program. The process will address beneficiary protections, person-centered care coordination, consumer-directed IHSS program protections, and quality. The strategy shall describe the State's planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific populations. The strategy will further articulate the State's efforts to ensure that the individuals have access to information and human assistance to understand the new systems and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for initial implementation and on-going operation of the CCI. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review, prior to implementation.

B. *CMS Review of Enrollee Communication.* The State will submit to CMS, 10 days in advance of finalizing the notice for production, any written communication from the state to enrollees to be used to explain the transition for CMS review and comment. The availability of resources for individual assistance should be clearly set forth in

materials developed by both the State and the health plans. The State will also submit to CMS for review and comment any directional memoranda or guidance documents provided to the counties, plans, and providers.

C. *Readability and Accessibility.* All informing and educational materials should be clear and easy to read, provide information beneficiaries need to help them navigate the transition, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

D. *Timing*. CCI Eligibles transitioning from Fee-For-Service will be notified at least 90-days in advance of the effective date of enrollment of upcoming changes in delivery systems; will be mailed reminder notices 30 and 60 days prior to enrollment, and final enrollment confirmation notices prior to the enrollment effective date. The State must attempt to contact the beneficiaries who have not made a plan selection by phone, at least two times, prior to 15 days before the transition.

E. *Validation of Beneficiary Addresses.* The state will submit to CMS, 45 days in advance of the transition, a comprehensive plan for ensuring mailings will be sent to the most appropriate beneficiary address (this plan should include the use of address validation software).

ii. For beneficiaries that are currently enrolled in Medi-Cal managed care and are now going to receive MLTSS through the managed care plan, the noticing requirements are as follows:

A. *CMS Review of Enrollee Communication.* The State will require the plans to notify their members at least 30 days in advance of implementation of the benefit. The plan will notify all members of the availability of the benefit for those members who are accessing the services prior to implementation, including information about continuity of care.

B. The plan will notify all members of the availability of the benefit through member informing materials for those who are not accessing the services prior to implementation.

C. *Readability and Accessibility*. All informing and educational materials should be clear and easy to read, provide information beneficiaries need to help them navigate the implementation, and be made available in the 12 Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

iii. *Provider and Community Based Organization (CBO) Notice*. The State shall develop and distribute written informing materials via a provider bulletin no later than 45 days prior to the transition. The State will submit these materials to CMS at least10 days prior to finalizing the notice for production.

iv. The State will ensure that the Medi-Cal managed care plans include in regular provider training key elements of operating a successful MLTSS program, including such topics as the applicable assessment tools and processes, person-centered care planning, coordination with the IHSS program, population specific training and self-direction, information technology, billing, and systems operations.

e. Approaches to Default

i. For CCI Eligible Beneficiaries who are now being mandatorily enrolled in Medi-Cal managed care and do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data (from Medi-Cal and, where appropriate, Medicare) to make a default selection into a plan based on usual and known sources of care, including previous providers (including prescribing providers), and utilization history. Default enrollees will have the opportunity to see their existing Medi-Cal providers for a period of 12 months after enrollment, as defined by the State. The default shall not occur until education and outreach efforts are conducted as noted above. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.

ii. For individuals currently enrolled in Medi-Cal managed care and who will have MLTSS integrated, the default will be to keep the enrollee in the current Medi-Cal managed care plan. Default enrollees will have the opportunity to change to another Medi-Cal managed care plan, in non-COHS counties.

iii. At least 30 days prior to the effective implementation date, the State will provide documentation and assurances for CMS review, that the infrastructure is in place at the State level, and across the plans, to effectively manage the default selection process.

iv. The State shall submit to CMS for review the enrollment protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to plan default assignment.

v. The State shall inform individuals of their opportunity to change plans at any time.

128. Benefit Package

a. Beneficiaries enrolled in a Medi-Cal managed care plan will be eligible for Medi-Cal benefits as identified in Attachment N – Capitated Services List/Managed Care Benefit Package. Attachment N has been updated to include the long term services and supports as a plan benefit. The State will assure that enrolled individuals have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package. The health plans are responsible for referrals and coordination of services in the State Plan, regardless of whether the services are included in the plan benefit package.

b. Assessments. The State shall require plans to incorporate into their current policy and procedure a process to assess members who can benefit from LTSS. The plan

MLTSS assessment does not preclude the use of specific tools for the determination of eligibility or level of service for MSSP, CBAS and IHSS.

i. *MSSP Assessment Tool:* The plans shall enter into a contract with each MSSP Site within the county so that the members have their choice of MSSP Site providers. The MSSP Site shall perform assessments and reassessments of potential MSSP beneficiaries pursuant to the 1915(c) Home and Community-Based Waiver CA.0141.R04.00 requirements. The MSSP Sites will manage their respective waitlists.

ii. *CBAS Assessment Tool:* The State shall ensure that the plans shall comply with STCs 91-97.

c. Effective in the authorized CCI counties, managed care benefits for the eligible MLTSS populations will be expanded to include the following long term services and supports (LTSS) as specified in Attachment N:

- In-home supportive services (IHSS);
- Multipurpose Senior Services Program (MSSP) services as defined in the 1915(c) waiver; and
- Skilled Nursing Facility services and Intermediate Care Facility services.

All services will be provided in compliance with the Americans with Disabilities Act (ADA). The State will assure compliance with the criteria for home and community based settings as referenced in the regulations implementing 1915(c) and 1915(i) and in accordance with the implementation/effective dates published in the Federal Register.

129. Efforts to Ensure Seamless Transitions for New CCI Eligible Beneficiaries:

a. The State will provide CMS its methodology for providing plans with a maximum of available data on service utilization and provider utilization for CCI Eligible Beneficiaries. The methodology shall be shared 45 days prior to implementation. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

b. The State shall provide documentation that information technology systems and infrastructure-are in place and can effectively manage the data exchange expectations set forth in this section to support smooth transition. The documentation shall be shared 45 days prior to implementation.

c. The State shall provide data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees prior to the effective date of coverage.

130. Plan Readiness and Contracts

a. <u>Plan Readiness – Initial and Ongoing</u>

The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the CCI Eligible Beneficiary population that ensures compliance with 42 CFR 438.

i. The State shall provide to CMS a methodology for evaluating network adequacy for LTSS 90 days prior to implementation. The methodology shall include assessing and monitoring plan capacity on an ongoing basis for the CCI population.

ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation at least 60 days prior to implementation.

iii. The State will complete network certifications for each county. Each county network certification will be done across the geographic area covered by the county in accordance with 42 CFR 438.

iv. The State will submit any updates to the network adequacy procedures upon changes.

b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply.

c. The State will submit to CMS for review a list of deliverables/submissions for readiness that is being requested from plans. The State will submit reporting requirements to CMS 30 days prior to implementation.

d. The State will submit to CMS for review the State's contingency plan for addressing insufficient network issues 60 days prior to implementation.

e. <u>Items Necessary for plan readiness, for MLTSS benefits and applicable CCI population</u>.

To the extent the State complies with any of the following requirements, the State must identify for CMS how they comply. If the State has met the requirement as part of the SPD transition or the Cal-MediConnect readiness process and CMS determines that no further LTSS incorporation is necessary; CMS shall not require additional documentation.

i. *Care Coordination***.** The State shall submit to CMS a summary of their procedures for ensuring that each plan has sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the CCI population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and

other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network and benefit package**.**

ii. *MLTSS Assessments*. The State shall provide detailed information regarding the process to conduct MLTSS health risk assessments for individuals at risk in accordance with STC 128(b)**.** LTSS assessments will be implemented by using specific tools for CBAS, IHSS, MSSP, and NF services. Further, the State shall institute a Stakeholder process to develop a Universal Assessment tool for LTSS to be adopted by plans and CBOs and to facilitate care planning and coordination of services. The state shall provide this information 60 days prior to implementation, but it must at a minimum assess the participant's physical, psychosocial, and functional needs. By using the CBAS, IHSS, MSSP, and NF assessment tools, the state ensures that these tools include such elements as current health status and treatment needs; social, and transportation needs and preferences; personal goals; participant and caregiver preferences for care; and back-up plans for situations when caregivers are unavailable. Additionally by using the CBAS, IHSS, MSSP, and NF assessment tools the state ensures that these instruments are capable of producing a similar assessment result from assessor to assessor (i.e. inter-rater reliability).

The State shall direct the plans to engage in a preliminary assessment process that assesses each new enrollee's risk level and needs; assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings; and uses a mechanism or algorithm to determine the health risk level of members. Based on the results of the health risk assessment, the plans shall be directed to develop individual care plans for higher risk beneficiaries.

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments.

iii. *Care Continuity: Initial and Ongoing*. The State shall ensure that the plans have mechanisms to provide continuity of care to enrolled individuals in order to furnish seamless care with existing Medi-Cal providers for a period of 12 months after enrollment-and established procedures to bring providers into network. Enrollees may keep current CBAS and Nursing Facility providers and services in their approved service plans, even if those providers are not in the network, for 12 months from first day of coverage, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.

The State shall submit to CMS 60 days in advance of implementation the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended period of care continuity for individuals with significant, complex or chronic medical conditions.

iv. *Person-Centered Planning and Service Design.*

A. For Medi-Cal only and partial Duals without Medicare Part B, the State shall ensure that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee. While definitions and models of person-centered planning vary, the protocols shall, at a minimum, address the

following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

B. For MSSP and all 1915(c) HCBS waiver programs which CCI Eligible Beneficiaries will be enrolled, the service plan will reflect the participant's or caregiver's needs and preferences and address how their needs will be met by a combination of covered services and available community supports. Person-centered service planning is holistic in addressing the full array of medical and non-medical services and supports provided both by the health plan or available in the community to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. CBO providers will coordinate the HCBS service plan with the health plans service plan. Participants must be permitted to include individuals of their choosing, along with their service providers, as part of their interdisciplinary team. CMS expects participants will have the ability to choose which team members should serve as the lead and the participant's main point of contact; if the participant does not want to choose a team lead, the interdisciplinary team will make the decision.

v. *Physical Accessibility.* The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

vi. *Interpreter Services - Information Technology*. The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.

vii. *Transportation – Specialized.* The State will ensure that each plan offers non-emergency medical transportation so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.

viii. *Fiscal Solvency.* The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis. California uses the Tangible Net Equity (TNE) standard for plan solvency.

The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c). Rates will be designed to support the population's ability to support and retain community placement. The state will have a process for

oversight and evaluation of payment structures and to inform areas of exploration for future program modifications.

ix. *Transparency*. The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to the LTSS eligible population.

The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.

x. *Timing*. For Medi-Cal only enrollees, the State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

131. Contract Requirements. Each of the elements noted above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains, for applicable populations. To the extent the plans already comply with any of the following requirements, the state shall identify for CMS how they comply.

a. <u>For Medi-Cal only and Partial Duals without Medicare Part A</u>. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:

   i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and

   ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution.

b. <u>For Medi-Cal only and Partial Duals without Medicare Part B</u>:

   i. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using FFS claims data as a source of clinical data on CCI enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

   ii. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.

   iii. Comprehensive health assessments for newly enrolled CCI Eligible Beneficiaries into a plan.

c. <u>For CCI Eligible Beneficiaries</u>:

   i. Each plan shall be required to submit service encounter data, for individuals

enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion within 90 days after initial plan enrollment.

ii. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.

iii. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable and as referenced in Attachment H.

For IHSS, the County will comply with 42 CFR 431, Subpart E. For MSSP, the MSSP Site will comply with 42 CFR 431,Subpart E.

iv. CCI Eligible Beneficiaries will be substantially involved in plan advisory groups and committees.

v. Provisions outlining when out-of-network care will be provided.

vi. Coordination of carved out services.

vii. To the extent possible, plans should incorporate the existing LTSS providers as health plans network providers. In the case of the IHSS program, plans shall coordinate with the counties in the administration of the IHSS program. The state shall provide support to traditional LTSS providers, in areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.

viii. Contract Termination Protections for participants:

State contracts with health plans must include expectations around health plans and provider phase-down when health plans or providers are terminating their contract with, or having their contract terminated by, the State or the health plans. These expectations must include the required amount of time for provider and participant notification and rules around the prohibition of new enrollments during the phase-down period.

132. Participant Rights and Safeguards.

a. Information. All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

b. Safeguards to Prevent Abuse, Neglect and Exploitation and Critical incident management systems**.** The state shall have a system in place to identify, report, and track critical incidents that occur within the delivery of MLTSS, as appropriate.

c. MLTSS shall continue to be provided in the same amount, duration, and scope while a modification, reduction, or termination is on appeal in accordance with state processes. The State will track the number of appeals of service authorization reductions or expirations. The state will use then use this collected data to intervene

when appropriate.

d. All 1915(c) Waiver requirements and safeguards apply to the individuals receiving MSSP Waiver services.
e. Prior to implementation, the state will conduct stakeholder engagement with non-duals who will be impacted by MLTSS, and dual eligible that are not eligible for MediConnect.
f. Independent Consumer Supports. To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the State shall create and ensure a permanent system of consumer supports independent from the managed care plans to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights.
    i. *Core Elements of the Independent Consumer Supports System*:
        1. Organizational Structure. The Independent Consumer Supports system shall operate independently from any managed care plan. The organizational structure of the supports system shall facilitate transparent and collaborative operation with beneficiaries, and health plans.
        2. Accessibility. The services of the Independent Consumer Supports system are available to all Medicaid beneficiaries receiving managed long-term services and supports (institutional, residential and community based).
        3. The Independent Consumer Supports system must be accessible through multiple entryways (e.g., phone, electronic mail) and must reach out to beneficiaries and/or authorized representatives through various means (e.g. mail, phone), as appropriate.
        4. Functions. The Independent Consumer Supports system assists beneficiaries to navigate and access covered health care services and supports. The below list encompasses the system's scope of activity. The State shall have the flexibility to offer these consumer reports through various venues.
            a. The program shall offer beneficiaries support in the pre-enrollment stage, such as unbiased health plan choice counseling and general program-related information.
            b. The program shall service as an access point for complaints and concerns about health plan enrollment, access to services, and other related matters.
            c. The program shall help enrollees understand the fair hearing, grievance, and appeal rights and processes within the health plan and at the state level and assist them through the process if needed/requested.
        5. Staffing and Training. The State shall ensure the appropriate training is provided to Consumer Support employees. In addition, the Independent Consumer Supports system shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency.

ii. *Data Collection and Reporting.* The Independent Consumer Supports system shall track the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the State, but no less frequently than quarterly. This information will inform the State of any provider or contractor issues and support the reporting requirements to CMS.

iii. *Consumer Supports Assessment.* The State shall report to CMS on the assessment of the Cal MediConnect Independent Consumer Supports program and incorporate efficient processes and lessons learned into the CCI Consumer Supports program.

iv. *Independent Consumer Supports Plan.* The State shall submit a plan to CMS describing the structure and operation of the Independent Consumer Supports system that aligns with the core elements provided in STC 133.f(i) within 90 days of approval of the CCI managed long term services and supports program.

g. The State shall conduct trainings with plans as well as providers on community-based resources and supports that can be linked with covered plan benefits.

h. CBAS Unbundled Services. The State will submit to CMS a corrective action plan detailing how and when the state will begin submitting information on unbundled CBAS services encounters, pursuant to STC 95-101.

133. Quality Oversight and Monitoring. In addition to all quality requirements set forth in 42 CFR 438, the state will ensure the following:

a. Encounter Data. The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by impacted beneficiaries in the CCI Eligible Beneficiary counties, in a manner that enables the State to assess performance by Demonstration plan, by county, and Demonstration wide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall share these trends and quality improvement activities with CMS quarterly within 60 days of analysis. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data from each plan in the authorized CCI Eligible Beneficiary counties is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the CCI Cal MediConnect and CCI Eligible Beneficiary program. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

b. Measurement Activities.

The State will submit a plan for developing and implementing additional HEDIS and QIP measures specific to the CCI Eligible Beneficiary population. The plan must be

submitted by January 1, 2015 to CMS and must include the timelines for developing and implementing such measures.

c. Stratification and Analysis by County and Plan. For all data collected from the plans and COHS the State will be able to stratify information by Demonstration population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the plans by county.

134. Monitoring and Reporting. The state will collect data and information on the Coordinated Care Initiative as described in Attachment V in order to monitor, measure and report on this initiative.

135. Notice of Change in Implementation Timeline. The state must notify CMS of any potential changes in the implementation and deliverables timelines as specified above.

136. Withholding Approval. At any time, CMS reserves the right to withhold approval of contracts/contract amendment and/or Federal financial participation (FFP) if CMS determined that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

IX. OTHER ADMINISTRATIVE REQUIREMENTS

137. Medicaid Management Information System (MMIS). In accordance with Title II (Administrative Simplification) provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the State must adopt the American Standards Committee X12 Group Version 5010 standard electronic transaction format and the International Classification of Diseases, 10th Revision (ICD-10) standard electronic code set by January 1, 2012 and October 1, 2013, respectively as a condition of the State continuing to receive 90% and 75% Federal financial participation for the design, development, implementation, and operations of the State's new Medicaid Management Information System (MMIS). FFP for the State's MMIS may be at risk if these standards are not implemented by the HIPAA-mandated compliance date.

138. National Correct Coding Initiative (NCCI). In accordance with Section 6507 of the 2010 Affordable Care Act - Mandatory State Use of National Correct Coding Initiative (NCCI), the State must incorporate all five CMS-defined NCCI methodologies into its existing and new Medicaid Management Information System (MMIS) and edit claims against these five NCCI methodologies for claims filed on or after October 1, 2010. The State must submit an Advanced Planning Document no later than March 1, 2011, to CMS for review and approval in order to effectively deactivate any NCCI edits after March 31, 2011. The State will not have the flexibility to deactivate any NCCI edits after March 31, 2011 due to lack of operational readiness.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

139. Quarterly Reports. The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the California's Bridge to Reform Demonstration under section 1115 authority which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. The CMS will provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI (Monitoring Budget Neutrality).

140. Reporting Expenditures under the Demonstration. In order to track expenditures under this Demonstration, California will report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM).

a. All Demonstration expenditures claimed under the authority of Title XIX of the Act must be reported each quarter on separate s CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term "expenditures subject to the budget neutrality cap," is defined in paragraph 105.

b. For each Demonstration year, fifty two (52) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration expenditures. The eligibility groups (EGs) that are used for calculation of the budget neutrality limit described in STC 148 and the specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver are described below.

Eligibility Group (EG)	**Demonstration Expenditures**	**CMS 64 Waiver Form**
Family – COHS	Family & Children – Pre-2013 expansion COHS counties, excludes those enrolled in MLTSS in CCI counties (starting no sooner than July 2014/DY 10) Low income pregnant women (starting 8/1/2015)	Families COHS

Eligibility Group (EG)	Demonstration Expenditures	CMS 64 Waiver Form
	Family & Children – 2013 managed care expansion COHS counties Low income pregnant women (starting 8/1/2015)	Exp Family COHS
Family – TPM/GMC	Family & Children – Pre-2013 TPM/GMC counties, excludes those enrolled in MLTSS in CCI counties (starting no sooner than July 2014/DY 10) Low income pregnant women (starting 8/1/2015)	Families TPM/GMC
	Family & Children – 2013 managed care expansion non-COHS counties (including San Benito and Imperial counties) Low income pregnant women (starting 8/1/2015)	Family TPM/GMC - Exp
SPD – COHS	Existing Seniors & People with Disabilities – Pre-2013 COHS counties. Starting DY 9 /July 2013, includes partial dual eligibles without Medicare Part A or B), excludes those enrolled in MLTSS in CCI counties	SPD COHS
	Seniors and Persons with Disabilities – 2013 managed care expansion COHS counties (except for those in PACE in Humboldt county starting in DY 9)	SPD COHS - Exp
	Seniors and Persons with Disabilities enrolled in PACE in Humboldt county, includes partial dual eligibles without Medicare Part A or B)	SPD COHS – Humboldt PACE

Eligibility Group (EG)	Demonstration Expenditures	CMS 64 Waiver Form
SPD – TPM/GMC	Existing Seniors & People with Disabilities – Pre-2013 expansion TPM/GMC counties. Starting DY 9 / July 2013 includes partial dual eligibles without Medicare Part A or B; excludes those enrolled in MLTSS in CCI counties.	SPD TPM/GMC
	Special Populations – SPDs in pre-2013 expansion counties mandatorily enrolled starting 2011. Starting DY 9 / July 2013 includes partial dual eligibles without Medicare Part A or B; excludes those enrolled in MLTSS in CCI counties	Special Pops – SPDs
	Seniors and Persons with Disabilities – 2013 managed care expansion non-COHS counties (including San Benito and Imperial counties)	SPD TPM/GMC - Exp
Duals - COHS	Beneficiaries with Medicare Part A and B– Pre-2013 expansion COHS counties, excluding CCI counties	Existing Duals - COHS
	Beneficiaries with Medicare Part A and B–2013 managed care expansion counties, excluding CCI counties and beneficiaries enrolled in PACE in Humboldt county	Expansion Duals - COHS
	Beneficiaries with Medicare Part A and B who are enrolled in PACE in Humboldt county	Expansion Duals - Humboldt PACE
Duals - TPM/GMC	Beneficiaries with Medicare Part A and B– Pre-2013 TPM/ GMC counties, excluding CCI counties	Existing Duals - TPM/GMC

Eligibility Group (EG)	Demonstration Expenditures	CMS 64 Waiver Form
	Beneficiaries with Medicare Part A and B–2013 managed care expansion non-COHS counties (including San Benito and Imperial counties)	Expansion Duals - TPM/GMC
Cal-Medi-Connect - COHS	Beneficiaries with Medicare Part A and B enrolled in Cal-Medi-Connect in COHS CCI counties	Cal-Medi-Connect - COHS
MLTSS Duals - COHS	Beneficiaries with Medicare Part A and B in COHS CCI counties not enrolled in Cal-Medi-Connect receiving MLTSS services	MLTSS Duals - COHS
MLTSS Family – COHS	Family & Children receiving MLTSS in COHS CCI counties Low income pregnant women (starting 8/1/2015)	MLTSS Family - COHS
MLTSS SPDs - COHS	Seniors & People with Disabilities receiving MLTSS in COHS CCI counties	MLTSS SPDs - COHS
Cal-Medi-Connect - TPM/GMC	Beneficiaries with Medicare Part A and B enrolled in Cal-Medi-Connect in TPM/GMC CCI counties	Cal-Medi-Connect - TPM/GMC
MLTSS Duals - TPM/GMC	Beneficiaries with Medicare Part A and B in TPM/GMC CCI counties not enrolled in Medi-Connect receiving MLTSS services	MLTSS Duals - TPM/GMC
MLTSS Family – TPM/GMC	Family & Children receiving MLTSS in TPM/GMC CCI counties Low income pregnant women (starting 8/1/2015)	MLTSS Family - TPM/GMC
MLTSS SPDs – TPM/GMC	Seniors & People with Disabilities receiving MLTSS in TPM/GMC CCI counties	MLTSS SPDs - TPM/GMC

Eligibility Group (EG)	Demonstration Expenditures	CMS 64 Waiver Form
CCS – State Plan Special Needs Child	Special Populations Special Needs Children	Special Pops – Child
	California Children Services	CCS – State Plan
ECM (through sunset date of services)	Enhanced Case Management	ECM
CBAS	Community Based Adult Services	CBAS
New Adult Group	New adult group (section 1902(a)(10)(A)(i)(VIII) of the Act)	New Adult Group
MCE	Low Income Health Program/ Medicaid Expansion	MCE
SNCP - Coverage Initiative	Low Income Health Program / Health Care Coverage Initiative	SNCP - HCCI
SNCP - Uncompensated Care	Safety Net Care Pool – Hospital Services	SNCP-Hosp
	Safety Net Care Pool – Non-Hospital Services	SNCP – Non-Hosp
SNCP - Investment/ Incentive Pool	Delivery System Reform Incentive Pool - Infrastructure Development	DSRIP - Cat 1
	Delivery System Reform Incentive Pool - Innovation & Redesign	DSRIP – Cat 2
	Delivery System Reform Incentive Pool – Population – focused Improvement	DSRIP – Cat 3
	Delivery System Reform Incentive Pool – Urgent Improvement in Care	DSRIP – Cat 4
SNCP - HIV Transition Incentive Program	Delivery System Reform Incentive Pool – HIV Transition, Improvements in Infrastructure and Program Design	DSRIP – Cat 5A
	Delivery System Reform Incentive Pool – HIV Transition, Improvements in Clinical and Operational Outcomes	DSRIP – Cat 5B
SNCP - IHS Uncompensated Care	Uncompensated care payments to IHS and 638 Facilities (IHS)	UC - IHS

Eligibility Group (EG)	Demonstration Expenditures	CMS 64 Waiver Form
SNCP – DSHP	California Children Services - Designated State Health Program	CCS - DSHP
	Genetically Handicapped Persons Program - Designated State Health Program	GHPP – DSHP
	Medically Indigent Adult Long Term Care - Designated State Health Program	MIALTC – DSHP
	Breast & Cervical Cancer Treatment Program - Designated State Health Program	BCCTP – DSHP
	AIDS Drug Assistance Program - Designated State Health Program	ADAP- DSHP
SNCP - DSHP (continued)	Workforce Development Programs - Designated State Health Program	Work – DSHP
	County Mental Health Services	CMHS – DSHP
	Every Woman Counts	EWC – DSHP
	IMProving, Counseling & Treatment	IMP – DSHP
	Expanded Access to Primary Care - Designated State Health Program	EAPC- DSHP
	Department of Developmental Services - Designated State Health Program	DDS – DSHP
Public Hospital Payments, Mental Health Supplements*	Designated Government-Operated Hospital Payments	D. Govt. Hosp
Private and Non-Designated Government-Operated Hospital Payments*	Private and Non-Designated Government-Operated Hospital Payments	P/ND Govt. Hosp
DMC-ODS	Drug Medi-Cal Organized Delivery System	DMC-ODS

* Note: These expenditures are excluded from the demonstration's budget neutrality cap, as

described below.

c. For each Demonstration year, a separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver must be completed to report expenditures for the following Demonstration expenditures. The specific waiver names to be used to identify these separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver appear in brackets below:
    i. MCHIP: The CMS 64.21-Waiver form must be completed to report expenditures for the Medicaid expansion demonstration population. [MCHIP]

141. Expenditures Subject to the Budget Neutrality Cap. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all expenditures, identified in paragraph 130, except for hospital payments to Designated Government-Operated and Private/ Non-Designated Government-Operated Hospitals, as noted on the table in STC 130(b). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver, and CMS 64.21 Waiver and/or 64.21P Waiver .

142. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration on Forms 64.10 Waiver and/or 64.10P Waiver. For each Demonstration year, 3 separate Forms CMS-64.10 Waiver and/or 64.10P Waiver must be completed to track, report, and identify administrative costs directly attributable to the Demonstration and those that are attributable to the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI) for each Low Income Health Program (LIHP) under the Demonstration. The specific waiver names to be used to identify these separate Forms CMS-64.10 Waiver and/or 64.910 Waiver appear in brackets below:

a. Administrative Costs - General [Non-LIHP Admin.];
b. Administrative Costs – Health Care Coverage Initiative [HCCI Admin.];
c. Administrative Costs - Medicaid Coverage Expansion [MCE Admin]

143. Administrative Costs Associated with Low Income Health Program. For these costs, the State must distinguish between direct services provided under the LIHP (MCE and HCCI) and administrative activities to ensure there is no duplicate claiming for the LIHP program.

144. Claiming Period. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2 year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

145. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. California must estimate matchable Medicaid expenditures (total computable and Federal share) subject to the budget neutrality cap and separately

report these expenditures by quarter for each Federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the appropriate Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

146. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding and in accordance with paragraphs 37 entitled Certified Public Expenditures and paragraph 50 entitled Federal Financial Participation for the Health Care Coverage Initiative, CMS will provide FFP at the applicable Federal reimbursement rate as outlined below, subject to the limits described in Section XI:

a. Administrative costs, including those associated with the administration of the California's Bridge to Reform Demonstration.

b. Net medical assistance payments/expenditures and prior period adjustments paid in accordance with the approved State Plan.

c. Net Safety Net Care Pool expenditures during the operation of this Demonstration.

d. Expenditures associated with MCE subject to paragraph 39.a.v.

e. Expenditures associated with the provision of the CBAS and ECM services (through sunset date of services) to SPDs and dual eligibles.

f. Uncompensated care payments to IHS and 638 Facilities.

147. Sources of Non-Federal Share. The State certifies that State and local monies are used as matching funds for the Demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations. Further, these sources and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies, any sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

148. Monitoring the Demonstration. The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

149. Cost-Claiming. All costs will be claimed in accordance with OMB Circular A-87 as defined within Attachment F, and any other cost claiming methodologies or protocols approved by CMS under this Demonstration.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

150. Quarterly Expenditure Reports. The State must report State Plan and Demonstration expenditures using the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following the routine CMS MBES system instructions. The State shall report on separate forms, CMS-64.21U Waiver and/or CMS-64.21UP Waiver, for Title XXI Demonstration expenditures for Medicaid Expansion children eligible for title XXI funding. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration expenditures that do not exceed the State's available title XXI funding.

151. Reporting Expenditures Under the Demonstration. In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, following routine CMS MBES system instructions. The State will report Title XXI Demonstration expenditures on separate Forms CMS-64.21U Waiver and CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State must identify the program code and coverage.

a. The State must submit all claims for expenditures related to the Demonstration (including any cost settlements) within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, the State must submit all claims for services during the Demonstration period (including cost settlements) within 2 years after the conclusion or termination of the Demonstration. During the 2-year period, the State must continue to identify separately, on the Form CMS-64, 21, net expenditures related to dates of service during the operation of the Demonstration.

b. The State will use standard MCHIP funding process during the Demonstration. The State must estimate matchable MCHIP expenditures on the quarterly Form CMS-37. On a separate CMS-37, the State shall provide updated estimates of expenditures for the Medicaid Expansion Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-64.21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the

Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

152. Limitations on Title XXI Funding. The State will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI separate child health program or Demonstration until the next allotment becomes available.

a. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this Demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

b. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

153. Premium contributions under the Demonstration shall be reported to CMS on Form CMS-21 Waiver, Line 29, in order to assure that the Demonstration is properly credited with premium collections.

154. If the state exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State must continue to provide coverage to the approved title XXI State plan separate child health program population and the demonstration population with State funds.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

155. Budget Neutrality Effective Date. All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning November 1, 2010. Notwithstanding this effective date, expenditures made by California during the temporary extension period of September 1, 2010 through October 31, 2010 must be applied against Demonstration Year 6 (DY 6) expenditures.

156. Limit on Title XIX Funding. California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the

Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California. Spending under the budget neutrality limit is authorized for managed care population expenditures for the following groups – family and children, SPD, and CCS, public hospital expenditures and for spending under the SNCP, and for the CBAS/ECM (as applicable through sunset date of ECM) services to SPDs and dual eligibles. Spending under the SNCP is for uncompensated care, DSHP, HCCI and DSRIP. Attachment C lists the designated public hospitals. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for Monitoring Budget Neutrality. The data supplied by the State to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

157. Risk. California will be at risk for the per capita cost for Demonstration enrollees (Medicaid State plan or hypothetical populations) under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

158. Budget Neutrality Annual Expenditure Limit. For each DY, two annual limits are calculated.

a. Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each eligibility group (EG) described as follows:

   i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section entitled General Reporting Requirements for each EG, including the hypothetical population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
   ii. Starting in SFY 2011, actual expenditures for the MCE EG will be included in the expenditure limit for the California. The amount of actual expenditures to be included will be the actual MCE per member per month cost experience for DY 6-10;
   iii. Starting in the fourth quarter of SFY 2012 (March-June), and continuing through August 31, 2014, actual expenditures for the CBAS and ECM benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the CBAS and ECM

services (whether provided through managed care or fee-for-service) to the SPD Medicaid-only population and to dual eligibles;

iv. Following approval of the DMC-ODS benefit and continuing through October 31, 2015, actual expenditures for the DMC-ODS benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be included will be the actual cost of providing the DMC-ODS benefit to the eligible population;

v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)[1]	**Trend Rate**	**DY 6 PMPM**	**DY 7 PMPM**	**DY 8 PMPM**	**DY 9 PMPM**	**DY 10 PMPM**
		State Plan Groups				
Families - COHS	5.30%	$171.68	$180.78	$190.36	$199.61	$206.82
Families – TPM/GMC	5.3%	$150.40	$158.37	$166.76	$177.02	$182.66
SPD – COHS	7.4%	$1,069.73	$1,148.89	$1,233.91	$1,660.90	$1,750.03
SPDs – TPM/GMC and Special Populations SPDs	7.4%	$730.43	$784.48	$842.53	$801.95	$864.53
CCS – State Plan Special Needs Child	3.28%	$1,390.66	$1,436.27	$1,483.38	$1,532.04	$1,582.29
Duals - COHS	2.47%	n/a	n/a	n/a	$428.67	$439.25
Duals - TPM/GMC	3.28%	n/a	n/a	n/a	$114.23	$117.97
Cal-Medi-Connect - COHS	1.61%	n/a	n/a	n/a	$642.42	$652.77
MLTSS Duals - COHS	1.61%	n/a	n/a	n/a	$642.42	$652.77
MLTSS Family – COHS	5.30%	n/a	n/a	n/a	$202.99	$213.75
MLTSS SPDs - COHS	7.40%	n/a	n/a	n/a	$1,892.75	$2,032.81

Eligibility Group (EG)[1]	Trend Rate	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM	DY 9 PMPM	DY 10 PMPM
		State Plan Groups				
Cal-Medi-Connect TPM/GMC	3.40%	n/a	n/a	n/a	$724.71	$749.35
MLTSS Duals – TPM/GMC	3.40%	n/a	n/a	n/a	$724.71	$749.35
MLTSS Family – TPM/GMC	5.30%	n/a	n/a	n/a	$178.35	$187.81
MLTSS SPDs – TPM/GMC	7.40%	n/a	n/a	n/a	$978.60	$1,051.02
		Hypothetical Populations[2]				
MCE	5.00%	$300.00	$315.00	$330.75	$347.29	$0
CBAS	3.16%		$916.60	$945.57	$975.45	$1,006.27
ECM			$10.00	$10.00	$10.00	$10.00
DMC-ODS						$735.42

Key: TPM = Two Plan Model counties, GMC = Geographic Managed Care counties

[1] The applicable reporting forms for expenditures in each eligibility group are described in STC 140.

[2] These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit. As described in paragraph (a)(ii) and (a)(iii) above, the actual expenditures for these hypothetical populations are included in the budget neutrality limit.

b. Limit B. The amount of the designated public hospital spending as determined in the chart below. Current State plan reimbursement is actual incurred cost as defined in the State plan. The State is prohibited from changing the reimbursement methodology or amounts of supplemental payments approved in the Medicaid State plan on November 1, 2010 that result in higher overall reimbursement without recalculating the Upper Payment Limit (UPL) for the period of the new or modified payments and adjusting the UPL diversion if necessary.

Total Computable IP Unspent Public Hospital Amounts	
DY 6	$396,364,787
DY 7	$443,813,467

DY 8	$518,660,641
DY 9	$675,984,270
DY 10	$863,054,068
5 Year Total	**$2,897,877,233**

i. The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that California can receive for expenditures on behalf of Demonstration populations as well as Demonstration expenditures under the Safety Net Care Pool described in paragraph 39.

ii. California must present to CMS for approval MCO contract modifications to include an increase in PMPM amounts due to adjustments associated with the inpatient hospital provider tax. The with waiver and without waiver budget neutrality PMPM limits will be adjusted for each EG with an affected rate due to requirements in the Affordable Care Act based on the increases in contracts, if necessary.

iii. For purposes of determining the UPL, the FFS increased Medi-Cal utilization of the newly eligible beneficiaries beginning in 2014 has been included. Expenditures for these beneficiaries starting in FY2014 will receive increased FMAP. However for any expenditures under the SNCP that are funded by the portion of the UPL gap associated with their FFS utilization, the State's regular FMAP applies.

159. 1115A Duals Demo Savings. When California's section 1115(a) demonstration is considered for an amendment, renewal, and at the end of the duals demonstration, CMS' Office of the Actuary (OACT) will estimate and certify actual title XIX savings to date under the duals demonstration attributable to populations and services provided under the 1115(a) demonstration. This amount will be subtracted from the 1115(a) budget neutrality savings approved for the renewal.

Specifically, OACT will estimate and certify actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration following the methodology below.

The actual title XIX savings attributable to populations and services provided under the 1115(a) demonstration are equal to the savings percentage specified in the 1115A duals demonstration MOU multiplied by the 1115A demonstration capitation rate and the number of 1115A duals demonstration beneficiaries enrolled in the 1115(a) demonstration. 1115A Demonstration capitation rate is reviewed by CMS's Medicare and Medicaid Coordination Office (MPLAN), MPLAN's contracted actuaries and CMS' Office of the Actuary (OACT), and was certified by the state's actuaries. Per the 1115A duals demonstration MOU, the actual Medicaid rate paid for beneficiaries enrolled in the 1115A demonstration is equivalent to the state's 1115A Medicaid capitation rate minus an established savings percentage (as outlined in the chart below). The state must track the number of member months for every

Medicare-Medicaid enrollee (MME) who participates in both the 1115(a) and 1115A demonstration.

The table below provides an illustrative example of how the savings attributable to populations and services provided under the 1115(a) demonstration is calculated

A. 1115A Demonstration Year	**B. Medicaid Capitation Rate (hypothetical)**	**C. Medicaid Savings Percentage Applied Per MOU (average)**	**D. Savings Per Month (B*C)**	**E. Member Months of MMEs who participated in 1115A and 1115(a) Demos (estimated)**	**F. Amount subtracted from 1115(a) BN savings/ margin (D*E)**
DY 1	$1,000 PMPM	1%	$10 PMPM	1,000	1,000* $10 PMPM = $10,000
DY 2	$1,000 PMPM	2%	$20 PMPM	1,000	1,000 * $20 PMPM = $20,000
DY 3	$1,000 PMPM	4%	$40 PMPM	1,000	1,000 * 40 PMPM = $40,000

In each quarterly report, the state must provide the information in the above-named chart (replacing estimated figures with actual data). Should rates differ by geographic area and/or rating category within the 1115A demonstration, this table should be done for each geographic area and/or rating category. In addition, the state must show the "amount subtracted from the 1115(a) BN savings" in the updated budget neutrality Excel worksheets that are submitted in each quarterly report.

Finally, in each quarterly CMS-64 submission and in each quarterly report, the state must indicate in the notes section: "For purposes of 1115(a) demonstration budget neutrality reporting purposes, the state reports the following information:

- Number of Medicare-Medicaid enrollees served under the 1115 duals demonstration = *[Insert number]*
- Number of member months = *[Insert number]*
- PMPM savings per dual beneficiary enrolled from the 1115A duals demonstration = *[Insert number]*

The State must make the necessary retroactive adjustments to the budget neutrality worksheets to reflect modifications to the rates paid in the 1115A demonstration. This must include any Medicaid payment triggered by the risk corridor, IGTs, or other retroactive adjustments. The State must add additional columns to the chart above in subsequent quarterly reporting to reflect those adjustments.

160. Monitoring of New Adult Group Spending and Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 140. The trend rates and per capita cost estimates for the new adult group are listed in the table below.

MEG	TREND	DY 9 – PMPM	DY 10 – PMPM
New Adult - COHS	4.1%	$899.62	$936.50
New Adult – TPM/ GMC	4.1%	$627.52	$653.25

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the new adult group PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the State has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than 11 months into the demonstration year for which the adjustment would take effect. Additional adjustments to the PMPM limit may be made pursuant to the process outlined in (d) below.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.

c. The State will not be allowed to obtain budget neutrality "savings" from this population. Excess spending for the new adult group does not count against the budget neutrality limit defined in STC 158.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state will submit plan to CMS for further modifying the PMPM limit as appropriate to ensure it is consistent with actual PMPM expenditures for the new adult group. The plan must identify the cause of the discrepancy between the state's initial estimates and actual costs and must describe a timeline for revising the state's projections.

161. Composite Federal Share Ratios. The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share Ratio. The Composite Federal Share Ratio is the ratio calculated by dividing the sum total of FFP received by California on actual Demonstration expenditures during the approval period,

as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable Demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms.

162. Deficit Spending. California will be allowed to make expenditures in DY 6 and 7 under the authority of the SNCP consistent with the limits described in paragraph 158 for each of the four categories of SNCP spending notwithstanding budget neutrality limits determined for each of those years. SNCP spending in DY 8-10 are subject to the limitations in paragraph 158.

163. Enforcement of Budget Neutrality. CMS shall enforce the budget neutrality agreement over the life of the Demonstration as adjusted November 1, 2010, rather than on an annual basis. However, expenditure authorities in the Safety Net Care pool will be reduced in DY 8 through 10 if California is unable to achieve savings associated with the State plan EG included in the Demonstration as described below:

a. By July 15, 2012 California must submit to CMS an analysis of enrollment in the Families, Existing SPD, and Mandatory SPD EGs and per member per month expenditures. If total expenditures exceed final expenditure projections for the 12 months of DY 7 as determined in the final budget neutrality projections in Attachment K by more than 10% for the period ending June 30, 2012, SNCP authority for expenditures DSHP or DSRIP will be reduced by $350 million dollars (Total Computable) in DY 8 (July 1, 2012 - June 30, 2013) with respect to the categories described in paragraph b.ii., and b.iii.
b. By January 15, 2013 California must submit to CMS an analysis of enrollment in the Families, Existing SPD, and Mandatory SPD EGs and per member per month expenditures. If total expenditures for the first 6 months of DY 8 exceed final expenditure projections as determined in the final budget neutrality projections in Attachment K by more than 10% for the period ending December 31, 2012, SNCP authority for expenditures for DSHP or DSRIP will be reduced by $350 million dollars (Total Computable) in DY 9 (July 1, 2013 - June 30, 2014) with respect to the categories described below in paragraph b.ii., and b. iii.

    i. California must provide a savings analysis associated with State plan EGs by July 31, 2012. If in the aggregate after analyzing each State plan EG, the aggregate PMPM savings falls below projections by more than 10 % as measured by actual expenditures through July 1, 2012, CA must submit a corrective action plan by November 1, 2012 reducing expenditures in the SNCP for DY 9 (July 1, 2013 - June 30, 2014) and DY 10 (July 1, 2014 - October 31, 2015) to ensure budget neutrality by the end of the Demonstration. The corrective action plan must reduce spending in the SNCP with reductions in categorical spending in the programs described below and should include any reductions in SNCP spending associated with clauses a and b above.
    ii. Designated State Health Programs (DSHP)
    iii. Delivery System Reform Incentive Pool (DSRIP)

c. If California must submit a corrective action plan, CMS will monitor budget savings on July 1, 2013, January 1, 2014, July 1, 2014 and January 1, 2015 to ensure that the Demonstration will be budget neutral by the end of DY 10. If the Demonstration spending as amended by the corrective action plan is not projected to be budget neutral, CA must further limit SNCP spending in DY 9 and DY 10 by August 1, 2013 and August 1, 2014
d. If actual enrollment and expenditures for EG in DY 8 or 9 produces savings that demonstrate that California is within 5% of their projected budget neutrality savings, California may submit an amendment seeking to restore SNCP spending authority as long as the amendment demonstrates that the State will be budget neutral by the end of DY 10.

164. Restoring SNCP Spending Authority. If actual enrollment and expenditures for EG in DY 8 or 9 produces savings that demonstrate that California is within 5% of their projected budget neutrality savings, California may submit an amendment seeking to restore SNCP spending authority as long as the amendment demonstrates that the State will be budget neutral by the end of DY 10.

165. Exceeding Budget Neutrality. If the budget neutrality expenditure limit defined in STC 158 has been exceeded at the end of the Demonstration period, the excess Federal funds must be returned to CMS using the methodology outlined in paragraph 161, composite Federal share ratio. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

166. Drug Medi-Cal Eligibility and Delivery System. The "Drug Medi-Cal Organized Delivery System (DMC-ODS)" is a Pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services, increased local control and accountability, greater administrative oversight, creates utilization controls to improve care and efficient use of resources, evidence based practices in substance abuse treatment, and increased coordination with other systems of care. This approach is expected to provide the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery.

a. <u>Delivery System</u>
The DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State will enter into an intergovernmental agreement with the county to provide DMC-ODS services. The county will, in turn, contract with DMC certified providers or provide

county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

A description of how the Tribal operated and urban Indian health providers, as well as American Indians and Alaska Natives Medi-Cal beneficiaries, will participate in the program through a Tribal Delivery System will be outlined in Attachment BB following approval of this amendment. The provisions in Attachment BB will be consistent with the authorities in the Indian Health Care Improvement Act (including the statutory exemption from state or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act) and will be developed in consultation with the California tribes, and Tribal and Urban Indian health programs located in the state, consistent with the Tribal Consultation SPA and the CMS Tribal Consultation Policy.

b. DMC-ODS Program Medical Criteria

In order to receive services through the DMC-ODS, the beneficiary must be enrolled in Medi-Cal, reside in a participating county and meet the following medical necessity criteria:

i. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).

ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

iii. If applicable, must meet the ASAM adolescent treatment criteria. As a point of clarification, beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

c. DMC-ODS Determination of Medicaid Eligibility and Medical Need

Determination of who may receive the DMC-ODS benefit will be performed as follows:

i. Medicaid eligibility must be verified by the county or county contracted provider. When the county contracted provider conducts the initial eligibility verification, it will be reviewed and approved by the county prior to payment for services, unless the individual is eligible to receive services from tribal health programs operating under the Indian Self Determination and Education Assistance Act (ISDEAA – Pub.L. 93-638, as amended) and urban Indian organizations operating under title

V of the IHCIA. If so eligible, the determination will be conducted as set forth in the Tribal Delivery System - Attachment BB to these STCs.

ii. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 3(a). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.

Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate; except for NTP services which will require reauthorization annually.

d. Grievances and Appeals

i. 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 denial of payment for services by a participating County.

ii. The Department of Health Care Services will provide beneficiaries access to a state fair hearing process.

iii. The grievance and appeals process for the Tribal Delivery System will be outlined in Attachment BB.

167. DMC-ODS Benefit and Individual Treatment Plan (ITP)

a. Standard DMC services approved through the State Plan Benefit will be available to all beneficiaries in all counties. Beneficiaries that reside in a Pilot County will receive DMC-ODS benefits in addition to other state plan services. County eligibility will be based on the MEDs file. In counties that do not opt into the Pilot, beneficiaries receive only those drug and substance use disorder treatment services outlined in the approved state plan (including EPSDT). Beneficiaries receiving services in counties which do not opt into the Pilot will not have access to the services outlined in the DMC-ODS. The benefits and ITP for the Tribal Delivery System will be discussed in Attachment BB.

Table ONE: State Plan and DMC-ODS Services Available to DMC-ODS Participants
(with Expenditure Authority and Units of Service)

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Early Intervention (Note: SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers.)	x (preventive service; physician services)			Annual screen, up to 4 brief interventions
Outpatient Drug Free	x (rehab services)			Counseling: 50 min session
Intensive Outpatient	x (rehab services)			per day
Partial Hospitalization		x		Diagnosis-related Group (DRG)/Certified Public Expenditures (CPE)
Withdrawal management General Acute Care Hospital (VID, INVID) (non-IMD)	x inpatient services			DRG/CPE
CDRH/Free Standing Psych (IMD)			x	DRG/CPE
Residential (perinatal, non-IMD)	x (rehab services)			Per day/bed rate
(all pop., non-IMD)		x		Per day/bed rate
(IMD)			x	Per day/bed rate
NTP	x (rehab services)			Per day dosing; 10 minute increments

DMC-ODS Service	Current State Plan	Allowable 1905(a) services – not covered in State Plan*	Costs Not Otherwise Matchable (CNOM)	Units Of Service
Additional MAT (drug products)	x (pharmacy)			Drug cost
(physician services)	x (physician services; rehab)			Per visit
Recovery Services		x		Counseling: 50 min session

*Allowable 1905(a) services are all Medicaid services that can be covered upon CMS approval in a State Plan.
**TCM is not available state-wide as per 1915(g) and is not currently covered in all counties.

b. The following services (Tables TWO and THREE) must be provided, as outlined in Table FOUR, to all eligible DMC-ODS beneficiaries for the identified level of care as follows. DMC-ODS benefits include a continuum of care that ensures that clients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses.

Table TWO: ASAM Criteria Continuum of Care Services and the DMC-ODS System

ASAM Level of Care	Title	Description	Provider
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Managed care or fee-for-service provider
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	DHCS Certified Intensive Outpatient Facilities
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or	DHCS Licensed and DHCS/ASAM Designated Residential Providers

ASAM Level of Care	Title	Description	Provider
		other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM Designated Residential Providers
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals, Hospital; Free Standing Psychiatric hospitals
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber

Table THREE: ASAM Criteria Withdrawal Services (Detoxification/Withdrawal Management) and the DMC-ODS System

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification; Physician, licensed prescriber; or OTP for opioids.
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification; licensed prescriber; or OTP.
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Physician, licensed prescriber; ability to promptly receive step-downs

Level of Withdrawal Management	Level	Description	Provider
			from acute level 4.
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Hospital, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals; ability to promptly receive step-downs from acute level 4
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Hospital, sometimes ICU, Chemical Dependency Recovery Hospitals; Free Standing Psychiatric hospitals

Counties are required to provide the following services outlined in the chart below. Upon State approval, counties may implement a regional model with other counties or contract with providers in other counties in order to provide the required services.

TABLE FOUR: Required and Optional DMC-ODS Services

Service	Required	Optional
Early Intervention (SBIRT)	• (Provided and funded through FFS/managed care)	
Outpatient Services	• Outpatient (includes oral naltrexone) • Intensive Outpatient	• Partial Hospitalization
Residential	• At least one ASAM level of service initially • All ASAM levels (3.1, 3.3, 3.5) within three years • Coordination with ASAM Levels 3.7 and 4.0 (provided and funded through FFS/managed care)	• Additional levels
NTP	• Required (includes buprenorphine, naloxone, disulfiram)	
Withdrawal Management	• At least one level of service	• Additional levels
Additional Medication Assisted Treatment		• Optional
Recovery Services	• Required	
Case Management	• Required	
Physician Consultation	• Required	

The continuum of care for SUD services outlined in Tables TWO and THREE are modeled after the levels identified in the ASAM Criteria. While counties will be responsible for the oversight and implementation of most of the levels in the continuum, a few of the levels (Early Intervention Services, Partial Hospitalization and Levels 3.7 and 4.0 for Residential and Withdrawal Management) are overseen and funded by other sources not under the DMC-ODS. These services are contained in the DMC-ODS Pilot in order to show the entire continuum of care of SUD services available to California's MediCal population.

i. Early Intervention Services (ASAM Level 0.5)
Screening, brief intervention and referral to treatment (SBIRT) services are provided by non-DMC providers to beneficiaries at risk of developing a substance use disorder. SBIRT services are not paid for under the DMC-ODS system. SBIRT services are paid for and provided by the managed care plans or by fee-for-service primary care providers. SBIRT attempts to intervene early with non-addicted people, and to identify those who do have a substance use disorder and need linking to formal treatment.

Referrals by managed care providers or plans to treatment in the DMC-ODS will be governed by the Memorandum of Understanding (MOU) held between the participating counties and managed care plans. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties' implementation plan and waiver intergovernmental agreements.

The components of Early Intervention are:

A. Screening: Primary Care physicians screen adults ages 18 years or older for alcohol misuse.
B. Counseling: Persons engaged in risky or hazardous drinking receive brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services, as medically necessary.
C. Referral: Managed Care Plans and fee-for-service primary care providers will make referrals from SBIRT to the county for treatment through the DMC-ODS.

ii. Outpatient Services (ASAM Level 1) counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Outpatient Services are:

A. Intake: The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
B. Individual Counseling: Contacts between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.
C. Group Counseling: Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served.
D. Family Therapy: The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery as well as their own recovery can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
E. Patient Education: Provide research based education on addiction, treatment, recovery and associated health risks.
F. Medication Services: The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
G. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
H. Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
I. Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan. The treatment plan shall include: a statement of problems to be addressed,

goals to be reached which address each problem, action steps which will be taken by the provider and/or beneficiary to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof. Treatment plans have specific quantifiable goal/treatment objectives related the beneficiary's substance use disorder diagnosis and multidimensional assessment. The treatment plan will identify the proposed type(s) of interventions/modality that includes a proposed frequency and duration. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the beneficiary and the Medical Director or LPHA.

J. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

iii. Intensive Outpatient Treatment (ASAM Level 2.1) structured programming services are provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts to be medically necessary and in accordance with an individualized client plan. Lengths of treatment can be extended when determined to be medically necessary. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a therapist or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone or by telehealth.

The Components of Intensive Outpatient are (see Outpatient Services for definitions):

A. Intake
B. Individual and/or Group Counseling
C. Patient Education
D. Family Therapy
E. Medication Services
F. Collateral Services
G. Crisis Intervention Services
H. Treatment Planning
I. Discharge Services

iv. Partial Hospitalization (ASAM Level 2.5) services feature 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. Providing this level of service is optional for participating counties.

v. Residential Treatment (ASAM Level 3) is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized treatment plan. Residential services are provided to non-perinatal and perinatal beneficiaries. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. In the residential treatment environment, an individual's functional cognitive deficits may require treatment that is primarily slower paced, more concrete and repetitive in nature. The daily regimen and structured patterns of activities are intended to restore cognitive functioning and build behavioral patterns within a community. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

Residential services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. Residential services can be provided in facilities with no bed capacity limit. The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents; unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. The average length of stay for residential services is 30 days. Peri-natal clients may receive a longer length of stay based on medical necessity. Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.

The components of Residential Treatment Services are (see Outpatient Services for definitions):

A. Intake
B. Individual and Group Counseling
C. Patient Education
D. Family Therapy

E. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
F. Collateral Services
G. Crisis Intervention Services
H. Treatment Planning
I. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
J. Discharge Services

vi. Withdrawal Management (Levels 1, 2, 3.2, 3.7 and 4 in ASAM) services are provided in a continuum of WM services as per the five levels of WM in the ASAM Criteria when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with an individualized client plan. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.

The components of withdrawal management services are:

A. Intake: The process of admitting a beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
B. Observation: The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.
C. Medication Services: The prescription or administration related to substance use disorder treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license.
D. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

vii. Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements. NTPs/OTPs are required to offer and prescribe

medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone and disulfiram.

A patient must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of Opioid (Narcotic) Treatment Programs are (see Outpatient Treatment Services for definitions):

A. Intake
B. Individual and Group Counseling
C. Patient Education
D. Medication Services
E. Collateral Services
F. Crisis Intervention Services
G. Treatment Planning
H. Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP/OTP on a one-on-one basis with the patient.
I. Discharge Services

viii. Additional Medication Assisted Treatment (ASAM OTP Level 1) includes the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber. Opioid and alcohol dependence, in particular, have well-established medication options. The current reimbursement mechanisms for medication assisted treatment (MAT) will remain the same except for the following changes for opt-in counties: buprenorphine, naloxone and disulfiram will be reimbursed for onsite administration and dispensing at NTP programs; additionally, physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment.

The components of Additional Medication Assisted Treatment are ordering, prescribing, administering, and monitoring of medication assisted treatment.

The goal of the DMC-ODS for MAT is to open up options for patients to receive MAT by requiring MAT services in all opt-in counties, educate counties on the various options pertaining to MAT and provide counties with technical assistance to implement any new services. These medications are available through the DMC-ODS and outside of Drug Medi-Cal programs. Further details explaining the financing and availability of MAT services in the Medi-Cal system are contained in Attachment CC.

ix. Recovery Services: Recovery services are important to the beneficiary's recovery and wellness. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, beneficiaries will be linked to applicable recovery services. The treatment community becomes a therapeutic agent through which patients are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients. Services are provided as medically necessary. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

The components of Recovery Services are:

A. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
B. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
C. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
D. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
E. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
F. Support Groups: Linkages to self-help and support, spiritual and faith-based support;
G. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

x. Case Management: Counties will coordinate case management services. Case management services can be provided at DMC provider sites, county locations, regional centers or as outlined by the county in the implementation plan; however, the county will be responsible for determining which entity monitors the case management activities. Services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.

Counties will be responsible for coordinating case management services for the SUD client. Counties will also coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination

of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

Case management services include:

A. Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
B. Transition to a higher or lower level SUD of care;
C. Development and periodic revision of a client plan that includes service activities;
D. Communication, coordination, referral and related activities;
E. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
F. Monitoring the beneficiary's progress;
G. Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services; and,
H. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

xi. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services are to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. Counties may contract with one or more physicians or pharmacists in order to provide consultation services. Physician consultation services can only be billed by and reimbursed to DMC providers.

xii. Intersection with the Criminal Justice System: Beneficiaries involved in the criminal justice system often are harder to treat for SUD. While research has shown that the criminal justice population can respond effectively to treatment services, the beneficiary may require more intensive services. Additional services for this population may include:

A. Eligibility: Counties recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to expanded Medi-Cal substance use disorder treatment services if the parolees and probationers are eligible. Currently incarcerated inmates are not eligible to receive FFP for DMC-ODS services.
B. Lengths of Stay: Additional lengths of stay for withdrawal and residential services for criminal justice offenders if assessed for need (e.g. up to 6 months residential; 3 months FFP with a one-time 30-day extension if found

to be medically necessary and if longer lengths are needed, other county identified funds can be used).

C. Promising Practices: Counties utilize promising practices such as Drug Court services.

168. DMC-ODS Provider Specifications

The following requirements will apply to DMC-ODS staff.

a. Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

b. Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff.

c. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.

d. Registered and certified alcohol and other drug counselors must adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

169. Responsibilities of Counties for DMC-ODS Benefits

The responsibilities of counties for the DMC-ODS benefit shall be consistent with each county's intergovernmental agreement with DHCS, and shall include that counties do the following.

a. <u>Selective Provider Contracting Requirements for Counties:</u>
Counties may choose the DMC providers to participate in the DMC-ODS. DMC certified providers that do not receive a county contract cannot receive a direct contract with the State in counties which opt into the Pilot. If a county does not participate in the Pilot or is removed from participation in the Pilot by the State, the county will continue to cover state plan services.

i. Access: Each county must ensure that all required services covered under the DMC-ODS Pilot are available and accessible to enrollees of the DMC-ODS. NTP services are an important modality within the continuum of care. Counties are required to provide this service. Access to medically necessary NTP services cannot be denied for DMC-ODS eligible beneficiaries. Eligible DMC-ODS beneficiaries will receive medically necessary services at a DMC certified NTP provider. All DMC-ODS services, including Medi-Cal NTP services, shall be furnished with reasonable promptness in accordance with federal Medicaid requirements and as specified in the county implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition). Medical attention for emergency and crisis medical

conditions must be provided immediately. If the DMC-ODS network is unable to provide services, the county must adequately and timely cover these services out-of-network for as long as the county is unable to provide them.

All counties must ensure that beneficiaries who live in an opt-out county, but receive NTP services in an opt-in county do not experience a disruption of services. The opt-out county will claim state plan expenditures for the reimbursement made to the out-of-county NTP providers in accordance with the approved state plan methodology for services furnished to beneficiaries. No persons eligible for DMC-ODS services, including Medi-Cal funded NTP treatment services, will be placed on waiting lists for such services due to budgetary constraints.

The DMC-ODS Pilot program is administered locally by each demonstration county and each county provides for, or arranges for, substance use disorder treatment for Medi-Cal beneficiaries. Access cannot be limited in any way when counties select providers. Access to State Plan services must remain at the current level or expand upon implementation of the Pilot. The county shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors and that is sufficient to provide adequate access to all services covered under this Pilot. Access for this purpose is defined as timeliness to care as specified below. In establishing and monitoring the network, the county must consider the following:

- Require its providers to meet Department standards for timely access to care and services as specified in the county implementation plan and state-county intergovernmental agreements (managed care contracts per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.
- The anticipated number of Medi-Cal eligible clients.
- The expected utilization of services, taking into account the characteristics and substance use disorder needs of beneficiaries.
- The expected number and types of providers in terms of training and experience needed to meet expected utilization.
- The number of network providers who are not accepting new beneficiaries.
- The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disable beneficiaries.

ii. Medication Assisted Treatment Services: Counties must describe in their implementation plan how they will guarantee access to medication assisted treatment services. Counties currently with inadequate access to medication assisted treatment services must describe in their implementation plan how they will provide the service modality.

Counties are encouraged to increase medication assisted treatment services by exploring the use of the following interventions:

- Extend NTP/OTP programs to remote locations using mobile units and contracted pharmacies which may have onsite counseling and urinalysis.
- Implement medication management protocols for alcohol dependence including naltrexone, disulfiram, and acamprosate. Alcohol maintenance medications may be dispensed onsite in NTPs/OTPs or prescribed by providers in outpatient programs.
- Provide ambulatory alcohol detoxification services in settings such as outpatient programs, NTPs/OTPs, and contracted pharmacies.

iii. Selection Criteria and Provider Contracting Requirements: In selecting providers to furnish services under this Pilot, counties must:

- Must have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this amendment and applicable federal laws and regulations.
- Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.
- Must not discriminate against persons who require high-risk or specialized services.
- May contract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
- Select only providers that have a license certification issued by the state that is in good standing.
- Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a “high” categorical risk prior to furnishing services under this pilot, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint-based background checks required under 42 CFR 455.434.
- Select only providers that have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a

Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

- Counties may contract individually with licensed LPHAs to provide services in the network.
- Must not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their certification.
- Must enter into contracts with providers that they have selected to furnish services under this pilot program. All contracts with providers must include the following provider requirements:
  - Services furnished to beneficiaries by the provider under this amendment are safe, effective, patient-centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine;
  - Possess the necessary license and/or certification;
  - Maintain a safe facility by adhering to the state licensing and certification regulations;
  - Maintain client records in a manner that meets state and federal standards;
  - Shall meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation, for residential services only, prior to providing Pilot services;
  - Be trained in the ASAM Criteria prior to providing services;
  - Meet quality assurance standards and any additional standards established by the county or other evaluation process; and
  - Provide for the appropriate supervision of staff.
- If a county elects to contract with a managed care plan to furnish services under this pilot, the contract must ensure that any provider furnishing services under this pilot on behalf of the managed care plan meets all of the requirements that apply to a provider (and any Medical Director) that is selected by a county under this section to furnish services under this Pilot.

iv. Contract Denial: Counties shall serve providers that apply to be a contract provider but are not selected a written decision including the basis for the denial.

- County Protest: Any solicitation document utilized by counties for the selection of DMC providers must include a protest provision.
  - Counties shall have a protest procedure for providers that are not awarded a contract.
  - The protest procedure shall include requirements outlined in the State/County intergovernmental agreements.
  - Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the Department of Health Care Services (DHCS). If the county does not render a decision within

30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the failure to DHCS.

v. DHCS Appeal Process: A provider may appeal to DHCS as outlined in Attachment Y.

b. Authorization: Counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider. Counties will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service. Counties shall have written policies and procedures for processing requests for initial and continuing authorization of services. Counties are to have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. Counties are to meet the established timelines for decisions for service authorization. Counties are required to track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied. This prior authorization for residential services is compliant with the Medicaid-applicable parity requirements established by the Mental Health Parity and Addiction Equity Act. Non-residential services shall not require authorization.

c. County Implementation Plan: Counties must submit to the State a plan on their implementation of DMC-ODS. The State will provide the template for the implementation plan, which is included here as Attachment Z. Counties cannot commence services without an implementation plan approved by the state and CMS. Counties must also have an executed State/County intergovernmental agreement (managed care contract per federal definition) with the county Board of Supervisors and approved by CMS. County implementation plans must ensure that providers are appropriately certified for the services contracted, implementing at least two evidenced based practices, trained in ASAM Criteria, and participating in efforts to promote culturally competent service delivery.

One ASAM level of Residential Treatment Services is required for approval of a county implementation plan in the first year. The county implementation plan must demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county intergovernmental agreement (managed care contract per federal definition). The county implementation plan must describe coordination for ASAM Levels 3.7 and 4.0.

Upon CMS approval of the implementation plan and an executed intergovernmental agreement, counties will be able to bill prospectively for services provided through this Pilot.

Below is a summary of the requirements that must be submitted with the county implementation plan:

Care coordination strategy • MOU with managed care plan • DMC transitions, especially aftercare and recovery supports
Service descriptions • Withdrawal Management • Outpatient • Intensive Outpatient • NTP/OTP • Additional MAT • Residential • Recovery Services • Case Management • Physician Consultation • Two evidence-based practices • Any optional services (including partial hospitalization)
Provider network development plan • By service • With timeline pegged to specified timeliness standard • Network adequacy requirements (will vary by county)
Phase-in description for a one-year provisional period* • By service • With timeline and deliverables pegged to timeliness measure

*Only applies to counties unable to meet all mandatory requirements.

d. Provisional Option: For counties that are unable to comply fully with the mandatory requirements upon implementation of this Pilot, at the time of approval by DHCS and CMS, there exists the option for a one-year provisional period. A one year-provisional option will provide counties the opportunity to participate in the DMC-ODS Pilot while taking the necessary steps to build system capacity, provide training, ensure appropriate care coordination, and implement a full network of providers as described in the Pilot.

In order to apply for the one-year provisional option, a county must include with their implementation plan a strategy for coming into full compliance with the terms of this Pilot. Specifically, each county must describe the steps it will take to provide all required DMC-ODS services that it cannot provide upon initial DMC-ODS implementation. The county will assure that all DMC-ODS services will be available to beneficiaries (whether the services are provided in-network,

out-of-network, or using telehealth) while meeting the timeliness requirement during the course of the one-year probation option.

At least sixty (60) days prior to the expiration of the one-year provisional period, counties must resubmit their revised implementation plans for renewal. The plans will describe how the county has implemented the requirements which they originally could not provide. DHCS and CMS will review the revised implementation plans, in conjunction with the state and county monitoring reports as described in Sections 5 and 6 of this amendment, to assess if the county is progressing towards complying fully with the terms of this Pilot. If a county originally awarded a one-year provisional option is able to fully comply with the terms of this Pilot upon renewal, they will be eligible to receive approval to participate in the remainder of the Pilot. If a county originally awarded a one-year provisional option is not able to fully comply with the terms of this Pilot, DHCS and CMS may approve a renewal pursuant to a Corrective Action Plan (CAP). The CAP will describe how the county will continue to implement its phase-in approach pursuant to its implementation plan, and will assure that all DMC-ODS services are available to beneficiaries in the interim (whether the services are provided are in-network, out-of-network, or using telehealth) within the timeliness requirement.

e. State-County Intergovernmental Agreement (Managed Care Contract per federal definition):

DHCS will require a State-County intergovernmental agreement (managed care contract per federal definition) to be signed between the state and the county in opt-in counties, subject to CMS approval. The intergovernmental agreement will provide further detailed requirements including but not limited to access, monitoring, appeals and other provisions. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). CMS will review and approve the State-County intergovernmental agreement (managed care contract per federal definition).

f. Coordination with DMC-ODS Providers:

Counties will include the following provider requirements within their contracts with the providers.

- Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services must be available for beneficiaries, as needed.

- Medication Assisted Treatment: Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of clients who are prescribed these medications unless the client refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.
- Evidenced Based Practices: Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP include:
    - *Motivational Interviewing*: A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes.
    - *Cognitive-Behavioral Therapy*: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
    - *Relapse Prevention*: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
    - *Trauma-Informed Treatment*: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
    - *Psycho-Education*: Psycho-educational groups are designed to educate clients about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives; to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

g. Beneficiary Access Number: All counties shall have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.

h. Beneficiary Informing: Upon first contact with a beneficiary or referral, counties shall inform beneficiaries about the amount, duration and scope of services under this waiver in sufficient detail to ensure that the beneficiaries understand the benefits to which they are entitled.

i. Care Coordination: Counties' implementation plans and state/county intergovernmental agreements (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement (managed care contracts per federal definition) how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement (managed care contract per federal definition) will indicate which beneficiaries receiving SUD services will receive care coordination.

The participating county shall enter into a memorandum of understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU. The components of the MOUs governing the interaction between the counties and managed care plans related to substance use disorder will be included as part of the counties' implementation plan. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s). Any MOU shall be consistent with the confidentiality provisions of 42 CFR Part 2.

The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;

- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems including bidirectional referral protocols.

j. Integration with Primary Care: DHCS is committed to participate in the Medicaid Innovation Accelerator Program initiative for substance use disorder, specifically in the Targeted Learning Opportunity topics on primary care and SUD integration.

DHCS is embarking on a strategy to integrate physical and behavioral health care services delivered to beneficiaries in order to improve health outcomes for beneficiaries with SUD and reduce costs in the Medi-Cal program. DHCS will explore options for identifying the best integration strategy upon approval of this waiver amendment and will commit to specifying an integration approach by April 1, 2016. DHCS will produce a concept design for an integrated care model by October 1, 2016, with the goal of implementing physical and behavioral health integration by April 1, 2017.

k. ASAM Designation for Residential Providers: In order to enroll in Medi-Cal and bill for services under the auspices of this waiver, all residential providers must be designated to have met the ASAM requirements described in Attachment XX. DHCS will develop a designation program by July 1, 2015 to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM criteria. As part of this designation program, DHCS will use an existing tool or develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1-3.5, develop standard program audit materials and protocols, and implement the ASAM designation program. The timeline for this designation program is outlined in Attachment A and will be technically amended after the program has been developed.

l. Services for Adolescents and Youth: At a minimum, assessment and services for adolescents will follow the ASAM adolescent treatment criteria. In addition, the state will identify recovery services geared towards adolescents, such as those described in the January 26, 2015 CMS Informational Bulletin "Coverage for Behavioral Health Services for Youth with Substance Use Disorder".

170. DMC-ODS State Oversight, Monitoring, and Reporting.

a. Monitoring Plan: The State shall maintain a plan for oversight and monitoring of DMC-ODS providers and counties to ensure compliance and corrective action with standards, access, and delivery of quality care and services. The state/county intergovernmental agreement (managed care contracts per federal definition) will require counties to monitor providers at least once per year, and the state to 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. The CAP must detail how and when the county will remedy the issue(s). DHCS may remove the county from participating in the Pilot if the CAP is not promptly implemented.

Timely Access. The state must ensure that demonstration counties comply with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to Medi-Cal population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed. Access standards and timeliness requirements that are specified and described in the county implementation plans will be referenced in the state/county intergovernmental agreements (managed care contract per federal definition). Medical attention for emergency and crisis medical conditions must be provided immediately.

Program Integrity. The State has taken action to ensure the integrity of oversight processes and will continue to closely monitor for any wrongdoing that impacts the DMC-ODS. The State will continue to direct investigative staff, including trained auditors, nurse evaluators and peace officers to continue to discover and eliminate complex scams aimed at profiting from Medi-Cal. Efforts include extensive mining and analyzing of data to identify suspicious Drug Medi-Cal providers; designating DMC providers as “high” risk which requires additional onsite visits, fingerprinting and background checks (except for county providers); and regulations that strengthen DMC program integrity by clarifying the requirements and responsibilities of DMC providers, DMC Medical Directors, and other provider personnel. In conducting site visits of providers seeking to furnish services under this Pilot, the State shall conduct a site visit monitoring review of every site through which the provider furnishes such services. In addition, providers that have not billed DMC in the last 12 months have been and will continue to be decertified. Counties are required to select and contract with providers according to the requirements specified in section 4(iv) of this amendment

The State will ensure that the counties are providing the required services in the DMC-ODS, including but not limited to the proper application of the ASAM Criteria, through the initial approval in the county implementation plan and through the ongoing county monitoring. The State will conduct a state monitoring review for residential facilities to provide an ASAM designation prior to facilities providing Pilot services. This review

will ensure that the facility meets the requirements to operate at the designated ASAM level (as explained in 4(k)).

b. Reporting of Activity: The State will report activity consistent with the Quarterly and Annual Progress Reports as set forth in this Waiver, Section IV, General Reporting Requirements. Such oversight, monitoring and reporting shall include all of the following:

i. Enrollment information to include the number of DMC-ODS beneficiaries served in the DMC-ODS program.
ii. Summary of operational, policy development, issues, complaints, grievances and appeals. The State will also include any trends discovered, the resolution of complaints and any actions taken or to be taken to prevent such issues, as appropriate.
iii. Number of days to first DMC-ODS service at appropriate level of care after referral
iv. Existence of a 24/7 telephone access line with prevalent non-English language(s)
v. Access to DMC-ODS services with translation services in the prevalent non-English language(s)
vi. Number, percentage and time period of authorization requests approved or denied

c. Triennial Reviews: During the triennial reviews, the State will review the status of the Quality Improvement Plan and the county monitoring activities. This review will include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review. This triennial review will provide the State with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity. The counties will receive a final report summarizing the findings of the triennial review and if out of compliance, the county must submit a plan of correction (POC) within 60 days of receipt of the final report. The State will follow-up with the POC to ensure compliance.

171. DMC-ODS County Oversight, Monitoring and Reporting.

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. For counties that have an integrated mental health and substance use disorders department, this Quality Improvement Plan may be combined with the Mental Health Plan (MHP) Quality Improvement Plan.

a. The county shall have a Quality Improvement committee to review the quality of substance use disorders services provided to the beneficiary. For counties with an

integrated mental health and substance use disorders department, the county may use the same committee with SUD participation as required in the MHP contract.

b. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment
    ii. Timeliness of services of the first dose of NTP services
    iii. Access to after-hours care
    iv. Responsiveness of the beneficiary access line
    v. Strategies to reduce avoidable hospitalizations
    vi. Coordination of physical and mental health services with waiver services at the provider level
    vii. Assessment of the beneficiaries' experiences
    viii. Telephone access line and services in the prevalent non-English languages.

c. Each county's QI Committee should review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol.
    i. Number of days to first DMC-ODS service at appropriate level of care after referral
    ii. Existence of a 24/7 telephone access line with prevalent non-English language(s)
    iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s)
    iv. Number, percentage of denied and time period of authorization requests approved or denied

d. Counties will have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care. Counties shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

e. Counties will provide the necessary data and information required in order to comply with the evaluation required by the DMC-ODS.

172. Financing

For claiming federal financial participation (FFP), Counties will certify the total allowable expenditures incurred in providing the DMC-ODS waiver services provided either through county-operated providers (based on actual costs, consistent with a cost allocation

methodology if warranted), contracted fee-for-service providers or contracted managed care plans (based on actual expenditures). For contracted FFS providers, counties will propose county-specific rates except for the NTP/OTP modality and the State will approve or disapprove those rates. NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide their county with financial data on an annual basis. This data is to be collected for the purpose of setting the rates after the expiration of the waiver. The DHCS Rates Setting Workgroup shall propose a recommended format for this annual financial data and the State will approve a final format. Counties shall provide this financial data to the DHCS Rates Setting Workgroup upon its request. The provision in the Welfare and Institutions Code, Section 14124.24(h)) remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

If during the State review process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services. Rates will be set in the State and County intergovernmental agreement. For contracted managed care plans, counties will reimburse the managed care organizations the contracted capitation rate. A CMS-approved CPE protocol, based on actual allowable costs, is required before FFP associated with waiver services is made available to the state. This approved CPE protocol (Attachment AA) must explain the process the State will use to determine costs incurred by the counties under this demonstration.

Only state plan DMC services will be provided prior to the DHCS and CMS approval of the State/County intergovernmental agreement (managed care contract per federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the state plan reimbursement methodologies until a county is approved to begin DMC-ODS services.

SB 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount which funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of October 1-September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate state agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The state will continue to monitor the BH subaccount and counties to ensure that SUD is not artificially underspent.

Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure, including but not limited to, for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and CMS will have the final approval of any alternative reimbursement structure pilot proposed by

the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

173. 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 the four key areas of access, quality, cost, and integration and coordination of care. Specifically, the data collection, reporting and analysis strategy for this waiver program will be designed to assess 1) the impact of providing intensive outpatient SUD services in the community; 2) the effectiveness of drug based SUD treatments; 3) the impact of providing residential SUD services; 4) whether the length of stay of residential SUD services affects the impact of such services; and 5) whether the residential treatment methods affect the impact of such services. These impacts will be assessed in terms of beneficiary access, health care costs, outcomes and service utilization, and will utilize a comparison between comparable populations in opt-in counties and other counties. The measurement strategy will track readmission rates to the same level of SUD care or higher, emergency department utilization and inpatient hospital utilization. The measurement strategy will also evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD continuum as well as linkages with primary care upon discharge. California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The design of the evaluation is contained in Attachment DD: UCLA Evaluation. The state will submit the complete design of the evaluation within 60 days of the approval of the amendment.

One of the focuses of the first year of the evaluation will be that each opt-in county has an adequate number of contracts with NTP providers, access to NTP services has remained consistent or increased and that no disruption to NTP services has occurred as a result of the DMC-ODS.

174. Federal 42 CFR 438 and other Managed Care Requirements

a. Any entity that receives a prepayment from the state to provide services to beneficiaries will be considered by federal definition, a managed care plan and held to all federal 42 CFR 438 requirements and requirements in this section. Accordingly, counties participating in this DMC-ODS Pilot program will be considered managed care plans. CMS will waive the following 438 requirement(s):

   438.310-370 (External Quality Review Organizations, or EQROs). Opt-in counties will include in their implementation plan a strategy and timeline for meeting EQR

requirements. EQR requirements must be phased in within 12 months of having an approved implementation plan. EQRO monitoring visits will begin in March 2016 in Phase One counties and Phase Two counties will begin in September 2016. By January 2017, the EQRO will begin monitoring all Pilot counties phased into the DMC-ODS.

b. Implementation cannot begin prior to CMS review and approval of the State/County intergovernmental agreement (managed care plan contracts per federal definition).

c. At least sixty (60) days prior to CMS intergovernmental agreement approval the state shall submit for each opt-in county the applicable network adequacy requirements as part of the county implementation plan. CMS concurrence with standards is required. At least sixty (60) days prior to CMS intergovernmental agreement approval the state shall provide all deliverables necessary to indicate compliance with network adequacy requirements.

Attachment A – Reserved For "Critical Path for SPD Enrollment" form

Attachment B – Reserved For "SPD Discharge Planning Checklist" form

http://www.medicare.gov/publications/pubs/pdf/11376.pdf

Attachment C – Government Hospitals to be Reimbursed on a Certified Public Expenditure Basis

State Government-operated University of California (UC) Hospitals

1. UC Davis Medical Center
2. UC Irvine Medical Center
3. UC San Diego Medical Center
4. UC San Francisco Medical Center
5. UC Los Angeles Medical Center
6 Santa Monica UCLA Medical Center (aka – Santa Monica UCLA Medical Center & Orthopedic Hospital)

<u>Non-State Government-operated</u>

Los Angeles County (LA Co.) Hospitals

1. LA Co. Harbor/UCLA Medical Center
2. LA Co. Olive View Medical Center
3. LA Co. Rancho Los Amigos National Rehabilitation Center
4. LA Co. University of Southern California Medical Center

Other Government-Operated Hospitals

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Ventura County Medical Center

Attachment C – Government Hospitals to be Reimbursed on a Certified Public Expenditure Basis

Attachment D - Additional Cost Elements for Government-Operated Hospitals Using Certified Public Expenditure (CPE) Methodology (For Purposes of Adjusting the CMS 2552-96 Cost Report)

Hospital Cost Element	Medi-Cal Payment			
	Regular Medi-Cal Inpatient CPE	SNCP UCC	DSH UCC	Offset DSH Limit
a) Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing. [1]	No	Yes	No	No
(b) Provider component of provider-based physician costs not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Costs of interns and residents in accredited programs.	Yes	Yes	Yes	Yes
(b) Costs of training and supervision provided by teaching physicians not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Non-physician practitioner costs	No	Yes	No	No
(b) For contracted therapy services, these costs will not be subject to Publication 15-1, Section 1400, limitations (but will be subject to applicable OMB Circular A-87 requirements.)	No	No	No	No
Non-hospital-based clinics that are under the hospital's license and are classified in the Cost Report as "Non-reimbursable Clinics"	No	Yes	No	No
Public hospital pensions	No	Yes	No	No
Administrative costs of the hospital's billing activities associated with physician services billed and received by the hospital.	No	Yes	No	No
Patient and community education programs, excluding cost of marketing activities	No	Yes	No	No

Investigational and "off-label" drugs	No	Yes	No	No
Dental services – Inpatient only	Yes	No	Yes	Yes
Telemedicine services	No	No	No	No
(a) Drugs and supplies provided to non-Medi-Cal patients in non-inpatient or non-outpatient settings (b) Drugs and supplies provided to non-Medi-Cal patients in inpatient and outpatient settings	No No	Yes Yes	No Yes	No Yes
Costs associated with securing free drugs for indigent persons	No	Yes	No	No

Hospital Cost Element	**Medi-Cal Payment**			
	Regular Medi-Cal Inpatient CPE	**Safety Net Care Pool UCC**	**DSH UCC**	**Offset DSH Limit**
Patient transportation	No	No	No	No
Services contracted to other providers, including services to treat uninsured patients	No	Yes	No	No
The actual cost incurred by the hospital for physicians' private offices, less the fair market value rent paid by the physicians.	No	No	No	No

Attachment E – Inpatient Hospital Component

The Inpatient Hospital Component (formerly called the Selective Provider Contracting Program and operated under section 1915(b)(4) of the Social Security Act) allows the State to selectively contract with hospitals for acute inpatient hospital services (excluding emergency services) and to limit beneficiary freedom of choice to those hospitals that agree to contract with the California Medical Assistance Commission for Medi-Cal (CMAC). It is jointly administered by the California Department of Health Care Services and CMAC.

This Demonstration incorporates the State's descriptions and assurances with respect to Beneficiary Access and Program Monitoring, as described in Chapters II and III of the "Selective Provider Contracting Program Federal Waiver Renewal" document dated September 2001. The State will ensure the Inpatient Hospital Component of this Demonstration will not substantially impair access to quality inpatient hospital services and will not restrict access to emergency services.

Attachment F

Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming

The State must modify this protocol as well as any portion of the approved Medicaid State Plan that utilizes certified public expenditures (CPEs) to reflect any changes in CPE regulations or policy that CMS may release.

I. SUMMARY OF MEDI-CAL 2552-96 COST REPORT AND STEP-DOWN PROCESS

Worksheet A
The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:
(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and,
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C
Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records. The cost-to-charge ratios are used in the Worksheet D series (see the apportionment process of ancillary and other non-routine cost centers).

Worksheet D
This series (including D-1) is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. For example, an apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost, Medicare hospital outpatient cost, as well as Medicaid hospital inpatient routine and ancillary cost, and Medicaid hospital outpatient cost, etc.

(i) Under the apportionment process for each routine service cost center, a per diem is computed by dividing the cost center's reimbursable cost by the cost center's total patient days. The resulting per diem is multiplied by the number of program days to arrive at program cost.

(ii) Under the apportionment process for each ancillary/outpatient /other non-routine reimbursable cost center, the cost-to-charge ratio from Worksheet C for each cost center is multiplied by the program charge for that cost center to arrive at program cost.

Worksheet E
This series contains the settlement worksheets that compute actual reimbursement and account for interim payments. The Medicaid costs computed from the Worksheet D series are transferred to Worksheet E-3, Part III (Title 19) for Medicaid.

NOTES:

(i) States making CPE-funded payments for non-hospital-based costs under section 1115(a)(2) waiver authority, must develop/identify a separate cost reporting tool and receive CMS approval for such cost reporting prior to claims for Federal matching funds.

(ii) For purposes of utilizing the Medi-Cal 2552-96 cost report to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

> The term "finalized Medi-Cal 2552-96 cost report" refers to the cost report that is settled by the Department of Health Care Services (DHCS), Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).
>
> The term "filed Medi-Cal 2552-96 cost report" refers to the cost report that is submitted by the hospital to A&I and is due 5 months after the end of the cost reporting period.
>
> Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

(iii) Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics such as relative value units in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this document. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE MEDICAID HOSPITAL COSTS

To determine a governmentally-operated hospital's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by a State through the certified public

expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Interim Medicaid Inpatient Hospital Payment Rate

The purpose of an interim Medicaid inpatient hospital payment rate is to provide an interim payment that will approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medi-Cal 2552-96 cost report, follow the Medi-Cal 2552-96 cost report apportionment process as prescribed in the Worksheet D series to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

   On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26, since Medi-Cal does not separately reimburse for Graduate Medical Education costs via a per-resident amount methodology. If the costs have been removed, the State should add allowable interns and residents costs back to each affected cost center prior to the computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. The State is to only add back allowable interns and residents costs that are consistent with Medicare cost principles. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as GME under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

   For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), the State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the Medicaid inpatient dental services identified in Attachment D to the Special Terms and Conditions. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

   Additionally, the State will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 cost report's Worksheet D series. This will include reviewing the

Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report. However, because the MMIS/claims system data would generally not include all paid claims until 18 months after the Fiscal Year Ending (FYE) of the cost report, the State will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in Step number 3 below.

3. The computed Medicaid non-psychiatric inpatient hospital cost computed in Step number 2 above should be divided by the number of Medicaid non-psychiatric inpatient hospital days as determined in Step number 2 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

4. The Medicaid per day amount computed in Step number 3 above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The Medicaid per day amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

   (i) Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
   (ii) Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

   Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid non-psychiatric inpatient hospital cost per day amount to be used for interim Medicaid inpatient hospital payment rate purposes.

5. An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

<u>Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate</u>

Attachment F

Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming

Each governmentally-operated hospital's interim Medicaid payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the cost report worksheet D series with Medicaid program data generated -from its MMIS/claims system for the respective cost reporting period. As explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, data generated from the MMIS/claims system will not be complete, and steps to verify the data will be taken by the State including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments and interim adjustments in a spending year will also be subsequently reconciled to its Medi-Cal 2552-96 cost report for that same spending year as finalized by A&I for purposes of Medicaid reimbursement. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series with Medicaid program data generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this final reconciliation process.

III. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE SAFETY NET AND DSH COSTS FOR HOSPITALS

To determine a governmentally-operated hospital's allowable Safety Net Care Pool (SNCP) costs and the associated SNCP reimbursements and to determine a hospital's allowable uncompensated care costs eligible for disproportionate share hospital (DSH) reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Safety Net Care Pool (SNCP) Payments to Hospitals

The purpose of interim SNCP payments is to provide an interim payment that will approximate the SNCP costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim SNCP payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instruction below.

1. The process of determining the allowable SNCP costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. The total allowable SNCP hospital cost should be computed by using the most recently filed Medi-Cal 2552-96 cost report.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the SNCP cost elements identified in Attachment D to the Special Terms and Conditions.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

In the cost report apportionment process in Worksheet D series, auditable uninsured program data (days and charges) will be used to determine uninsured hospital cost. This data will be submitted to the State by the hospitals based on data from the hospital's records. Only program data for medical services eligible for SNCP should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

The costs described in this document eligible under the SNCP relate strictly to individuals with no source of third party insurance coverage for the inpatient and outpatient hospital services they receive that would have been benefits eligible for federal reimbursement under Title XIX had these individuals been eligible Medi-Cal beneficiaries, and those costs identified in Attachment D of the Special Terms and Conditions. The determination of other costs eligible for SNCP funding (e.g., clinic costs, medical care costs incurred by the State or counties) will be addressed in a separate methodology within the protocol document.

The program data should be for the period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

Any SNCP-eligible cost that is not reported on the hospital cost report or that the State believes should not be subject to the cost report apportionment process must be identified separately to and approved by CMS.

Any self-pay payments made by or on behalf of uninsured patients to the hospital for services of which the costs are already included in the SNCP cost computation described above should be offset against the computed SNCP-eligible costs. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

3. The net SNCP cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net SNCP costs

may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

ii. Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.

iii. Inpatient and outpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

4. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

5. The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

   i. Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
   ii Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
   iii. Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments
   iv. Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
   v. Total non-hospital costs funded by SNCP payments.

   An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

6. Interim SNCP payments can be made based on the SNCP certifiable expenditures as computed above. The interim payments can be on a quarterly or other periodic basis approved by CMS. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim SNCP Payments to Hospitals

Each governmentally-operated hospital's interim SNCP certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total SNCP certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under the interim reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim SNCP Payments to Hospitals

Each governmentally-operated hospital's interim SNCP certifiable expenditures (and any interim adjustments) will also subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certifiable SNCP expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the finalized Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under this final reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

<u>Disproportionate Share Hospital (DSH) Payments</u>

The purpose of an interim DSH payment is to provide an interim payment that will approximate the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs ("shortfall") eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable DSH costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. The total Medicaid managed care and Medicaid psychiatric inpatient and outpatient hospital shortfall and the uninsured hospital inpatient and outpatient costs should be computed by using the most recently filed Medi-Cal 2552-96 cost report.[1]

   As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

   In the cost report apportionment process in the Worksheet D series, auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) will be used to compute the hospital's eligible DSH cost. This data will be submitted to the State. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. The program data should be from the period which corresponds to the most recently filed Medi-Cal cost report. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

   Uninsured individuals are individuals with no source of third party insurance coverage for the inpatient hospital and outpatient hospital services they receive and as defined in governing federal statute and regulation.

3. All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost from Step number 2 above to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

[1] No shortfall related to fee-for-service Medicaid inpatient hospital and /or Medicaid outpatient hospital services is anticipated based on the certification of public expenditures up to total Medicaid inpatient and Medicaid outpatient hospital costs.

4. The net DSH cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net DSH costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

   (i) Inpatient and outpatient hospital costs not reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
   (ii) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

   Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

   An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

5. The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

   (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
   (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
   (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
   (iv) inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
   (v) Total non-hospital costs funded by SNCP payments.

6. Interim DSH payments can be made based on the eligible DSH expenditure computed above. The interim payments can be on a quarterly or other periodic basis, but such payments must account for all revenue offsets. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim DSH Payments

Attachment F

Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming

Each governmentally-operated hospital's interim DSH certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;

(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim DSH Payments

Each governmentally-operated hospital's interim DSH certifiable expenditures (and any interim adjustments) will subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the finalized Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital’s expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the

computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

<u>NOTES</u>:

(i) All disproportionate share hospital (DSH) payments, funded through certified public expenditures or otherwise, are subject to the State of California's aggregate DSH allotment.
(ii) Based on the State of California's proposal to certify total Medicaid inpatient and outpatient hospital costs (non-managed care), there would be no fee-for-service Medicaid inpatient and/or outpatient hospital cost "shortfall" for purposes of the hospital-specific DSH limits.
(iii) For California's DSH hospitals that qualify for 175% DSH payment under the Benefits, Improvements, and Protections Act of 2000, during waiver years one and two, for the specific purpose of computing 175% of the OBRA 1993 hospital-specific uncompensated care cost (UCC) limit, UCC is computed without an offset for Safety Net Care Pool (SNCP) claims made for the uninsured. However, the combination of SNCP funds and DSH funds that are claimed will not exceed 175 percent of UCC (for those hospitals subject to the 175 percent authority), to ensure no duplication of claiming. For purposes of the preceding sentence, each hospital's SNCP certifiable expenditures (excluding costs that are ineligible for DSH claiming) that are actually used by the State for claiming SNCP funds shall be counted against the above

hospital-specific claiming limits, rather than the amounts actually distributed to the hospital by the State.

(iv) Claims that are based on CPEs of qualifying UCC (determined as described in this document) may be submitted for Federal reimbursement from a combination of SNCP and DSH funds, at the State's discretion. The State may also claim federal DSH funds with respect to DSH payments made to hospitals equivalent to costs between 100 and 175 percent of eligible UCC, regardless of whether the combined amount of DSH and SNCP funds have been claimed based on CPEs to 100 percent of the hospital's UCC, provided that 100 percent of UCC has been certified as actually expended. There will be no duplication of UCC claimed for SNCP and DSH reimbursement.

Attachment F – Supplement 1
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)

SCNP Payments – Physician and Non Physician Professional Services

To determine a government-operated hospital's allowable physician and non-physician professional service costs eligible for SNCP reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation.

The purpose of interim SNCP payments for physician and non-physician practitioner professional costs is to provide an interim payment that will approximate the SNCP costs eligible Federal financial participation through the CPE process. This computation of establishing interim physician and non-physician practitioner professional services payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instruction below.

The government-operated hospitals identified in Attachment C and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers.

The eligible SNCP costs are uncompensated costs incurred by each provider described above for the furnishing of physician and non-physician professional services to uninsured individuals in accordance with STCs Items 43 – 50.

Eligible professional costs are reported on the designated hospitals' Medi-Cal 2552 cost report and, in the case of the University of California (UC) hospitals, the UC School of Medicine physician/non-physician practitioner cost report as approved by the Centers for Medicare & Medicaid Services.

1. Non-UC Provider Steps

   a. The professional component of physician costs are identified from each hospital's most recently filed Medi-Cal 2552 cost report Worksheet A-8-2, Column 4. These professional costs are:

      1. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
      2. For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
      3. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities));

SCNP Payments – Physician and Non Physician Professional Services

4. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
5. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for uninsured physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services furnished by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medi-Cal cost report. The practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

1. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line

with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore are not included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

1. these costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. they are directly identified on ws A-8 as adjustments to hospital costs;
3. they are otherwise allowable and auditable provider costs; and
4. they are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records. Los Angeles County hospitals, due to their all-inclusive billing limitations, do not have itemized physician or non-physician practitioner charges. Therefore, these hospitals are to use the hospital RVU system to apportion professional costs to uninsured services under the SNCP claiming; this is the same RVU system as that used by Los Angeles County hospitals for Medicare and Medi-Cal cost reporting purposes. Where charges are mentioned in this paragraph and later paragraphs in this subsection, Los Angeles County will use its RVUs.

SCNP Payments – Physician and Non Physician Professional Services

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1.

i The total professional charges for each cost center related to eligible uninsured physician services, billed directly by the hospital, are identified using auditable hospital financial records. Hospitals must map the charges to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible uninsured professional charges, billed directly by the hospital, are identified using auditable hospital financial records. Hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

j. The total uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total uninsured costs related to non-physician practitioner professional services are determined by multiplying total uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total uninsured costs eligible for SNCP claiming are determined by subtracting all revenues received for the uninsured physician/practitioner services from the uninsured costs as established in paragraph j of subsection 1. The amount of the SNCP interim payment will be based on the costs for the period coinciding with the latest as-filed cost report; the data sources for uninsured claims are from the auditable hospital records. All revenues received (other than the SNCP professional payments being computed here in this section) for the uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other

payers. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only.

l. The uninsured physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The uninsured amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

1. Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

2. Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the uninsured physician/practitioner amount to be used for interim SNCP payment purposes.

2. UC Provider Steps

a. The physician compensation costs are identified from each UC School of Medicine's trial balance and reported on a CMS-approved UC physician/practitioner cost report. These professional compensation costs are limited to identifiable and auditable costs that have been incurred by the UC School of Medicines' physician practice group(s) for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the UC practice groups and at sites not owned or operated by the UC for which the UC practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the UC physician cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated

between clinical and non-clinical activities using a CMS-approved time-study. Prior to July 1, 2008, the UCs may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate UC physician compensation costs between clinical and non-clinical activities only. The result of the CMS-approved time study (or the benchmark RVU methodology before July 1, 2008) is the physician compensation costs pertaining only to clinical, patient care activities.

c. The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for uninsured professional cost determination purposes. There will be offset of revenues received for services furnished by such professionals to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

d. Reimbursement for non-physician practitioner compensation costs will also be included. The practitioner types to be included on the UC physician/practitioner cost reports are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

e. These non-physician practitioner compensation costs are recognized if they meet the following criteria:

(1) the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
(2) the non-physician practitioner compensation costs are derived from an identifiable and auditable data source by practitioner type;
(3) a CMS approved time study will be employed to allocate practitioner compensation between clinical and non-clinical costs;
(4) the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for

services furnished by such practitioners to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. Each non-physician practitioner type is reported in its own cost center on the UC physician/practitioner cost report.

f. The above physician or non-physician practitioner compensation costs must not be duplicative of any costs claimed on the UC hospital cost reports.

g. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipments used in the furnishing of direct patient care.

h. Overhead costs will be recognized through the application of each UC's cognizant agency-approved rate for indirect costs. The indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician and/or non-physician practitioner compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center.

Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

i. Total billed professional charges by cost center related to physician services are identified from provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records.

j. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-h of subsection 2 by the total billed professional charges for each cost center as established in paragraph i of subsection 2. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-h of subsection 2 by the total billed professional charges for each practitioner type as established in paragraph i of subsection 2.

k. The total professional charges for each cost center related to eligible uninsured physician services, billed directly by UC, are identified using auditable UC financial records. UCs must map the claims to their cost centers using information from their billing systems. Each charge must be mapped to only one cost center to

prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible uninsured professional charges, billed directly by the UC, are identified using auditable UC financial records. UCs must map the claims to non-physician practitioner type using information from their billing systems. Each charge must only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

l. The total uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total uninsured charges as established in paragraph k of subsection 2 by the respective cost to charge ratio for the cost center as established in paragraph j of subsection 2.

For each non-physician practitioner type, the total uninsured costs related to non-physician practitioner professional services are determined by multiplying total uninsured charges as established in paragraph k of subsection 2 by the respective cost to charge ratios as established in paragraph j of subsection 2.

m. The total uninsured costs eligible for SNCP claiming are determined by subtracting all revenues received for uninsured physician practitioner services from the uninsured costs as established in paragraph l of subsection 2. The amount of the SNCP interim payment will be based on the costs for the period coinciding with the latest as-filed cost report; the data sources for uninsured claims are from the auditable UC records. All revenues received (other than the SNCP professional payments being computed here in this section) for the uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other payers. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only.

n. The uninsured physician/practitioner amount computed in paragraph m above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The uninsured amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental

payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

(2) Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the UCs and subject to review by the State and CMS. The result is the uninsured physician/practitioner amount to be used for interim SNCP payment purposes.

Interim Reconciliation of Physician and Non-Physician Practitioner Professional Services Payments to Hospitals

The physician and non-physician practitioner SNCP payments determined under subsections 1 and 2, which are paid for services furnished during the applicable state fiscal year, are reconciled to the as-filed Medi-Cal 2552 and UC physician/practitioner cost reports for the same year once the cost reports have been filed with the State. The UC physician/practitioner cost report should be filed, reviewed, and finalized by the State in a manner and timeframe consistent with the Medi-Cal hospital cost report process. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, and the provider will receive an adjusted payment amount. For purposes of this reconciliation the same steps as outlined for the interim payment method are carried out except as noted below:

1. For the determinations made under paragraphs a through h of subsection 1 and paragraphs a through j of subsection 2 of Section C, the costs and charges from the as-filed physician/practitioner cost report for the expenditure year are used.

2. For the determinations made under paragraph i of subsection 1 and paragraph k of subsection 2, uninsured professional charges for covered services furnished during the applicable fiscal year are used. The State will perform those tests necessary to determine the reasonableness of the uninsured physician/practitioner charges from the as-filed physician/practitioner cost report. Only eligible uninsured data related to the furnishing of physician/practitioner professional medical services should be used in the apportionment process.

3. For the determinations made under paragraph k of subsection 1 and paragraph m of subsection 2, uninsured professional services furnished during the applicable state fiscal year are used.

Final Reconciliation of Physician and Non-Physician Practitioner Professional Services Payments to Hospitals

SCNP Payments – Physician and Non Physician Professional Services

Once the Medi-Cal 2552 and the UC physician/practitioner cost report for the expenditure year have been finalized by the State, a reconciliation of the finalized costs to all SNCP payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medi-Cal 2552 and UC physician/practitioner cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The following shall apply to determine the allowable costs of providing services to uninsured individuals in government owned or operated non-hospital clinics (i.e., clinics that are not hospital outpatient departments), for purposes of calculating certified public expenditures that may be used to claim federal financial participation (FFP) from the Safety Net Care Pool (SNCP).

Cost Finding Methodology – General Provisions

Costs, as determined under this Supplement, will be computed in accordance with Title 42 of the Code of Federal Regulations (CFR) Part 413; the Provider Reimbursement Manual (CMS Pub. 15-1); and other applicable federal directives that establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the uninsured program, except as expressly modified in this Supplement.

The allowable SNCP non-hospital clinic costs determined under this methodology include direct, ancillary, physician/non physician practitioner, and overhead costs, which are incurred in providing health care services that are not identified as hospital services under the Special Terms and Conditions and applicable State law to uninsured beneficiaries in eligible facilities, and determined to be allowable under the regulations and publications specified above.

Allowable non-hospital clinic costs will be derived from the clinic's general ledger and reported on the approved clinic cost reporting forms. General ledger supporting schedules which group costs into direct service and overhead cost centers will accompany the filed clinic cost reports. Direct service costs and overhead expenses will be reported on separate cost center lines, and non-allowable costs will either be reclassified to non-reimbursable cost centers or removed through discrete adjustments. Reclassifications and adjustments to the working trial balance, including the assignment of costs to non-reimbursable cost centers, or and the discrete disallowance of expenses, will be recorded on supporting schedules which will be submitted with the approved cost reporting forms.

Clinic overhead costs will be equitably allocated to non-allowable activities based on the use of such overhead costs by the non-allowable activities.

The allowable costs for non-hospital clinic services provided to uninsured patients will be based on the clinic's cost report which includes data for visits. The clinic cost report will determine the per-visit cost for a patient. For the purposes of determining the per-visit cost, a "visit" is defined as a face-to-face encounter between a clinic patient and health professional pursuant to paragraph F, below, for which the services provided have been documented.

Determination of Allowable SNCP Costs for Services Provided to Uninsured Individuals in Government owned and Operated Non-hospital Clinics

The per-visit cost will be multiplied by the number of uninsured visits to determine the total uninsured costs for the clinic.
The total uninsured costs for the non-hospital clinics computed above must be offset by any payments received by the clinic from or on behalf of the patient for such uninsured clinic services. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or local government (e.g., state-only, local-only, or joint state-local health programs) for services provided to indigents shall not be offset.
The net uninsured costs computed above will be reduced by 13.95 percent to account for non-emergency care furnished to unqualified aliens.
Interim SNCP certified expenditures for non-hospital clinic services will be determined for each fiscal period pursuant to the steps outlined above using the most recently available clinic cost report (if appropriate trended to the current year based on Market Basket update factor(s) or other health care related indices as approved by CMS), that are submitted to the State in conjunction with the Interim Hospital Payment Rate Workbook.
Interim Reconciliation

The certified expenditures for non-hospital clinic services for each fiscal period will be subject to an interim reconciliation. Allowable costs will be computed pursuant to the steps described in subparagraphs A.1 through A.8, above, using cost, visit, and payment data from each clinic's as-filed cost report and other supplemental data for the applicable fiscal period that are submitted to the State in conjunction with the Interim Hospital Payment Rate Workbook.
The State may, if appropriate, make adjustments to costs reported on the as-filed cost report based on the results of the most recently completed audit, settlement or appeal determination of a prior year cost report.
The State will adjust the amount of SNCP funds claimed and any overpayment will be credited to the federal government.
Final Reconciliations

The certified expenditures for non-hospital clinic services for each fiscal period will be subject to a final reconciliation. Allowable costs will be computed pursuant to the steps described in subparagraphs A.1 through A.9, above, using cost, visit, and payment data from the clinic's cost report for the applicable fiscal period and other supplemental data for the period submitted in conjunction with the Interim Hospital Payment Rate Workbook that is finalized by the State during its audit and settlement process..
The State will adjust the amount of SNCP funds claimed and any overpayment will be credited to the federal government.
Eligible Clinic Reporting Requirements

The governmental entity that reports on behalf of any eligible non-hospital clinic must do all of the following:

Determination of Allowable SNCP Costs for Services Provided to Uninsured Individuals in Government owned and Operated Non-hospital Clinics

Report costs annually on cost reporting forms approved by the State. The clinics will use clinic cost reporting forms that are modeled on the CMS approved Federally Qualified Health Center (FQHC) cost reporting form, and that have been approved by the State and CMS.
Complete the cost report which is due five months after the fiscal period in order to submit the annual workbook and cost certification to the State in a timeframe specified by the State.
Provide evidence supporting the cost report and the cost determination as specified by the State.
Keep, maintain and have readily retrievable, such records as specified by the State to fully disclose reimbursement amounts to which the eligible clinic is entitled, and any other records required by CMS.

Definition of Visit

For the purposes of determining the per-visit cost pursuant to paragraph A, above, a "visit" is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, clinical psychologist, or licensed clinical social worker, hereafter referred to as a "health professional." For purposes of this paragraph E, "physician" includes the following:

(a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

(b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

(c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.

(d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license.

(e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of determining a per visit cost, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

Determination of Allowable SNCP Costs for Services Provided to Uninsured Individuals in Government owned and Operated Non-hospital Clinics

(a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

(b) When the clinic patient is seen by a dentist and sees any one of the following providers: physician (as defined in subparagraphs (1)(a) through (1)(e), above), physician assistant, nurse practitioner, clinical psychologist, or licensed clinical social worker, two visits may be counted.

Attachment F – Supplement 3
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)
Determination of Allowable Costs to Uninsured Individuals in Designated State Health Programs

The Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration, approved by the federal Centers for Medicare and Medicaid Services (CMS) on November 2, 2010, allow the State to use allowable costs in Designated State Health Programs (DSHPs) incurred from November 1, 2010 through October 31, 2015 for federal claiming against the Safety Net Care Pool (SNCP).

DSHPs, as described under this Supplement, have two components, State Only Medical Programs (SOMPs) and Workforce Development Programs (WDPs). SOMPs are the following eleven programs funded with state and/or local funds:
California Children Services (CCS);
Genetically Handicapped Persons Program (GHPP);
Medically Indigent Adult Long-Term Care (MIA/LTC);
Breast & Cervical Cancer Treatment Program (BCCTP);
County Medical Services Program (CMSP) – for the period November 1, 2010 through December 31, 2011;
Expanded Access to Primary Care (EAPC);
AIDS Drug Assistance Program (ADAP);
County Mental Health Services for the Uninsured (CMHS);
Every Woman Counts (EWC); Prostate Cancer Treatment Program (PCTP);
Department of Developmental Services (DDS)

The allowable costs incurred in the SOMPs for claiming against the SNCP relate strictly to expenditures for uncompensated care provided to individuals with no sources of third party insurance coverage. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

To determine allowable SNCP costs and the associated SNCP reimbursement when such costs are incurred by the State and/or the local government as certified public expenditures (CPEs), the following steps must be taken to ensure federal financial participation (FFP):

I. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR CCS, GHPP, MIA/LTC, BCCTP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS

A. General Provisions

Program costs, for each program described above, mean the total expenditures incurred in the State Fiscal Year (SFY) ended June 30 from all the funding sources. Allowable DSHP expenditures will be applied against each Demonstration Year using the date of service information from each paid claim.

Net program costs are program costs for health care services only.

DSHP costs, for each program described above, are net program costs funded by the State and/or local funds.

Allowable DSHP costs are DSHP costs for health care services which are allowable under section 1905(a) of the Social Security Act, rendered to the uninsured population.

Allowable SNCP costs, for each program described above, except for CMSP, are limited to the allowable DSHP costs incurred for the months of Demonstration Year (DY) per the STCs. Allowable SNCP costs for CMSP are limited to the allowable DSHP costs incurred for the period of November 1, 2010 through December 31, 2011.

For the purpose of interim claiming, the estimated program costs for each SFY are the budget amount of Fund Appropriation for the applicable fiscal period that the State and other funding authorities commit to each SOMP. The estimated program cost for each fiscal period is reduced by funding for administrative activities to arrive at estimated net program cost. Estimated net program cost is reduced by budgeted funding from non-State, non-local sources to arrive at estimated DSHP cost. Estimated DSHP cost is multiplied by an interim allocation percentage to arrive at the estimated allowable SNCP cost for the fiscal period.

For SFY 2010-11, the interim allocation percentage, for each program described above, is the ratio of total allowable SNCP costs from November 1 to June 30 of the prior period to the total twelve-month DSHP costs of the prior period.
For SFYs 2011-12, 2012-13, and 2014-15, the interim allocation percentage, for each program described above, is the ratio of total allowable SNCP costs from July 1 to June 30 of the prior period to the total twelve-month DSHP costs of the prior period.
For SFY 2015-16, the interim allocation percentage, for each program described above, is the ratio of total allowable SNCP costs from July 1 to October 31 of the prior period to the total twelve-month DSHP costs of the prior period

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. To implement this limitation, 13.95 percent of total certified public expenditures for services to uninsured individuals will be treated as expended for non-emergency care to non-qualified aliens. The State will implement this requirement for the following DSHPs:

- CCS, GHPP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS– A 13.95 percent reduction factor is applied to the total certified SNCP expenditures before costs are claimed.

- MIA/LTC and BCCTP - No reduction factor is applied to the total certified SNCP expenditures before costs are claimed. There are no unqualified aliens receiving services under the MIA/LTC program. Expenditures related to non-emergency services for unqualified aliens under the BCCTP will be identified and excluded by aid codes.

B. Program Description

California Children Services (CCS)
CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age.
Genetically Handicapped Persons Program (GHPP)
GHPP provides comprehensive health care coverage for persons over 21 years of age with specified genetic disease, including cystic fibrosis, hemophilia, sickle cell diseases and thalassemia, and chronic degenerative neurological diseases.
Medically Indigent Adult Long-Term Care (MIA/LTC)
MIA/LTC provides the medically necessary services required as part of the patient's day-to-day plan of care in the long-term care facility, including pharmacy, support surface and therapies.
Breast and Cervical Cancer Treatment Program (BCCTP)
BCCTP provides cancer treatments for eligible low-income California (CA) residents who are screened by Cancer Detection Program and Family Planning, Access, Care and Treatment (Family PACT).

* Eligibility
CCS: A child under 21 years old with family income of $40,000 or less is a resident of CA and has out-of-pocket medical expenses expected to be more than 20% of family adjusted gross income.
GHPP: California residents ages 21 years or older have genetic conditions specified in the CA Code of Regulations, Title 17, Section 2932.
MIA/LTC: Individuals age 21 or older and under 65 year of age who do not have linkage to another program and who are US citizens or legal residents and are residing in a Nursing Facility Level A or B.
BCCTP: A CA resident, who is male of any age or any immigration status, a female under 65 years of age with non-citizen or unsatisfactory immigration status, or a female 65 years of age or older, has been screened and found in need of treatment for breast and/or cervical cancer, follow-up care for cancer or precancerous cervical lesions/conditions.

* Funding Sources/Flow
CCS, GHPP, MIA/LTC, and BCCTP are State-Only funded programs and funded by the State General Funds. The State fiscal intermediary pays the program claims.

* DSHP Costs
CCS, GHPP, MIA/LTC and BCCTP services are Medicaid-like services. The total program costs for each program funded by the State General Fund for the uninsured population will be used to determine allowable DSHP costs for SNCP reimbursement.

* Report Format

CCS, GHPP, MIA/LTC, and BCCTP program costs will be compiled from the State fiscal intermediary Paid Claims Data using the specific Aid Codes to identify eligibility and the specific Billing Provider Type to identify the services types by date of services.

County Medical Services Program (CMSP)
CMSP provides comprehensive health care services, including hospital inpatient and outpatient services, professional medical services, pharmacy, dental, and vision services, to medically indigent adults residing in California counties. Excluded benefits under CMSP include pregnancy-related services, long-term care or skilled nursing facility services, psychological services provided by non-psychiatrist providers, and methadone maintenance services.

* Eligibility
California residents ages 21 through 64 who are citizens of the US, national of the US, or an alien lawfully admitted for permanent residence, reside in a CMSP participating county, have an income at or below 200 percent of the federal poverty level (FPL), and who are not eligible for Medi-Cal benefits and are not otherwise insured.

* Funding Sources/Flow
Currently, CMSP is funded exclusively by State Realignment funds (motor vehicles license fees and sales taxes) and county general funds. All CMSP funds are permissible sources for the non-federal share of payments under the SNCP. The CMSP Governing Board, through its contractors, is responsible for providing policy direction, setting program eligibility requirements, determining the scope of covered health care benefits, and setting the payment rates paid to health care providers. The State Realignment revenue allocated to CMSP is directly deposited into a Governing Board account used to pay CMSP program cost. The authorized contractors issue checks from the Governing Board account for the payment of claims.
* DSHP Costs
CMSP services are Medicaid-like services. CMSP total program costs funded by State Realignment funds and county general funds will be used to determine allowable DSHP costs for SNCP reimbursement.

* Report Format
CMSP program costs will be compiled from CMSP Paid Claims Data using specific Aid Codes to identify eligibility and Billing Provider Type to identify the service category by date of services.

Expanded Access to Primary Care Program (EAPC)
EAPC was established to improve the quality and expand the access of outpatient health care for medically indigent persons residing in under-served areas of California. The program reimburses community-based primary care clinics, which are primarily Federally Qualified Health Centers (FQHCs) or rural health centers, for uncompensated care visits on a per visit basis. Primary care clinics are funded by EAPC for the delivery of comprehensive primary and

preventive health care services, including medical diagnosis, treatment, support, and smoking prevention and cessation health education.

* Eligibility
Individuals in families with incomes at or below 200 percent of the FPL who do not have third party coverage for any medical services. EAPC is not available to those individuals who are eligible for Medi-Cal services, with the exception of individuals who are eligible for limited Medi-Cal benefits, such as pregnancy services, and emergency services, or recipients of care under the EAPC who have unmet Medi-Cal share of costs.

* Funding Sources/Flow
EAPC is mainly funded by the Cigarette and Tobacco Products Surtax Fund, authorized by the Tobacco Tax and Health Protection Act of 1988 (Proposition 99) and the State General Fund. The program also receives federal Title V funds for expenditures incurred in the California Department of Public Health (CDPH) Children's Medical Services Program, which requires a state match. Federal Title V and Proposition 99 funds are deposited into the State General Fund to pay claims. The State fiscal intermediary pays the program claims.

* DSHP Costs
EAPC services are Medicaid-like services except for the share of cost payments covered under the program for a limited number of EAPC participants. EAPC total program costs funded by the Proposition 99 funds and the State General Fund, net of federal matching requirement and costs incurred for payments for Medi-Cal share of costs or payments for services furnished to individuals who are eligible for limited Medi-Cal, will be used to determine allowable DSHP costs for SNCP reimbursement.

* Report Format
EAPC program costs will be compiled from EAPC Paid Claims Data using the specific Aid Codes to identify the eligibility and the EAPC Billing Codes to identify the services types by date of services.

AIDS Drug Assistance Program (ADAP)
ADAP, established in 1987, provides prescription drug coverage for the HIV positive uninsured and under-insured individuals who are HIV positive, to ensure that they have access to medication. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 established the ADAP nationally and provides the federal fund (CARE Act Fund) for this program.

* Eligibility
HIV-infected individuals who are California residents and 18 years of age or older who:

- Have a Federal Adjusted Gross Income (FAGI) that does not exceed $50,000;
- Have a valid prescription from a licensed California physician; and

- Have limited or no prescription drug benefits from another source.

Federal and State laws require that ADAP funds be used as the payer of last resort and ensure that ADAP is used only after all other potential payer options are exhausted. ADAP participants with limited prescription drug benefits will be eligible for financial assistance in meeting their out-of-pocket costs or premiums payment assistance. ADAP also pays the Share of Cost for individuals who are Medi-Cal beneficiaries.

* Funding Sources/Flow
ADAP is funded by the State General Fund, the Federal fund (CARE Act Fund), and the Special Fund (drug rebate). CDPH is the State's grantee for the federal CARE Act Fund. CDPH is required to meet the annual federal maintenance of effort (MOE) requirements for the grant. Federal CARE Act and Special Funds are deposited into the State General Fund to pay claims. The State pays the program claims.

* DSHP Costs
ADAP services are Medicaid-like services except for payments of share of cost for a limited number of ADAP participants. ADAP program costs funded by the State General Fund and Special Fund that are not used for the CARE Act MOE and matching requirements, net of costs incurred for Medi-Cal share of cost payments or costs incurred for individuals who are otherwise insured, will be used to determine allowable DSHP cost for SNCP reimbursement.
* Report Format
ADAP program costs will be compiled from ADAP Paid Claims Data by funding sources and the eligible population. Claims data is compiled from CDPH paid claims database.

Every Woman Counts (EWC)
EWC is a cancer detection programs that provides CA low income, uninsured and medically underserved women access to screening, and diagnostic services for breast and cervical cancer. EWC offers multi-faceted, early detection and diagnosis services for breast and cervical cancer, coupled with continuous monitoring to reduce missed or delayed cancer diagnoses. EWC provides the direct services including: (1) screening and diagnostic mammography; (2) clinical breast exams; (3) pelvic exams; (4) case management, including follow–up and referrals for abnormal screens; and (5) cervical cancer screening.

* Eligibility
CA female residents with household income at or below 200 percent of the Federal poverty level have no medical insurance coverage for these services or have a high insurance deductible or co-payment and are not getting these services through Medi-Cal or another government-sponsored program. To receive free breast cancer screening services, the individuals must be at least 40 years of ages; to receive free cervical cancer prevention services, the individuals must be at least 25 years of age.

* Funding Sources/Flow
EWC is mainly funded by a federal grant from Disease Control and Prevention (CDC), the tobacco tax revenue, including the Breast Cancer Control Account (BCCA) fund and Proposition 99 fund, and State General Fund. At least 60% of EWC's federal CDC grant must be spent on direct services. After meeting this 60 percent obligation, remaining federal grant funds can be spent for program administration. The CDC grant requires MOE in addition to a three to one matching requirement. The program delivers these direct services through a statewide network of medical providers who enroll women into the program and submit claims to EWC to be reimbursed for delivering the clinical services.

* DSHP Costs
EWC services are Medicaid-like services. EWC total program costs, which are reduced by any program costs for services provided to individuals with high insurance deductible or co-payment and funded by State General Fund, BCCA fund, and Proposition 99 fund that are not used for CDC MOE and matching requirements, will be used to determine allowable DSHP costs for SNCP reimbursement.

* Report Format
EWC program costs will be compiled from EWC Paid Claim Data by the eligible population. Claims data is compile from CDPH paid claims database.

Prostate Cancer Treatment Program (PCTP)
PCTP provides prostate cancer early detection, diagnosis, and comprehensive treatment services to low-income and uninsured men to prevent and reduce the devastating effects of prostate cancer. The direct treatment services include brachytherapy, chemotherapy, hormone therapy, orchiectomy, radical retropubic prostatectomy, radiation therapy, transurethral resection of the prostate and active surveillance. In addition to the direct treatment services, PCTP also offers support services, such as psychosocial therapy, nutrition counseling, patient education, incontinence supplies and transportation assistance. PCTP is administered through a contract with the University of California, Los Angeles (UCLA).

* Eligibility
CA male residents, who are 18 years old or older with household income at or below 200 percent of the Federal poverty level, have no medical insurance coverage for these services and do not qualify for Medicare or Medi-Cal.

* Funding Sources/Flow
PCTP is funded by State General Fund. Eighty seven percent of the total contract funding shall be used for direct patient care. No less than seventy percent of the total contract funding shall be expended on direct patient care treatment, which is defined as funding for fee-for-service providers for Medi-Cal eligible services at established Medi-Cal rate.

* DSHP Costs
PCTP services for direct patient care treatment are Medicaid-like services. PCTP is the payer of last resort for men who are not eligible for Medi-Cal or Medicare and have no access to local or county resources. PCTP total program costs incurred for direct patient care treatment will be used to determine allowable DSPH costs for SNCP reimbursement.

* Report Format
PCTP program costs will be compiled from PCTP Paid Claim Data by treatment category and by the eligible population.

Department of Developmental Services (DDS)
DDS is responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that more than 246,000 people with developmental disabilities receive the services and supports needed to live independent and productive lives. These disabilities include mental retardation, cerebral palsy, epilepsy, autism and related conditions. Services are delivered directly through four state-operated developmental centers and one community facility (Developmental Center Services), and under contract with a statewide network of 21 private, nonprofit regional centers (Community Based Services).

The Lanterman Act establishes an entitlement to services and supports for persons with developmental disabilities and their families that are determined through an individualized planning process that occurs after a series of discussions or interactions among a team of people including the person with a developmental disability, their family (when appropriate), regional center representative(s) and others. The Individual Program Plan (IPP) may include a wide array of services such as: residential, day program and employment, independent and supported living, transportation, behavioral, respite and other family supports, and case management/service coordination. Regional centers are payers of last resort, requiring consumers to access generic resources when available to meet their individual needs.

*Eligibility
- A person with a developmental disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, as defined in California Welfare and Institutions Code (W&I Code) Section 4512. A developmental disability includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation. It does not include conditions that are solely physical in nature.
- Infants and toddlers (age 0 to 36 months) who have a developmental delay (defined in Section 95014 of CA Government Code) also receive services from DDS.

*Funding Sources/Flows

Attachment F – Supplement 3
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)
Determination of Allowable Costs to Uninsured Individuals in Designated State Health Programs

DDS Community-Based Services are funded by the following funding sources:
State Funds:

- State General Fund
- Mental Health Services Fund
- California Children and Family Trust Fund (Proposition 10 funding to create a comprehensive and integrated system of information and services to promote early childhood development (from prenatal to age 5) and school readiness, including community health care, quality child care, and education programs for young children)

Federal Funds:

- Medicaid (e.g. Home and Community Based Services Waiver (HCBS), Medicaid Administration, Targeted Case Management, 1915(i) State Plan Amendment, and Money Follows the Person Grant)
- Title XX Block Grant (no State match or MOE is required)
- Early Start Program Grant for infants and toddlers age 0 to 36 months
- Foster Grandparents Program (administrative funding supports the volunteer program that establishes person-to-person relationship between low income senior, age 55 years or older, and children with intellectual disabilities)
- Homeland Security Grant (funding to regional centers for equipment, training, and exercise to prevent, respond to, and recover from acts of terrorism and other catastrophic events)

Others:

- Program Development Fund (fees assessed to parents of children under the age of 18 who receive 24-hour out-of-home services purchased with State funds through a regional center)
- Vocational Rehabilitation (funding by HCBS and GF for transportation expenditures)
- Developmental Disabilities Services Account (application fees paid by housing developers to reimburse DDS' costs for review and approval of the housing proposals)

The above represents all funding received by DDS for community-based services.

The federal funds are deposited into the State General Fund as reimbursement for appropriate claims initially paid from the General Fund.

*DSHP Costs
DDS services to individuals not eligible for Medi-Cal are Medicaid-like services in that they are the same services as State plan approved services and services provided under approved HCBS waivers for Medi-Cal beneficiaries. DDS services applicable to this claiming protocol include uninsured Medicaid-like services provided under Community Based Services to individuals age 3 years and older, including assessment, evaluation and diagnostic services.

Allowable DSHP costs will be the community-based Purchase of Services (POS) expenditures, which exclude administrative expenditures, adjusted for the following exclusions:

DDS community-based POS costs that are not related to Medicaid-like healthcare services, including:

- POS contract costs
- Expenditures for Community Placement Plan (funds paid to regional centers for permanent housing placement)
- Expenditures for Medical Facilities (payments to Intermediate Care Facilities and Developmentally Disabled Continuous Nursing Care for services not eligible for Medi-Cal).
- Propposition 10/California & Family Trust Fund expenditures (funds paid to regional centers for development of comprehensive and integrated system of information and services to promote early childhood development and school readiness).

DDS community-based POS costs related to Medicaid-like healthcare services funded by other payers, including:

- Expenditures for Early Start program (including federal funds and State matching/MOE funds)
- Expenditures for services to Medi-Cal beneficiaries(including federal funds, State matching funds, and Vocational Rehabilitation funds)
- Expenditures related to services eligible for Federal Title XX funds
- Program Development Fund

*Report Format
DDS program costs will be compiled from DDS POS Claims Data file using Eligibility Codes to identify the uninsured population, Budget Codes to identify the funding sources, and Service Codes to identify the eligible services.

C. DSHP Interim Claiming
The purpose of DSHP interim claiming is to provide an interim payment that will approximate the allowable costs for Medicaid-like services in SOMPs that are eligible for FFP through the CPE process.

For each demonstration year, the process of determining the allowable costs eligible for FFP begins with the use of most recently completed Paid Claims Data reports for CCS, GHPP, MIA/LTC, BCCTP, CMSP, EAPC, ADAP, EWC, PCTP, and DDS. The fiscal year covered by the most recently completed Paid Claims Data reports will serve as the prior period.
The net program costs, for each program described above, will be determined by using the most recently completed Paid Claims Data report provided by its governing agency. The costs from the Paid Claims Data report represent net program costs incurred by the governing agency for

medical services and are net of any self-payment or copayments made by or on behalf of the patients.
Net program costs are reduced by other funding and subsidies made by a federal government, MOE and other matching requirements, or other third party to the program costs to arrive at the computed DSHP costs.
DSHP costs are further reduced by any program costs incurred for payments made for non-Medicaid-equivalent services or payments for services furnished to any individuals who are otherwise insured. The result is the allowable DSHP costs.
Allowable SNCP costs are determined as the following:
SFY2010-11: The allowable SNCP costs are the allowable DSHP costs incurred for November – June of the prior period.
SFY 2011-12 to FY 2014-15: The allowable SNCP costs are the allowable DSHP costs incurred for the prior period.
SFY 2015-16: The allowable SNCP costs are the allowable DSHP costs incurred for July – October of the prior period.
An interim allocation percentage is computed by dividing the allowable SNCP costs for each fiscal year by the total DSHP costs from Step 3 computed above.
SFYs 2010-2011 to 2015-2016 DSHP costs will be computed pursuant to the step 3, except for interim claiming purposes, the DSHP costs will be based on budgeted appropriations and funding amounts rather than actual paid claims reports.
Interim certified public expenditures of the DSHPs will be equal to the amounts of SFYs 2010-11 to 2015-2016 DSHP costs in Step 6 multiplied by the interim allocation percentage for the applicable fiscal period computed in step 5 and reduced by 13.95 percent as described in subsection A to account for non-emergency care furnished to non-qualified aliens.
SNCP interim claiming for the federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.
D. Final Reconciliation of DSHP Interim Claiming
The DSHP interim certified public expenditures will be reconciled based on the actual Paid Claims Data for the applicable fiscal periods as finalized by its governing agencies for each program.

Allowable SNCP costs for each SFY will be computed pursuant to the steps described in subsection C.1 through C.5 above, using actual paid claims reports and actual funding and expenditure amounts for each SFY.

The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified DSHP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR CMHS

Attachment F – Supplement 3
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)
Determination of Allowable Costs to Uninsured Individuals in Designated State Health Programs

A. Cost Finding Methodology
California counties, which receive federal and state funds for providing public mental health services, are required to submit a fiscal year-end (July to June) Mental Health Cost Report with the Department of Mental Health (DMH) by December 31 following the close of each fiscal year. The cost report forms, cost determination, and allocation methodologies are approved by the State and in compliance with the Federal Medicaid regulations.

County total mental health costs are reported in four primary groups of service categories:
Administrative Costs.
Research & Evaluation Costs.
Utilization Review Costs.
Direct Service Costs.

The eligible SNCP costs are direct service costs funded by the State Realignment Funds and Mental Health Services Act (MHSA) Fund incurred by each county for the furnishing of mental health services allowable under Section 1905(a) of the Social Security Act to uninsured individuals.

The allowable SNCP costs, computed under this Supplement, are limited to the eligible SNCP costs incurred for months of DYs. Allowable SNCP costs claimable under this Supplement should not include any uninsured mental health costs incurred by counties which operate Designated Public Hospitals (DPHs); such uninsured costs are separately addressed in Attachment F - Supplement 4.

Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. A 13.95 percent reduction factor is applied to the total certified SNCP expenditures before costs are claimed.

B. Summary of Mental Health Cost Report
The Mental Health Cost Report includes
Detail Cost Report: Detail forms for each legal entity, including county and contract providers.
Summary Cost Report: Aggregate county mental health costs for the Fiscal Year.

Legal entity means each county mental health department or agency and each private provider furnishing public mental health services under contract with the county department or agency.

Direct service costs are reported by Modes of Service (MS) and Service Functions (SF). MS describes a classification of service types. SF identifies the specific type of service received under a MS.

Attachment F – Supplement 3
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)
Determination of Allowable Costs to Uninsured Individuals in Designated State Health Programs

Allowable SNCP costs are captured by the following MS and SF (which represent specialty mental health services that would be covered by Medi-Cal if furnished to Medi-Cal recipients):
05 (Hospital Inpatient and other 24 Hour Services)
SF 10-18: Local Hospital Inpatient
SF 19: Hospital Administrative Days
SF 20-29: Psychiatric Health Facility
SF 40-49: Adult Crisis Residential
SF 65-79: Adult Residential
10 (Less than 24 Hour Day Treatment Program Services)
SF 20-29: Crisis Stabilization
SF 81-89: Day Treatment Intensive
SF 91-99: Day Rehabilitation
15 (Outpatient Services) All SFs.
The above MS and SF do not include any service that is subject to the Institutions for Mental Diseases (IMDs) exclusion per Section 1905(a) of the Social Security Act.

MH 1901 Schedule B (Worksheet for Units of Service and Revenue by Mode & Service Function
The individual legal entity's worksheet for units of service by MS and SF codes under the following categories
Medi-Cal Units:
Regular Medi-Cal
Medicare/Medi-Cal Crossover
Enhanced Medi-Cal (Children and Refugees)
Healthy Families
Non Medi-Cal Units

MH 1901 Schedule C (Allocated costs to Mode of Service & Service Function)
The individual legal entity's supporting documentation to distribute the direct service costs to MS and SF.

MH 1960 (Calculation of Program Costs)
The individual legal entity's worksheet to identify the allowable costs for allocation applicable to the four major service categories.

MH 1966 (Allocation of Costs to Service Function – Mode Total)
The individual legal entity's worksheet to compute the cost per unit and the allocation costs to SFs. The units of service are derived from MH 1901 Schedule B; the total allocated costs are derived from MH 1901 Schedule C.

MH 1992 (Funding Sources)
The individual legal entity's total mental health costs by funding sources and service categories.

MH 1992 SUM (Summary Funding Sources)
The county total mental health costs (from all reporting legal entities) by funding sources and service categories.
C. DSHP Interim Claiming
The process of determining the allowable SNCP costs eligible for FFP begins with the use of most recently filed Mental Health Cost Report. The period covered by this most recently filed cost report will serve as the base period for interim payment computation.

Cost per unit for each SF will be computed by using the total direct service costs from MH 1901 Schedule C divided by the total units of service from MH 1901 Schedule B.

Non Medi-Cal units of service form MH 1901 Schedule B will be reduced, using additional auditable county and provider records, to determine the uninsured units of service.

Cost per unit will be multiplied by the number of uninsured units of service computed above for each eligible SF to determine the total uninsured costs. If a legal entity has a contract with the county limiting its cost per unit and the contracted cost per unit is lower than the cost per unit computed in the cost report, the lower contracted cost per unit will be used to determine the total uninsured costs for the legal entity.

The total uninsured costs computed above can be trended to current year based on Consumer Price Index (CPI) for U.S City Average by commodity for Hospital and related services.

In order to identify the total uninsured costs funded by the State Realignment Funds and the MHSA Fund, the State will compute the allocation percentage based on funding sources for each direct service MS. By using the Summary Cost Report, MH 1992 SUM, the Realignment Funds and MHSA Funds for each direct service MS will be adjusted to exclude the matching funds used for Short-Doyle/Medi-Cal and Healthy Families FFP.

The allocation percentage for each direct service MS is the ratio of direct service costs funded by the net State Realignment Funds and MHSA Funds computed above to the total direct service costs from all funding sources.

The eligible SNCP costs will be the total trended uninsured costs for each MS computed in step 3 multiplied by the applicable allocation percentage.

Uninsured mental health costs claimable under this Supplement do not include uninsured mental health costs incurred by counties which operate DPHs; those costs are addressed in Attachment F - Supplement 4. Furthermore, any county uninsured mental health costs incurred for other SNCP claiming, , such as the Medicaid Coverage Expansion and the Health Care Coverage Initiative, will be offset against the computed eligible SNCP costs.

The net eligible SNCP costs will be multiplied by the following ratio to determine the allowable SNCP costs:

SFY 2010-11:	67.67% (8 months over 12 months)
SFYs 2011-12 to 2014-15:	100%
SFY 2015-16:	33.33% (4 months over 12 months)

Interim certified public expenditures for CMHS are the allowable SNCP costs computed above reduced by 13.95 percent to account for non-emergency care furnished to non-qualified aliens.

DSHP interim claiming for federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.

D. Interim and Final Reconciliations of DSHP Interim Claiming

The interim certified public expenditures for CMHS will be first reconciled based on the Mental Health Cost Reports for the applicable fiscal years accepted by DMH.

The interim certified public expenditures for CMHS will also be subsequently reconciled based on Mental Health Cost Reports for the applicable fiscal years as settled and audited by DMH.

Allowable SNCP costs for each SFY will be computed pursuant to the steps described in subsection C, except that the cost report for the applicable SFYs will be used to determine actual expenditures incurred. For DY 10, allowable SNCP costs for the partial period of July 1, 2015 through October 31, 2015 will be computed pursuant to the steps described in subsection C, except that the cost report for the SFY 2015-2016 will be used to determine actual expenditures incurred.

If legal entities costs are not fully reimbursed by the county, such as the application of legal entity contract limits, thereby reducing actual expenditures incurred by the county below legal entity costs, such reduction must be proportionately applied to the allowable SNCP costs. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified SNCP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

Any prospective revision to the Medi-Cal mental health cost reports, as approved by CMS, must be incorporated into the mental health cost reporting methodology used in this CPE protocol.

Attachment F – Supplement 4
Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool
Determination of Allowable Costs to Uninsured Individuals for Mental Health Services

This Attachment F–Supplement 4 addresses mental health costs incurred by county mental health plans in those counties that operate Designated Public Hospitals ("DPHs"). This Supplement 4 addresses the allowable certified public expenditures ("CPEs") for the Safety Net Care Pool ("SNCP") for such counties that are based on the cost of mental health services provided to uninsured individuals by county owned and operated non-hospital clinics (i.e., clinics that are not hospital outpatient departments) and county expenditures for mental health services to uninsured individuals under contracts with other providers.

The allowable SNCP mental health costs incurred by counties that do not operate DPHs are addressed in Attachment F–Supplement 3.

The allowable costs incurred by county mental health plans in counties that operate DPHs for claiming against the SNCP relate strictly to individuals who have no sources of third party insurance coverage for the mental health services they receive and who receive Medicaid-like services, in other words, mental health services that would have been eligible for federal reimbursement under Title XIX if these individuals were eligible under the Medi-Cal program.

To determine the allowable SNCP costs and the associated SNCP reimbursement when such costs are incurred by a county, the following steps must be taken to ensure federal financial participation ("FFP").

I. DETERMINATION OF ALLOWABLE COSTS FOR MENTAL HEALTH INPATIENT AND OUTPATIENT SERVICES PROVIDED TO UNINSURED INDIVIDUALS BY COUNTY HOSPITALS

A. The costs of mental health services provided by a county hospital to uninsured inpatients and uninsured outpatients will be included in the Interim Hospital Payment Rate Workbook, in accordance with the cost finding guidelines set forth in Attachment F.

B. The payments to a county hospital for mental health services provided by a county hospital to uninsured inpatients and uninsured outpatients will be determined in accordance with the provisions for SNCP payments as set forth in Attachment F, including the provisions for interim reconciliations and final reconciliations.

C. The costs of physician and non-physician practitioner professional mental health services provided to uninsured inpatients and uninsured outpatients at a county hospital will be included in the Interim Hospital Payment Rate Workbook, in accordance with the cost finding guidelines set forth in Attachment F, Supplement 1, entitled SNCP Payments-Physician and Non-Physician Professional Services, including the provisions for interim reconciliations and final reconciliations.

D. The payments to a county hospital for professional mental health services provided by physicians and non-physician practitioners at a county hospital will be determined in accordance with the provisions for SNCP payments set forth in Attachment F–Supplement 1, entitled SNCP Payments-Physician and Non-Physician Professional Services, including the provisions for interim reconciliations and final reconciliations.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR COUNTY MENTAL HEALTH SERVICES PROVIDED TO UNINSURED INDIVIDUALS OTHER THAN IN COUNTY HOSPITALS

A. Cost Finding Methodology

California counties, which receive federal and state funds for providing public mental health services, are required to submit a fiscal year-end (July to June) Mental Health Cost Report to the Department of Health Care Services ("DHCS") by December 31 following the close of each fiscal year. The cost report forms, cost determination, and allocation methodologies are approved by the State and are in compliance with the Federal Medicaid regulations.
County total mental health costs are reported in three primary groups of service categories:

- Administrative Costs.
- Utilization Review Costs.
- Direct Service Costs.

The eligible SNCP costs are direct service costs funded by the State, county, or local government funding and subsidies that are incurred by each county for the furnishing of mental health services allowable under Section 1905(a) of the Social Security Act to uninsured individuals. Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. A 13.95 percent reduction factor is applied to the total certified SNCP expenditures before costs are claimed.

B. Summary of Mental Health Cost Report

The Mental Health Cost Report includes:

- Detail Cost Report: Detail forms for each legal entity, including county and contract providers.
- Summary Cost Report: Aggregate county mental health costs for the Fiscal Year.

The county submits a detail county legal entity(ies) cost report(s) as well as summary cost report aggregating all contracted and county legal entities. A legal entity can be a county mental health department or agency, a county owned and operated hospital, another governmentally-operated hospital, a privately-operated hospital, or a privately-operated organizational provider furnishing public mental health services under contract with the county department or agency.

The allowable mental health costs include expenditures made by counties for mental health services furnished by other providers. The allowable expenditures for inpatient, outpatient, clinic and other mental health services provided to uninsured individuals by providers through a contract with the county will be based on the payment methodology set forth in the contract.

Direct service costs are reported by Modes of Service ("MS") and Service Functions ("SF"). MS describes a classification of service types. SF identifies the specific type of service received under a MS. Allowable SNCP costs are captured by the following MS and SF (which represent specialty mental health services that would be covered by Medi-Cal if furnished to Medi-Cal recipients):

- 05 (Hospital Inpatient and other 24 Hour Services).
  - SF 10-18: Local Hospital Inpatient
  - SF 19: Hospital Administrative Days
  - SF 20-29: Psychiatric Health Facility
  - SF 40-49: Adult Crisis Residential
  - SF 65-79: Adult Residential

- 10 (Less than 24 Hour Day Treatment Program Services)
  - SF 20-29: Crisis Stabilization
  - SF 81-89: Day Treatment Intensive
  - SF 91-99: Day Rehabilitative

- 15 (Outpatient Services) All SFs.

All MS 05, 10 and 15 services provided by county hospitals will be reported on the hospital's Medi-Cal 2552-96 cost report and in its Interim Hospital Rate Workbook, and will be paid under Attachment F.The above MS and SF do not include any service that is subject to the Institutions for Mental Disease (IMDs) exclusion per Section 1905(a) of the Social Security Act.

MH 1901 Schedule B (Worksheet for Units of Service and Revenue by Mode & Service Function) The individual legal entity's worksheet for units of service by MS and SF codes under the following categories:

- Medi-Cal Units (for both enhanced, such as M-CHIP, Refugee, BCCTP, and non-enhanced federal reimbursement).
- Non Medi-Cal Units

MH 1901 Schedule C (Allocated costs to Mode of Service & Service Function) The individual legal entity's supporting documentation to distribute the direct service costs to MS and SF.

MH 1960 (Calculation of Program Costs)
The individual legal entity's worksheet to identify the allowable costs for allocation applicable to the four major service categories.

MH 1960_HOSP_COSTS
The individual hospital's worksheet to determine the cost per day for routine cost centers and cost-to-charge ratio for ancillary, outpatient, and other cost centers.

MH 1960_HOSP_MS
The individual hospital's worksheets by mode of service that apportion hospital costs to the Medi-Cal program using the cost-per-day and cost-to-charge ratios calculated on the MH 1960_HOSP_COSTS.

MH 1960_PHYS_MS

The individual hospital's worksheets by mode of service that apportion professional costs to the Medi-Cal program using the cost-to-charge ratios calculated on the MH 1960_HOSP_COSTS.

MH 1966 (Allocation of Costs to Service Function – Mode Total)
The individual legal entity's worksheet to compute the cost per unit and the allocation of costs to SFs. The units of service are derived from MH 1901 Schedule B; the total allocated costs are derived from MH 1901 Schedule C.

MH 1992 (Funding Sources)
The individual legal entity's total mental health costs by funding sources and service categories.

MH 1992 SUM (Summary Funding Sources)
The county total mental health costs (from all reporting legal entities) by funding sources and service categories.

C. Interim Claiming

1. The process of determining the allowable SNCP costs eligible for FFP begins with the use of the most recently filed Mental Health Cost Report. The period covered by this most recently filed cost report will serve as the base period for interim payment computation.

2. Cost per unit for each SF will be computed by using the total direct service costs from MH 1901 Schedule C divided by the total units of service from MH 1901 Schedule B. Non Medi-Cal units of service from MH 1901 Schedule B will be adjusted, using additional auditable county and provider records, to determine the uninsured units of service.

Cost per unit will be multiplied by the number of uninsured units of service computed above for each eligible SF to determine the total uninsured costs. If a legal entity has a contract with the county limiting its cost per unit and the contracted cost per unit is lower than the cost per unit computed in the cost report, the lower contracted cost per unit will be used to determine the total uninsured costs for the legal entity.

3. The total uninsured costs computed above can be trended to current year based on Market Basket update factors(s) or other related indices approved by CMS.

4. Any self-pay or third party payments made by or on behalf of uninsured individuals to the county mental health plan for services of which the costs are included in the uninsured cost computation described above should be offset against the computed uninsured-eligible costs. For purposes of the preceding sentence, State and county funds payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a county mental health plan for mental health services provided to uninsured individuals shall not be considered a source of third party payment. The offset should also include funds that have been matched under maintenance of effort (MOE) and other matching requirements, if applicable.

5. Interim certified public expenditures for mental health services are the allowable SNCP costs computed above reduced by 13.95 percent to account for non-emergency care furnished to non-qualified aliens.

6. Interim claiming for federal reimbursement will be made based on the interim certified public expenditures as computed above.

D. Interim and Final Reconciliations of Interim Claiming

The interim certified public expenditures for mental health services will be first reconciled based on the Mental Health Cost Reports for the applicable fiscal years accepted by DHCS.

The interim certified public expenditures for mental health services will also be subject to a final reconciliation based on Mental Health Cost Reports for the applicable fiscal years as settled and audited by DMH. The final reconciliation will follow the same cost methodology as used for interim claiming, as set forth in Section II.C above, except that the final reconciliation will be based on the Mental Health Cost Reports for the applicable years as settled and audited by DHCS.

If legal entities costs are not fully reimbursed by the county, such as the application of legal entity contract limits, thereby reducing actual expenditures incurred by the county below legal entity costs, such reduction must be proportionately applied to the allowable SNCP costs. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

Any prospective revision to the Medi-Cal mental health cost reports, as approved by CMS, must be incorporated into the mental health cost reporting methodology used in this CPE protocol.

Attachment F – Supplement 5
Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool
Determination of Allowable Costs to Workforce Development Programs in Designated State Health Programs

The Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration, approved by the federal Centers for Medicare and Medicaid Services (CMS) on November 2, 2010, allow the State to use allowable costs in Designated State Health Programs (DSHPs) incurred from November 1, 2010 through October 31, 2015 for federal claiming against the Safety Net Care Pool (SNCP).

DSHPs, as described under this Supplement, have two components, State Only Medical Programs (SOMPs) and Workforce Development Programs (WDPs). WDPs are integral to the successful transition to the era of health care reform. They improve access to healthcare in underserved areas of CA by providing scholarship, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas. WDPs also provide educational opportunities in health professional training through established state educational institutions and state department programs. WDPs include the following state/local funded programs:

- Office of Statewide Health Planning & Development (OSHPD)
    - Song-Brown Healthcare Workforce Training Program (Song-Brown)
    - Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)
    - Mental Health Loan Assumption Program (MHLAP)

The allowable costs incurred in the WDPs for claiming against the SNCP are the State program expenditures incurred in the months of Demonstration Year (DY) per the STCs.

To determine allowable SNCP costs and the associated SNCP reimbursement when such costs are incurred by the State as certified public expenditures (CPEs), the following steps must be taken to ensure federal financial participation (FFP):

I. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE COSTS FOR OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT

A. General Provision

Program costs, for each OSHPD program described above, mean the total expenditures incurred in the State Fiscal Year (SFY) ended June 30 from all the funding sources. Program costs are the expenditures necessary to maintain and support WDPs, including State operation expenditures, loan repayment, and award payments.

Net program costs are program costs for award or loan repayments funded by the State or local only.

Allowable SNCP costs, for each OSHPD program described above, are limited to the net program costs paid in the months of Demonstration Year (DY) per the STCs.

For the purpose of interim claiming, the estimated program costs for each SFY are the total budget amount of Fund Appropriation for the applicable fiscal period that the State commits to each OSHPD program. The estimated program cost for each fiscal period is reduced by

budgeted funding for State operation costs and from non-State, non-local sources to arrive at the estimated net program cost. The estimated net program cost is multiplied by an interim allocation percentage to arrive at the estimated allowable SNCP cost for the fiscal period.
For SFY 2010-11, the interim allocation percentage is the ratio of 8 months over 12 months. For SFYs 2011-12 to 2014-15, the interim allocation percentage is 100%. For SFY 2015-16, the interim allocation percentage is the ratio of 4 months over 12 months.

B. Program Description

Song-Brown Healthcare Workforce Training Program

The Song-Brown Health Care Workforce Training Act (Song-Brown Program), established in 1973, provides financial support to various healthcare education programs with an emphasis on primary care and encourages primary care health professionals to provide healthcare in medically underserved areas.

*Eligibility

The Song-Brown Program provides award funding to institutions (not individual students) that provide clinical training for Family Practice Residents, Family Nurse Practitioners, Physician Assistants, and Registered Nurses in rural and urban undeserved areas. The awards are utilized by the residence programs to develop curriculum, clinical training sites and other necessary expenses to increase the number of health professional training slots in established medical schools. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas, and provides financial support to family practice residency, nurse practitioner, physician assistant, and registered nurse education programs through CA. It does not help cover resident tuition.

*Funding Source

The Song-Brown Program is currently funded by the California Health Data and Planning Fund (CHDPF), a special fee charged to CA licensed health facilities, and the State General Fund (GF). The State pays the program claims.

*Report Format

Song-Brown Program costs will be compiled from the State CalSTARS system, which uses Object of Expenditure Codes, Program Cost Account (PCA), and Category to identify the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)

The purpose of STLRP is to encourage physicians to practice in medically underserved areas of California by authorizing a plan for repayment of their educational loans. STLRP repays up to $105,000 in outstanding government or commercial educational loans for expenses incurred for undergraduate education and graduate medical education.

*Eligibility

Loan repayment awards are available to physicians who hold a full and unrestricted license to practice medicine in CA. Physicians awarded under this program must complete a three years service obligation to practice as a full-time physician in a medically underserved area of CA providing direct patient care.

*Funding Source
STLRP is funded through $25 surcharge for renewal of allopathic physician licenses in CA and through the Managed Care Administrative Fines and Penalties Fund.

*Report Format
STLRP program cost will be compiled from the State CalSTARS system, which uses Object of Expenditure Codes, Program Cost Account (PCA), and Category to identify the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

Mental Health Loan Assumption Program (MHLAP)
The MHLAP, created by the Mental Health Services Act, encourages mental health providers to practice in underserved locations in CA by authorizing a plan for repayment of some or all of their educational loans in exchange for their services in a designated hard-to-fill/retain position in the Public Mental Health System. Each eligible participant may receive up to $10,000 award. In no event shall the amount of the award exceed the amount of the participant's outstanding educational debt.

*Eligibility
Loan repayment awards are available to mental health provides who have a current, full, permanent, unencumbered, unrestricted health provider license, registration, or waiver and work or volunteer in the Public Mental Health System. Award recipients are required to complete a minimum 12 months consecutive or equivalent paid or unpaid service obligation and work or volunteer either full-time or part-time.

*Funding Source
The MHLAP is funded through the Mental Health Services Act, which receives the funding from special tax revenue to expand mental health services. The annual MHLAP funding is used to administer the programs, including awards, marketing, program operations, and staff.

*Report Format
MHLAP program cost will be compiled from the State CalSTARS system, which uses Object of Expenditure Codes, Program Cost Account (PCA), and Category to identify the actual State expenditures for award payments. All costs claimed must be reasonable, allowable, and allocable under OMB Circular A-87.

C. DSHP Interim Claiming

The purpose of DSHP interim claiming is to provide an interim payment that will approximate the allowable costs in OSHPD programs that are eligible for FFP through the CPE process.

1. The process of determining the allowable costs eligible for FFP begins with the use of annual budget amount of Funding Appropriation for each OSHPD program described above.
2. The estimated program costs are reduced by program operation costs and other funding and subsidies made by a federal government or other third party to arrive at the net program costs. For the OSHPD Workforce Development Programs, there is no funding other than State funding. Therefore, program operation costs are the only funding reduction needed to arrive at net program costs.
3. The net program costs for each SFY will be multiplied by the following interim allocation percentage to determine the allowable SNCP costs:
   SFY 2010-11: 67.67% (8 months over 12 months)
   SFYs 2011-12 to 2014-15: 100%
   SFY 2015-16: 33.33% (4 months over 12 months)
4. DSHP Interim certified public expenditures for OSHPD programs are the allowable SNCP costs as computed above.
5. SNCP interim claiming for the federal reimbursement will be made quarterly based on the interim certified public expenditures as computed above.

D. Final Reconciliation of DSHP Interim Claiming

The DSHP interim certified public expenditures will be reconciled based on the actual expenditures data for the applicable fiscal periods as finalized by its governing agencies for each program.

Allowable SNCP costs are the net program costs paid in the months of each DY, using actual expenditures reports for each SFY.

The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certified DSHP expenditures determined under this final reconciliation. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration, approved by the federal Centers for Medicare and Medicaid Services (CMS) on November 1, 2010, allow for claiming against the Safety Net Care Pool ("SNCP") of the uncompensated cost of care and services that meet the definition of "medical assistance" contained in section 1905(a) of the Social Security Act that are provided to individuals with no source of third party coverage for the services they receive ("the uninsured"). This Attachment F–Supplement 6 addresses contracted health care services costs (including services for the diagnosis and treatment of behavioral health and substance abuse conditions not covered by Attachment F- Supplement 4) for the uninsured incurred by Designated Public Hospitals (DPHs) and/or other governmental entities (These "other governmental entities" participate in the SNCP under the Demonstration Special Terms and Conditions and Article 5.2 of the Welfare and Institutions Code, Section 14166 *et seq.* and include counties that own and operate a DPH, Alameda County, the Alameda County Medical Center Hospital Authority, and the University of California.) This Attachment F -Supplement 6 addresses the allowable certified public expenditures ("CPEs") for the SNCP for such DPHs and/or other governmental entities that are based on the payments for contracted services provided to the uninsured by service providers that are not owned and operated by the reporting DPHs and/or other governmental entity. The allowable costs incurred by DPHs and/or other governmental for claiming against the SNCP relate strictly to individuals who have no sources of third party insurance coverage for the medical services they receive and who receive Medicaid-like services, in other words, medical assistance that would have been eligible for federal reimbursement under Title XIX if these individuals were Medicaid eligible.

To determine the allowable SNCP costs and the associated SNCP reimbursement, the following steps must be taken to ensure federal financial participation ("FFP").

CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE CONTRACTED COSTS FOR SERVICES PROVIDED TO THE UNINSURED.

A. Description of Allowable Costs

SNCP eligible expenditures are made by DPHs and/or other governmental entities as payments to other entities under a contract, for eligible medical services provided to the uninsured for: (1) specific specialized services that are not available at the DPH or its affiliated providers, but that are available in other hospitals or outpatient facilities, (2) services provided by other providers such as clinics or hospitals to ensure access to care, or when a DPH is not available, or (3) for professional services to the uninsured through contracts with physicians and non-physician practitioners.

The contracted expenditures described below are consistent with the intent of the establishment of the SNCP to ensure continued government support for the provision of health care services to uninsured populations. By providing these services through contracts, the public entities are able to expand access to needed primary and specialty care, inpatient and outpatient hospital, and other health care services for the uninsured. By making available additional primary and specialty care services, they are able to provide more appropriate care at the right time and in the right place. The SNCP is therefore able to assist DPHs and/or other governmental entities in

providing services to the uninsured through these cost effective contracts with other providers. All costs are reported as certified public expenditures through the DPH Workbook and include, but are not limited to the following:

1. Categories of DSH/SNCP expenditures for services to the uninsured who are patients of the DPH --that are added on Schedule 2.1 of the Workbook:

The following costs that are eligible for both DSH and SNCP will be added only if they have been separately identified on the DPH cost report as expenditures for the uninsured only and have not been included in the cost apportionment process.

- The costs of drugs and supplies purchased solely for uninsured patients in the hospital. These costs are entered on Schedule 2.1 as DSH/SNCP costs.

2. Categories of SNCP-only contract expenditures for services rendered to the uninsured either in the DPH or another location, by entities other than the reporting DPH (and/or other governmental entity) that are reported on Schedule 4 of the Workbook:

(Note: This section does not address those expenditures made to contracted providers for services to LIHP enrollees that are also reported on Schedule 4. See Attachment G for the claiming protocol for LIHP expenditures.).

Expenditures reported on Schedule 4 may include the following SNCP-only expenditures:

- Expenditures recorded on the books and records of the DPH. The relevant contracts often require the providers to bill directly to third party payers, but allow the providers to bill the DPH for uninsured patients. If these costs are billed to the DPH and reflected on the books of the DPH, they would be separately identified on the cost report and are not included in the apportionment process; and

- Expenditures recorded on the books and records of a governmental entity that is related to the reporting DPH, such as a county, the University of California, or the Alameda County Medical Center Hospital Authority.

Contract expenditures to be reported on Schedule 4 for care and services that meet the definition of "medical assistance" contained in section 1905(a) of the Social Security Act include the following:

- Payments for services that DPHs do not provide for uninsured individuals that are purchased from other hospital providers.

- Payments for services rendered by physicians, non-physician practitioners, and/or physician groups purchased solely for the uninsured and provided at the DPH. The expenditures under these contracts may be identified separately on the cost report. Because the costs are only for services to the uninsured they are not included in the apportionment process described in Attachment F, Supplement 1.

- Expenditures for securing and purchasing drugs and medical supplies solely for the uninsured outside the hospital setting.

- Payments to facilities and vendors that provide consultative, diagnostic, therapeutic care or other services, durable medical equipment, prosthetics and orthotic devices, and medical supplies to the uninsured population.

- Payments for medically necessary ambulance service for uninsured patients.

- Payments under contracts with individual physicians, non-physician practitioners and/or physician groups to provide professional services to uninsured patients, including but not limited to primary and specialty care and emergency and trauma medical services provided outside of the reporting DPH or its related providers.

- Payments under contracts with non-DPH trauma hospitals for reimbursement of trauma and emergency care provided to uninsured patients, and to augment ER/Trauma services in underserved areas for reimbursement of medical services provided to uninsured patients.

- Payments under contracts for primary care, dental and specialty care services at community clinics to provide health services in a culturally and linguistically-appropriate environment to low income and uninsured persons, increasing access and preserving vital community clinic capacity.

- Payments under contracts with private clinics and providers for specialty care and other health care services to uninsured patients.

- Payments under contracts with providers of home health services rendered to uninsured patients.

- Payments under contracts with non-DPH hospitals and nursing facilities for services provided to uninsured patients.

- Payments under contracts with mental health providers for allowable mental health services to the uninsured that are eliminated from the Short-Doyle cost report in Schedule MH 1962, and are not reported pursuant to Attachment F – Supplement 4.

3. Specific Requirements for all Contracted Costs

- Contract costs reported on Schedule 4 under this Attachment F, Supplement 6 must be separately identified as follows:

  A. If the contract costs reported on Schedule 4 are reflected in the books and records of the DPH's enterprise fund, then the costs must be reported on Schedule 4A.B. If the contract costs are reflected as expenditures on the books and records

in another portion of the county, university or authority, such as the general fund, the costs must be reported on Schedule 4B.

C. If the contract costs are reflected as expenditures in the books and records of any other affiliated governmental entity, the costs must be reported on Schedule 4C . If the costs of more than one other affiliated governmental entity are reported in Schedule 4C, each affiliated governmental entity must be specifically identified.

- Contracted costs incurred by DPHs and/or other governmental entities must be consistent with OMB Circular A-87 and supported by adequate documentation which may include contracts, invoices and expenditure detail. Such documentation will be maintained by the DPH and other governmental entities and made available for review and audit by the California Department of Health Care Services. The DPH will submit summary information with the P14 workbook that identifies each contractor, the total amount paid, and documents the source books and records of the DPH (or other government entity) where the reported contract expenditures are recorded.

- The allowable SNCP costs, computed under this supplement, are limited to the eligible SNCP costs incurred for services rendered during the applicable Demonstration Year (DY).

- Costs are net of any self-pay or third party payments made by or on behalf of the patient. For purposes of the preceding sentence, payment and other funding and subsidies made by a state or unit of local government (e.g. state-only, local-only, or joint state-local health programs) for services provided to indigent patients shall not be considered a source of third party payment.

- To ensure that there is no duplication of claims, the contracting provider that receives a payment reported under this Attachment F – Supplement 6 must identify and offset any contract payments received from its otherwise allowable costs of services to the uninsured. Using the summary payment information provided by the DPH, DHCS will monitor reporting to ensure that no duplicate claims are made under Attachment F or any other cost reporting mechanism applicable to payments for the uninsured, such as the DSH hospital-specific limit calculation.

- In accordance with Attachment F, there will be no duplication of claiming of cost with respect to SNCP expenditures and DSH certifiable expenditures.

- No cost shall be reported under Attachment F – Supplement 3 as a DSHP expenditure if the same expenditure has been reported under this Attachment F – Supplement 6.

- If the costs of services provided to the uninsured under contracts with physicians or non-physician professionals were reported on the DPH's Medi-Cal cost report as costs related to all patients (not solely for the uninsured), then those costs should be addressed

pursuant to Attachment F – Supplement 1 and reported on Worksheet 1B, and should not be reported pursuant to this Attachment F - Supplement 6.

- Costs associated with providing non-emergency services to non-qualified aliens cannot be claimed against the SNCP. To implement this limitation, 13.95 percent of total certified public expenditures for services under this protocol will be treated as expended for non-emergency care to non-qualified aliens.

- When a system includes more than one DPH, costs incurred at the system level for services rendered in a location other than one of the DPHs may be reported on Schedule 4 of the Workbook of any DPH within the system. Upon request, the DPH will identify and document the source books and records of the DPH (or other government entity) where the reported contract expenditures are recorded. Such costs may only be reported by one DPH within the system and no duplicate claiming may occur.

B. Interim Claiming

1. The process of determining the allowable SNCP contracted health service costs eligible for FFP begins with the use of the most recently filed DPH Workbook. The period covered by this most recently filed workbook will serve as the base period for interim payment computation. For fiscal years 2010-2011 and after, the P14 Workbook contains a new schedule that allows detailed projections for all categories of Uninsured, HCCI and MCE costs. Contract costs discussed above will be projected based on the best information available with regard to each contract when the reports are filed.
2. The net SNCP cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net SNCP costs may be further adjusted to reflect increased or decreased costs incurred resulting from changes in operations or circumstances. Individual contract adjustments can be made on a new Schedule 2A-1 to assure reasonable projections.
3. Interim SNCP payments can be made based on the SNCP certifiable expenditures as computed above. The DPH (or other government entity) will confirm the reasonableness of the projections in the workbook. The interim payments can be on a quarterly or other periodic basis approved by CMS.

C. Interim and Final Reconciliations of Interim Claiming

1. The interim certified public expenditures for contracted health service costs to the uninsured will be first reconciled based on the filed Workbook for the applicable fiscal years accepted by DHCS.
2. The interim certified public expenditures for contracted health service costs will also be subject to a final reconciliation based on the final Workbook for the applicable fiscal years as settled and audited by DHCS.

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from April 5, 2013 through October 31, 2015 as required by STC 39.b.iii. Using the methodology described below in section (A), the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services between April 5, 2013 and December 31, 2013 to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP). Using the methodology described below in section (A) and (B), the state shall also make supplemental payments to account for the uncompensated costs of furnishing services between April 5, 2013 and December 31, 2014 to individuals enrolled in the Medi-Cal program for benefits that were eliminated from the state plan pursuant to state plan amendment 09-001 and are not covered by Medi-Cal. Costs for optional dental and psychology, that were eliminated through SPA 09-001, but have been added back in through State Plan Amendments are not available for reimbursement through these supplemental payments.

A. <u>Provider Claiming Methodology for services provided April 5, 2013 through December 31, 2013</u>

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an uninsured individual;
    d. Whether the service was provided to a Medi-Cal beneficiary; and
    e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating facilities shall have procedures to determine if individuals are Medi-Cal eligible or uninsured, and if uninsured to determine their income level (which could include a protocol based on self-attestation) and whether they are enrolled in LIHP.
5. Participating IHS and tribal 638 facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
6. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care or formerly Medi-Cal), type of individual (uninsured or Medi-Cal individual) and status of individual as IHS-eligible (Indian or Alaskan Native).

7. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
8. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1.A) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.
9. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

B. <u>Provider Claiming Methodology for services provided January 1, 2014 through October 31, 2015</u>

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
   a. The qualifying Medi-Cal service provided to a Medi-Cal beneficiary;
   b. Whether the service was provided to an IHS eligible individual; and
   e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments

due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility for uncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

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Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

Exhibit 1.A: Aggregate Encounter Report for April 5, 2013 through December 31, 2013

Facility Name	IHS Eligible Individuals	
	Uninsured: non-LIHP/non-Medi-Cal	Medi-Cal beneficiaries
Total Number of Encounters		
	X	**x**
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

Exhibit 1.B: Aggregate Ecnounter Report for January 1, 2014 through October 31, 2015

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

Facility Name	IHS Eligible Medi-Cal Beneficiaries
Total Number of Encounters	
	X
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

Certification:

I HEREBY CERTIFY THAT:

1. I have examined this statement, for the period from XXX to XXX and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the IHS/Tribal 638 facilities and CRIHB.

2. The information contained in this report is current, complete, and accurate.

_____ _____

Signature (officer of the governmental entity) Date

_____

Title

Attachment G

Low Income Health Program

Purpose of Protocol

This attachment provides the parameters for claiming Federal Financial Participation (FFP) for qualifying expenditures under the Low Income Health Program (LIHP) authorized under these Special Terms and Conditions (STCs) of California's Section 1115(a) Bridge to Reform Demonstration (Demonstration). The State statutory framework for the development and implementation of the LIHP is provided by Part 3.6 (commencing with section 15909) to Division 9 of the Welfare and Institutions Code. The provisions of Part 3.6 are incorporated by reference into this document.

Under the Demonstration, beginning November 1, 2010 California will begin to phase in coverage for individuals who will be eligible for Medi-Cal or for coverage under the California Health Benefit Exchange in 2014 through the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI) components of the LIHP.

Funding for qualifying expenditures for services rendered to HCCI enrollees is limited to the annual amounts of $360 million (total computable) under the Safety Net Care Pool (SNCP) in Demonstration Years (DY) 6 through 8, and $180 million (total computable) under the SNCP in DY 9, as specified in paragraph 35 of the STCs. Funds allocated for the Extension Period ($60 million total computable) will be charged against the DY 6 HCCI allocation.

Funding for services rendered to MCE enrollees is not subject to a cap on federal funding.

Definitions

Coverage Initiative or "CI": The Health Care Coverage Initiative authorized by the Prior Demonstration, entitled Medi-Cal Hospital/Uninsured Care Demonstration and implemented by Part 3.5 (commencing with Section 15900) of the Welfare and Institutions Code in the State of California .

Extension Period: The Extension Period is the period that begins on September 1, 2010, and ends on October 31, 2010, which is the extension period for the Prior Demonstration.

HCCI Enrollees:

New HCCI Enrollees: as specified in paragraph 48.a.ii.1 and 58.a.iv.A. of the STCs .

Existing HCCI Enrollees: as specified in paragraph 48.a.ii.2. and 58.a.iv.C. of the STCs .

Low Income Health Program (LIHP): the county-based elective program to provide benefits for low-income individuals that is authorized by the Demonstration and implemented by Part 3.6 (commencing with Section 15909) of the Welfare and Institutions Code. The LIHP consists of two components – a Medicaid Coverage Expansion (MCE) program, and, at the option of the Participating Entity, a Health Care Coverage Initiative (HCCI) program.

MCE Enrollees:

New MCE Enrollees: as specified in paragraph 48.a.i.1. and 58.a.ii.A. of the STCs.

Existing MCE Enrollees: as specified in paragraph 48.a.i.2. and 58.a.ii.B. of the STCs .

Attachment G

Low Income Health Program

Participating Entity: A governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority, that submits an application and receives approval to implement a LIHP.

Prior Demonstration: The Medi-Cal Hospital/Uninsured Care Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services, effective for the period of September 1, 2005, through October 31, 2010.

Transition Period: Transition Period means the period that begins on November 1, 2010 and extends through June 30, 2011.

Claiming under Supplements 1 – 2 of Attachment G

The supplements to this Attachment include:

Supplement 1 to Attachment G: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims Based on Certified Public Expenditures; and

Supplement 2 to Attachment G: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims Based on Actuarially Sound Rates

A Participating Entity will be paid Federal Financial Participation (FFP) received by the State which is based on Certified Public Expenditures (CPEs) of the LIHP, a governmental entity with which it is affiliated, or any other eligible public entity that voluntarily agrees to participate in the LIHP for Covered Services, as defined in the Participating Entity's executed agreements with the Department of Health Care Services (DHCS). (*i.e.*, the LIHP Contract, and the LIHP-Mental Health (LIHP-MH) Contract, if mental health services are provided through a carved-out delivery system that is separate from the LIHP).

The cost claiming protocol based on CPEs of the LIHP is described in Supplement 1 to Attachment G. A Participating Entity may receive actuarially sound rates for LIHP services. The claiming protocol for actuarially sound rates is described in Supplement 2 to Attachment G. If the Participating Entity receives actuarially sound rates for LIHP services, qualifying expenditures for services that are not considered in the determination of the capitation rate may be claimed on a cost basis under Supplement 1 to Attachment G. A LIHP-specific protocol will be adopted for each Participating Entity that will reflect the methods for claiming based on this Attachment G and its supplements.

Attachment G

Low Income Health Program

Funding Purpose

Federal funds are available to expand health care coverage to eligible persons in accordance with the requirements of Federal and State law and the requirement detailed within these STCs.

Low Income Health Program

Entities Eligible for LIHP

The following entities are eligible to participate in the LIHP: a governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority.

DY 6: Claiming During Transition Period for Existing CI Counties

For the period of November 1, 2010 and through June 30, 2011, counties that participated in the CI in the Prior Demonstration (CI Counties) may claim FFP for qualifying expenditures for services rendered through June 30, 2011, to enrollees with family incomes from 0 through 200 percent of the FPL, as the counties implement the new MCE coverage requirements, consistent with Attachments G and J of the STCs of the Prior Demonstration (as in effect on October 31, 2010). Upon approval of this Attachment G and Supplement 1 by CMS, the interim payments made under the protocols in Attachment G and Supplement 1 of the STCs of the Prior Demonstration will be reconciled to the approved Attachment G and Supplement 1. Because all existing CI counties met the new MCE program requirements by July 1, 2011, FFP for the qualifying expenditures for enrollees with family incomes at or below 133 percent of FPL are to be claimed under the MCE Eligibility Group (EG) (hypothetical) category for the Transition Period and are not charged against the HCCI allocation for the Transition Period.

DY 7-10: Claiming During DY 7 – 10

For CI Counties that have implemented a LIHP in DY 7, FFP will be claimed from the MCE EG for MCE enrollees and from the SNCP for HCCI enrollees from July 1, 2011.

For newly Participating Entities, all FFP for MCE enrollees from the period that enrollment begins in the MCE program will be treated as MCE EG expenditures. For qualifying expenditures for services rendered to HCCI enrollees, FFP will be claimed against the HCCI allocation from the period that enrollment begins.

LIHP-Specific Funding and Claiming Protocols

The State will submit a funding and claiming protocol to CMS with respect to each entity that has been approved to implement a LIHP. Each protocol will be based on template claiming protocols that demonstrate that the individual LIHP will claim consistent with this Attachment G, and will identify those claiming procedures in the supplements to Attachment G that will apply to its LIHP. Once the Participating Entity's funding and claiming protocol is approved, FFP will be available for services rendered as of the date of implementation of its LIHP.

Expenditures for health care services rendered to LIHP enrollees must be documented by each Participating Entity and must be in accordance with the Office of Management and Budget

Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." Expenditures will be claimed in accordance with Attachment G and supplements thereto, as applicable.

HCCI Allocations

Consistent with paragraph 47 of the STCs, HCCI allocations for expenditures from SNCP funds for each year of the Demonstration will be established in each Participating Entity's LIHP Contract as appropriate, and LIHP MH Contract as appropriate (if mental health services are provided through a carved-out delivery system that is separate from the LIHP). The CI Counties will receive, at minimum, an allocation in an amount adequate to ensure that their existing HCCI enrollees can continue to receive services under the LIHP. The allocations will be the maximum levels of SNCP funding that will be available to pay for expenditures for HCCI enrollees in each Participating Entity's LIHP during the DY, as established in the LIHP Contract and any amendments thereof.

MCE Funding

There is no cap on funds, nor any allocation process, for the MCE programs.

Source of Funds for Nonfederal Share

The State must have permissible sources for the non-federal share of LIHP expenditures, which may include CPEs or permissible Intergovernmental Transfers (IGTs) from government-operated entities and state funds. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include Delivery System Reform Incentive Payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, LIHP, Medicare, or Medicaid. Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a specified purpose or program cannot be used as the non-federal share of funds for programs under the LIHP. However, those programs could be expanded by additional sources of non-federal funds. In addition to the funding mechanisms described above, the State may fund the nonfederal share of LIHP program payments for out-of-network emergency services with provider fee revenues that comply with section 1903(w). Further, In the event that the use of CPEs or permissible IGTs by the State and government-operated entities is insufficient to fully utilize the full amount of annual funding for the SNCP, the State may propose alternate legitimate funding mechanisms. However, CMS must review and approve any such alternate funding prior to its use as the non-federal share of a payment under Title XIX.

The government operated hospitals listed in Attachment C, the State, a county, or a city are eligible for FFP based upon CPEs determined through an approved cost reimbursement methodology. The State may add other governmental entities (a governmental entity with which a LIHP is affiliated, or any other eligible public entity that voluntarily provides the non-Federal share of expenditures, including providers established under State statutes authorizing hospital authorities, hospital districts, or similar entities) to this list. The State must notify CMS when an entity on Attachment C is removed.

Citizenship Identity Documentation Requirements

LIHPs must comply with the requirements of section 42 USC 1396b(x) [Social Security Act section 1903b(x)] and 42 USC 1396a(a)(46)(B) [1902(a)(46)(B)] regarding documentation of immigration status. Thus, the reduction to the amount of expenditures for claims from the SNCP will not be applied to expenditures associated with MCE or HCCI enrollees, pursuant to Paragraph 40 of the STCs.

Attachment G Low Income Health Program Allocations for the Health Care Coverage Initiative Population
By Demonstration Year (DY) — Total Computable —

Introduction: The following Table reflects the HCCI allocations for expenditures in each county for years 6 through 9 of the Demonstration. The allocations will be the maximum levels of SNCP funding that will be available to pay for expenditures for HCCI recipients in each county during the Demonstration year.

If FFP is to be provided based on county certified public expenditures, the expenditures for health care coverage service costs for county HCCI recipients must be documented by each county and. must be compliant with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." Expenditures will be claimed in accordance with the CMS-approved HCCI claiming protocol in a Supplement to Attachment G.

LIHP		Extension Period 9/1 – 10/31/10*	DY 6 Total	DY 6 + Extension Period	DY 7 Total	DY 8 Total	DY 9 Total
1	Alameda County Health Care Services Agency	$2,215,148	$33,129,413	$35,344,561	$52,800,000	$52,800,000	$26,400,000
2	Contra Costa Health Services	$4,117,501	$16,096,080	$20,213,581	$30,030,000	$31,527,600	$33,111,000
3	Kern Medical Center	$2,700,001	$7,040,000	$9,740,001	$6,000,000	$5,000,000	$2,500,000
4	Los Angeles, County of	$14,580,000	$269,280	$14,849,280	$742,000	$41,365,000	$23,850,000
5	Orange, County of	$4,555,327	$40,040,000	$44,595,327	$66,300,000	$66,300,000	$33,800,000
6	Riverside County					$10,500,000	$5,250,000
7	San Diego, County of	$3,520,799	$2,464,000	$5,984,799	$4,000,000	$4,200,000	$2,400,000
8	San Francisco Department of Public Health	$6,579,901	$18,692,590	$25,272,491	$26,428,000	$28,348,000	$15,202,000
9	San Mateo County	$2,042,326	$4,928,000	$6,970,000	$7,250,000	$7,450,000	$3,770,000
10	Santa Clara, County of	$5,589,000	$6,160,000	$11,749,000	$7,100,000	$6,200,000	$3,000,000
11	Ventura County Health Care Agency	$2,700,001	$6,336,000	$9,036,001	$13,000,000	$9,500,000	$5,000,000

Attachment G Low Income Health Program Allocations for the Health Care Coverage Initiative Population
By Demonstration Year (DY) — Total Computable —

	Total	**$48,600,004**	**$135,155,363**	**$183,755,367**	**$213,650,000**	**$263,190,600**	**$154,283,000**

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

The purpose of this Attachment G–Supplement 1 is to set forth the cost claiming guidelines and payment process for services provided by Participating Entities under the Low Income Health Program (LIHP), when the claim for federal financial participation (FFP) is based on Certified Public Expenditures (CPEs). The following guidelines must be met in order to ensure FFP.

A Participating Entity may provide services under the LIHP that are claimed based on CPEs, and may also provide services under the LIHP that are paid on the basis of actuarially sound capitation rates. The cost claiming for services reimbursed on the basis of CPEs will be governed by this Attachment G–Supplement 1. The cost claiming for services reimbursed on the basis of actuarially sound capitation rates will be governed by Attachment G–Supplement 2.

The LIHP costs being claimed under this protocol are limited to the costs incurred under the Participating Entity's executed contract(s) with the Department of Health Care Services (DHCS) (*i.e.*, the LIHP Contract, and the LIHP-Mental Health (LIHP-MH) Contract, if mental health services are provided through a carved-out delivery system that is separate from the LIHP) and in accordance with Attachment G, entitled *"Low Income Health Program,"* of the Special Terms and Conditions (STCs) of California's Section 1115(a) *Bridge to Reform Demonstration*. Each Participating Entity will receive as payment for services rendered to LIHP enrollees, FFP received by the State based on the CPEs for that Participating Entity's LIHP. All references to interim, quarterly or reconciled payments to a LIHP refer to the FFP received by the State based on the CPEs for that Participating Entity's LIHP.

Unless expressly discussed below, the LIHP costs being claimed under this methodology will be determined in accordance with Attachment F, entitled *"Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool,"* of the STCs of the *Bridge to Reform Demonstration*, and in accordance with the methodologies for claiming hospital and non-hospital costs that have been approved by the Centers for Medicare & Medicaid Services (CMS).

Unless expressly discussed below or in the documents referred to above, the Participating Entity and the Department of Health Care Services (DHCS) must follow Medicare cost principles in identifying eligible costs.

I. Methods for Delivery, Cost Reporting, and Payment for LIHP Services

Each Participating Entity will enter into a contract(s) with DHCS to provide services under the LIHP program. The contract(s) will identify the covered services that the Participating Entity will provide under the LIHP and the method of payment for such services.

The method of reporting certain costs of providing LIHP services depends on whether or not the Participating Entity operates one or more Designated Public Hospitals (DPHs). All costs will be claimed in accordance with OMB Circular A-87 and Attachment F, as applicable. The HCCI allocation will be set forth in the LIHP contracts with DHCS and will be the maximum level of

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

SNCP funding that will be available to pay for expenditures for HCCI enrollees in each Participating Entity's LIHP during the DY. There is no cap on funding for the MCE program.

A. DPH-Based LIHP

Participating Entities that operate a DPH (DPH-Based LIHP)will include the costs of providing health care services to LIHP enrollees on the *Interim Hospital Payment Rate Workbook* (Workbook), established pursuant to Attachment F of the STCs.

DPH-Based LIHPs will report the costs of providing those inpatient hospital, outpatient hospital, and non-hospital services, including those services approved in Attachment D of the STCs, entitled *"Additional Cost Elements for Government-Operated Hospitals Using Certified Public Expenditures (CPEs),"* to LIHP enrollees on the Workbook. The Workbook is completed using each hospital's most recently filed or audited Medi-Cal 2552-96 cost report for the period, as applicable. The LIHP inpatient days, inpatient and outpatient charges, and the resulting costs are calculated on Schedules 1, 1A and lB of the Workbook. Additional costs of LIHP services, as allowed under Attachment D of the STCs, are identified on Schedules 4 and 5 of the Workbook. Such costs include expenditures made by, or costs incurred by the DPH or by the governmental entity that operates the DPH.

DPH-Based LIHPs that provide services to LIHP enrollees through one or more contracts (Subcontract(s)) will report their contract costs on the Workbook as specified in Section III.E below. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

DHCS will make interim quarterly payments to DPH-Based LIHPs based on the estimated expenditures data included in Schedule 2A of the Workbook in accordance with the Interim Quarterly Payments for the Expenditure Year section below. DPH-based LIHPs will estimate costs for the expenditure year by utilizing volume and trend adjustment factors contained in the Workbook, based on estimated changes to factors such as enrollment, network provider contracts and DPH cost of providing services. DHCS will reconcile the interim quarterly payments as specified in the Interim Review and Reconciliation Process section below. Also, in accordance with the Final Reconciliation and Settlement and Payment/Recovery for the Expenditure Year section below, DHCS will perform a final reconciliation and settlement, and payment/recovery, after the claiming period using the hospital's Medi-Cal 2552-96 cost report for that same claiming period, as finalized by the Audits and Investigations Division (A&I) of DHCS, for the purposes of Medicaid reimbursement.

B. Non DPH-Based LIHP

Participating Entities that do not operate a DPH (Non DPH-Based LIHP) will determine their LIHP costs, for the purpose of establishing CPEs, through invoices that contain the actual costs of contracted services and, if applicable, the same cost-reporting protocols for services not

provided through a contract but provided in clinics or other provider types operated by the Participating Entity (e.g. a county-owned clinic). Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

For services provided through a contract, Non-DPH-Based LIHPs will submit quarterly invoices or claims for reimbursement for LIHP services, to DHCS and DHCS will make quarterly payments to the Non-DPH-Based LIHPs based on such claims, in accordance with the Interim Quarterly Payments for the Expenditure Year section below. DHCS will reconcile the interim quarterly payments as specified in the Interim Review and Reconciliation Process section below, if appropriate. Also, in accordance with the Final Reconciliation and Settlement and Payment/Recovery for the Expenditure Year section below, DHCS will perform a final reconciliation and settlement, and payment/recovery after the claiming period using appropriate data, if appropriate.

For services not provided through a contract but provided through a facility operated by the Participating entity, if the Non DPH-Based LIHP provides services through a hospital that it operates, DHCS will base the final reconciliation and settlement, and payment/recovery, on the hospital's Medi-Cal 2552-96 cost report for that same claiming period, as finalized by the Audits and Investigations Division (A&I) of DHCS, for the purposes of Medicaid reimbursement and reported costs based on this cost report through a Workbook that includes the same elements as the Workbook used for the DPH-Based LIHPs.

II. Interim Quarterly Payments for the Expenditure Year

A.

1. DHCS will compute the interim quarterly payments for DPH-Based LIHPs on an annual basis using the Participating Entity's estimated total funds expenditures as estimated using the most currently filed Workbook adjusted by cost trend and utilization factors. DHCS will make interim quarterly payments in a manner consistent with the instructions herein.

The interim quarterly payments will be separately identified for the MCE and HCCI enrollee populations. DHCS will make interim quarterly payments to the DPH-Based LIHPs within 45 days after the end of a calendar quarter, for services provided during that quarter.

2. DHCS will make quarterly payments to the Non DPH-Based LIHPs, which are separately identified for the MCE and HCCI enrollee populations. DHCS will reimburse the Participating Entity the contract cost for services provided through a subcontract. For services provided through a hospital or other provider type operated by the Participating Entity, DHCS will determine quarterly interim payments using one-fourth of the annual estimated expenditures for the project year. DHCS will make the quarterly interim payments within 45 days of receipt

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of a complete approvable claim for services provided during that quarter.

3. For DPH-Based and Non DPH-Based LIHPs, the purpose of an interim quarterly payment for services provided to MCE enrollees is to provide an interim payment that will approximate the actual reimbursable LIHP program costs related to the services provided to eligible MCE enrollees that may be claimed by DHCS using the Participating Entity's CPEs.

The interim quarterly payment for services provided to HCCI enrollees will be determined by DHCS under the same methodology as the interim payment for MCE enrollees, except that an interim quarterly payment will be limited to one-fourth of the annual HCCI allocation for the Participating Entity.

The Participating Entity operating a DPH-Based LIHP or a Non DPH-Based LIHP operating all or part of its program through a hospital or other facility it operates will review its projected costs and utilization under the LIHP program each quarter, and will notify DHCS if there are material changes in such data. For this purpose, a "material change" means a change that would have the effect of increasing or decreasing the interim quarterly payment amount by at least 5%. DHCS will make appropriate adjustments to the interim quarterly payments as necessary to reflect material changes in costs. DHCS and the Participating Entity will collaborate in determining the appropriate adjustments to the interim quarterly payments based on auditable cost and utilization data.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided to DHCS upon request, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail.

B. Special Provisions Regarding Payments During the Extension Period (September 1, 2010 to October 31, 2010)

During the period from September 1, 2010 to October 31, 2010 (Extension Period), the DPH-Based entities and the Non-DPH-Based entities that participated in the Coverage Initiative (CI) under the Prior Demonstration will continue to be eligible to receive reimbursement under the CI pursuant to the Prior Demonstration.

Payments for services provided to CI enrollees during the period of September 1, 2010 to October 31, 2010 will be determined by DHCS based on Supplement 1 to Attachment G of the STCs under the Prior Demonstration. Payments for the Extension Period will be limited to one-

sixth of the Participating Entity's allocation of CI funds for the CI year September 1, 2009 to August 31, 2010. The CI payments for the period of September 1, 2010 to October 31, 2010 will be charged to the HCCI allotment for Demonstration Year 6, as set forth in paragraph 3 of Attachment G.

C. Special Provisions Regarding Interim Payments for the Transition Period from November 1, 2010 Through June 30, 2011

DHCS will base the interim payments for those DPH-Based entities that participated in the CI under the Prior Demonstration for services provided to MCE enrollees during the period from November 1, 2010 through June 30, 2011 on the DPH-Based entity's costs as reflected in the most currently filed Workbook. Supplemental data will be requested by DHCS to appropriately reconcile expenditures reimbursed by the interim payments between MCE and HCCI enrollees as necessary. For those Non-DPH-Based entities that participated in the CI under the Prior Demonstration and provided services through subcontracts, DHCS will base the payments for services provided to MCE enrollees during the Transition Period on the Non DPH-Based entity's invoices.

The interim quarterly payment for services provided to HCCI enrollees will be determined by DHCS under the same methodology as the interim payment for MCE enrollees, except that an interim quarterly payment will be limited to the Participating Entity's unused allocation of HCCI funds for the period of September 1, 2010 through June 30, 2011.

III. Cost Reporting and Cost Determination

The Participating Entity's contract with DHCS will identify the types of services that it will provide under the LIHP. The Participating Entity will follow the instructions below in determining the costs of the services described below.

For each cost category, the Participating Entity will separately identify the cost of services provided to the two populations covered under the LIHP, *i.e.*, the MCE and HCCI populations. The cost calculations will be based on appropriate data, such as days, charges, and/or units of service for MCE and HCCI enrollees.

Any revenue received from or on behalf of patients for the LIHP services are applied as offsets to arrive at uncompensated costs.

A. Non-Hospital Based Clinics, Including Public Health Clinics – For DPH-Based LIHPs (non-FQHCs)

The allowable cost for services provided to LIHP enrollees in a non-hospital based clinic that is owned or operated by a DPH-Based LIHP is based on a rate per visit (total costs divided by total visits).

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Non-hospital based clinic costs are captured in the clinic records at each individual site, and the cost per visit is established through a clinic cost report. Clinic cost report data must be entered on the clinic cost finding forms that have been approved by CMS to establish the clinic rate and determine costs. Those DPH-Based LIHPs providing outpatient services to LIHP enrollees in a clinic setting that they own or operate and that is non-hospital based, must determine costs as specified in Supplement 2 to Attachment F of the STCs.

DPH-Based LIHPs will be reimbursed by DHCS for services based on the number of documented LIHP program visits times the established clinic rate for the specific service period.

DPH-Based LIHPs providing clinic services to LIHP enrollees through a subcontract will be reimbursed based on the cost of the subcontract reported on the Workbook in accordance with Section III.E. DPH-Based LIHPs will ensure that the services provided under a subcontract are allowable and will be claimed as specified in Attachment G and this Supplement 1. DPH-Based LIHPs must provide documentation to DHCS, upon request that is sufficient to support the subcontract costs, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

B. Non-Hospital Based Clinics, Including Public Health Clinics – For Non DPH-Based LIHPs

The allowable costs for services provided to LIHP enrollees in a non-hospital based clinic that is owned or operated by a Non DPH-Based LIHP is based on the same cost-reporting utilized for the uninsured as described in Attachment F Supplement 2.

Non-hospital based clinic costs are captured in the clinic records at each individual site.

Non DPH-Based LIHPs providing clinic services to LIHP enrollees through a subcontract will be reimbursed based on the cost of the subcontract in accordance with Section III.E. Non DPH-Based LIHPs will ensure that the services provided under a subcontract are allowable and will be claimed as specified in Attachment G and this Supplement 1. Non DPH-Based LIHPs must provide DHCS, upon request, documentation sufficient to support the subcontract costs, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

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C. Participating Entities Providing Services to LIHP Enrollees in Federally Qualified Health Clinics (FQHCs) – Hospital-Based and Non Hospital-Based

For FQHCs owned by the participating entity, DHCS and CMS, in collaboration with the affected Participating Entities, will work on revisions to this protocol or a separate protocol that will comply with the Waiver and other applicable federal requirements with the intention of completing this work within 60 days. Until such time that such a protocol is approved, participating entities will not be permitted to claim or receive federal financial participation for services provide in FQHCs owned by the participating entity.

1. FQHC Contractor Unrelated to Participating Entity

Participating entities that provide FQHC services to LIHP enrollees by contracting with an FQHC that is not owned by the Participating Entity, may use an alternative payment methodology pursuant to the Benefits Improvement and Protection Act of 2000, Section 702, and will be reimbursed based on the amount paid by the Participating Entity to the FQHC pursuant to the contract in accordance with Section III.D., below, which will be no less than the rate established pursuant to 42 U.S.C. sec. 1902(bb).

D. Participating Entities Providing Hospital and/or Non-Hospital Services to LIHP Enrollees under a Contract (Subcontract) for Services

DHCS will reimburse Participating Entities that provide services to LIHP enrollees through contracts with providers of services (subcontracts) based on the payments made by the Participating Entities to their subcontractors. Participating Entities will ensure that the services provided under a subcontract are allowable and can be claimed as specified in Attachment G of the STCs. Upon request by DHCS, Participating Entities must provide documentation sufficient to support their payments to subcontractors under the subcontracts, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

Cost associated with providing LIHP program services through a subcontract may include negotiated amounts or rates, such as a cost per visit, or rate based on fee schedule. The basis for reimbursement of the services provided pursuant to the subcontract will be established in the payment provisions of the subcontract, and the Participating Entity will report CPEs and be reimbursed based on payments to the subcontractors.

Costs associated with providing LIHP program services through a subcontract may be incurred under an agreement by the Participating Entity to reimburse the subcontractor based on the subcontractor's allowable costs. The total funds expenditures reported for such services will be the amount paid by the Participating Entity to the subcontractor pursuant to the subcontract.

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E. Participating Entities Providing all Healthcare Services under a Contract (Subcontract) to a Managed Care Plan

This section E of the protocol is subject to change upon CMS review and approval of the rates, if such review and approval is determined to be necessary.

DHCS will reimburse Participating Entities that provide services to LIHP enrollees through contracts with health plans (subcontracts) based on the payments made by the Participating Entities to their subcontractor health plan. Participating Entities will ensure that the services provided under a subcontract are allowable and can be claimed as specified in Attachment G of the STCs. Upon request by DHCS, Participating Entities must provide documentation sufficient to support their payments to subcontractors under the subcontracts, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

Cost associated with providing LIHP program services through a subcontract with a managed care plan may include contractually provided rates per member per month (PMPM) as adjusted by contractual risk sharing and pay for performance arrangements. The basis for reimbursement of the services provided pursuant to the subcontract will be established in the payment provisions of the subcontract, and the Participating Entity will report CPEs and be reimbursed based on payments to the subcontractors. The Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontractor that is recovered as a result of contractual risk sharing and pay for performance arrangements. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe.

The total funds expenditures reported for such services will be the amount paid by the Participating Entity to the subcontractor on a PMPM basis pursuant to the subcontract and all subsequent adjustments for risk sharing and pay for performance.

Participating Entities will reimburse subcontracting health plans on a PMPM basis paid to subcontracting health plan for LIHP enrollees. The Participating Entity may reimburse using two separate PMPM rates, one for people previously eligible for Participating Entity coverage and a second for newly eligible people with HIV transferring from the state AIDS Drug Assistance Program (ADAP) or the Ryan White program.

Each PMPM is a single payment with three components. After receiving the PMPM payment, the subcontracting health plan will be required to place each component in a separate interest bearing investment account for Healthcare Costs, Administrative Costs, and Pay for Performance (P4P).

The Healthcare Costs will include the cost of all outpatient, inpatient, primary care, and specialty claims that are paid to providers, including county providers. Funds placed in the Healthcare

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Costs account will be visible to the Participating Entity, traceable to an audit, and restricted in use by contract terms to healthcare costs approved by Participating Entity. All investment income for the funds in this account will be posted to this account. For the first 6 months of the LIHP, the Participating Entity will begin payment with a higher PMPM rate so that a Reserve Account can be built to address the uncertainties of the new LIHP. The Participating Entity will adjust the rate at least every six months in an effort to set a PMPM rate that is comparable with the cost of healthcare services. The Participating Entity takes full risk for the healthcare costs.

Administration Costs will be based on a contractually provided percentage of healthcare costs. All costs for member services, network development, utilization management, claims adjudication, grievances and appeals, are covered in this percentage. The subcontractor will be entirely at risk for the Administration costs. This Administration Cost will not include the Participating Entity's cost of administering the LIHP, such as eligibility determinations, program administration, and oversight of the subcontractor, which will be separately claimed under administrative claiming protocols.

Pay for Performance (P4P) will be based on a contractually provided percentage of healthcare costs and will not exceed 105% of the PMPM. The subcontracting health plan is at full risk for these measures as well. Any funds paid in the PMPM for performance standards not met, will be returned to the Participating Entity. The Participating Entity will return to DHCS the Federal share of the returned funds. DHCS will return those funds to CMS on the CMS-64 form within the required timeframe.

Final Reconciliation/Recovery

Healthcare expenditures will be reconciled to PMPM payments and interest will be deposited in the Healthcare account. Unspent funds, including interest, will be returned to Participating Entity and Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontracting health plan. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe. In the event that this account has a deficit the Participating Entity will reimburse the subcontracting health plan for this amount and certify this expense. DHCS will reimburse the Participating Entity the federal share of this payment.

Through this reconciliation process, the Participating Entity and the federal government will only pay for the actual healthcare expenditures made by the subcontracting health plan on behalf of the LIHP.

After the Healthcare account is adjusted, payments for Administration and P4P will be reconciled to actual Healthcare costs. The final payment to the subcontracting health plan for Administration costs will be equal to the contractual percentage; however, the amount paid to the subcontracting health plan cannot be less than a contractually provided minimum dollar amount PMPM. The final payment to the subcontracting health plan for P4P costs will be equal to the contractual percentage less any funds returned to the Participating Entity for failure to meet a

performance standard.

Any payments due the Participating Entity, including interest, will be returned to Participating Entity and Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontracting health plan. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe. In the event that the Participating Entity has reimbursed subcontracting health plan for additional Healthcare costs, the Participating Entity will provide additional reimbursement to the subcontracting health plan for Administration and P4P based on the contractually provided percentages and the Participating Entity will certify this expense. DHCS will reimburse the Participating Entity the federal share of this payment.

F. Participating Entities Providing Mental Health Services to LIHP Enrollees

The costs of mental health services whether provided through a carved-out delivery system that is separate from the LIHP, or through the LIHP, will be determined as set forth below.

The costs of inpatient and outpatient mental health services provided to LIHP enrollees by DPH-Based LIHPs at a DPH will be determined in accordance with Attachment F of the STCs and reported on the Workbook.

The costs of mental health services provided to LIHP enrollees by DPH-Based LIHPs, other than mental health services provided at the DPH, including mental health services provided under a subcontract, will be determined in accordance with Attachment F–Supplement 4, and will be reported in Schedule 5 of the Workbook.

The costs of inpatient and outpatient mental health services provided to LIHP enrollees by Non DPH-Based LIHPs at a hospital operated by the Non DPH-Based LIHPs will be determined in accordance with the cost finding methodology for the Medi-Cal 2552 cost report.

The costs of mental health services provided to LIHP enrollees by Non DPH-Based LIHPs, other than mental health services provided at a hospital operated by the Non DPH-Based LIHP, including mental health services provided under a subcontract, will be determined in accordance with the cost finding methodology specified above in the first two paragraphs of section III. B. Non DPH-Based LIHP.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of mental health services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided upon request. .

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G. Participating Entities Providing Substance Use Disorder/Drug Rehabilitation Services to LIHP Enrollees

1. DPH-Based LIHP

If provided as an add-on service pursuant to the LIHP Contract, the costs of outpatient substance abuse and drug rehabilitation services (substance abuse services) provided to LIHP enrollees by DPH-Based LIHPs at a DPH will be determined in accordance with Attachment F of the STCs and reported on the Workbook.

The costs of other substance abuse services provided by Participating Entities to LIHP enrollees will be determined using specific service codes that will capture utilization data for LIHP program participants as captured in the Alcohol and Drug Program Cost Reports required under the California Code of Regulations, Title 9. The cost related to the LIHP program will be based on a ratio of total substance abuse services costs and total utilization, times LIHP program utilization. Utilization data used to apportion cost to the LIHP program will be based on the appropriate apportionment measures for the respective provider types and services. The Participating Entity will be reimbursed for substance abuse services through interim quarterly payments based on the documented substance abuse costs times the calculated ratio to determine program services costs for the specific service period.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of substance abuse services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided upon request.

For those DPH-Based Participating Entities providing substance abuse services to LIHP enrollees through a subcontract, the Participating Entities will be reimbursed based on their subcontract costs as discussed above. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

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2. Non DPH-Based LIHP

a) Participating Entities that provide substance abuse services that are claimed based on invoices for actual cost will determine their costs in accordance with Section I.B of this Supplement.

b) For those Participating Entities providing substance abuse services to LIHP enrollees through a subcontract, the Participating Entities will be reimbursed based on their subcontract costs as discussed above. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

H. Costs Incurred by Participating Entities for Emergency and Post-Stabilization Services Furnished by Out Of Network Providers to LIHP Enrollees

Participating Entities that operate their LIHP program through a closed provider network are generally not required to pay for services that are provided outside their approved delivery system. Under limited circumstances, however, LIHPs that operate a closed provider network may be required to pay for medically necessary emergency care services and required post-stabilization care for MCE enrollees. Participating Entities are required to pay for out-of-network emergency and post-stabilization services only if the out-of-network provider furnishes timely notice to the LIHP of the patient's emergency room visit and adheres to the LIHP's protocol for approval of post-stabilization services.

The allowable cost for out of network emergency and post-stabilization services provided to MCE enrollees is the amount paid by the Participating Entity to the out-of-network provider. For covered inpatient hospital services furnished in state, the Participating Entity must pay at least 30% of the applicable regional unweighted average of per diem rates paid to Selective Provider Contracting Program contracted hospitals, which rates are published annually by DHCS Medi-Cal Managed Care Division in its MMCD All Plan Letters to All Medi-Cal Managed Care Health Plans (for example, MMCD All Plan Letters 11-016 and 11-017). For covered inpatient hospital services furnished out of state, the Participating Entity must pay at least 30% of the statewide per diem average of contract rates as of December 1 of the prior calendar year for acute inpatient hospital services provided by California hospitals with at least 300 beds, or 30% of the hospital's actual billed charges, whichever is less. For mental health services provided by out-of-network providers, the Participating Entity may pay 30 percent of the average rate that is paid by the mental health plan in the county of the LIHP enrollee's residence. For covered services other than mental health services, the Participating Entity must pay the out-of-network provider at least 30% of the applicable regulatory fee-for-service rate (excluding any supplemental payments).

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DPH-Based LIHPs will report the costs of emergency and post-stabilization services furnished by out of network providers on Schedule 4 of the Workbook.

Non DPH-Based LIHPs will be reimbursed based on quarterly invoices for the cost of emergency and post-stabilization services furnished by out of network providers and supporting documentation.

I. Costs Incurred for Providing Services to LIHP (MCE) Enrollees Determined Eligible by DHCS and Who are Only Eligible While Admitted as Hospital Inpatients

FFP is available for the health care services provided for specific LIHP enrollees under the MCE component of the program who are eligible only while they are admitted as an inpatient in a medical institution, pursuant to Medicaid policy and regulations. [2] A Participating Entity may report State expenditures for inpatient hospital services provided to specific LIHP enrollees whose eligibility is determined by DHCS and who are enrolled in the Participating Entity's LIHP.

DHCS will determine eligibility based on the following: (a) whether the individual's county of last legal residence operates or participates in a LIHP, (b) whether the individual meets the income standards of the MCE component of the Participating Entity's LIHP; and (c) whether the individual meets all other eligibility criteria for enrollment in the Participating Entity's LIHP.

Expenditures for costs incurred from providing inpatient hospital services by the state agency that is responsible for providing medical services to the individual will be reported to the Participating Entity and fully documented by that agency. The responsible state agency determines when medical care is needed, contracts with the hospitals for services for the individuals, and arranges for payment using funds allocated from the state agency. For each LIHP enrollee the state agency will send a quarterly invoice to the Participating Entity indicating the amount expended by the state agency for allowable inpatient hospital services. The state agency will certify that the information on these invoices is true and accurate and that the expenditure is eligible for FFP, and will transmit the certification to the Participating Entity.

Upon receipt of the invoices and certifications, the Participating Entity may submit the expenditures certified by state agency as part of the Participating Entity's claim to DHCS. The Participating Entity will separately identify those expenditures as being the expenditures of the state agency. In addition to the certifications received from the state agency, the Participating Entity will submit a statement signed by the Participating Entity's designated representative that the Participating Entity's claim is based on the expenditures submitted and certified by the state

[2] Sections I and J of this Protocol provide additional detail regarding claiming for services rendered to inmates who receive care in a medical institution, as outlined in DHCS's letter to Gloria Nagle, Associate Regional Administrator for CMS Region IX, dated February 24, 2011, at pages 4-6.

agency. The state agency shall provide sufficient information to allow the Participating Entity to comply with the requirements of 42 C.F.R. §§ 438.604 and 438.606. DHCS will submit the claim for FFP based on the expenditures reported by the Participating Entity for services provided to these LIHP enrollees. DHCS will pay the FFP to the contributing state entity directly.

DPHs that provide inpatient hospital services to the subject individuals may report in their Workbooks the costs of providing those services and any additional allowable expenditures for services that are provided to the enrollees during the time in which the enrollee is an inpatient in the DPH including physician, laboratory, pharmacy and other services, but only to the extent that such costs exceed the amount paid to the DPH by the contributing state entity for that service.

DPHs will make appropriate adjustments to expenditures reported in their Workbooks to ensure that there is no duplicate claim for FFP. DPHs will not report expenditures for services provided to the subject individuals that are not allowable for claiming.

J. Costs Incurred for LIHP (MCE) Enrollees Determined Eligible by the Participating Entity and Who are Only Eligible While Admitted as Hospital Inpatients

FFP is available for health care services provided for specific individuals enrolled in the LIHP under the MCE component who are eligible only while they are admitted as an inpatient in a medical institution, pursuant to Medicaid policy and regulations. [1]A Participating Entity (or the DPH with which it is affiliated) may submit the cost of inpatient hospital services provided to these individuals if they are determined eligible by the Participating Entity and enrolled in the Participating Entity's LIHP. The Participating Entity (or the DPH with which it is affiliated) may also report any additional expenditure allowable for claiming that are provided to these enrollees during the time in which these individuals are inpatients in the acute care hospital, including physician, laboratory, pharmacy and other services. The Participating Entity shall submit these in accordance with the applicable provisions of this Attachment G, Supplement 1. The Participating Entity will determine whether the individual meets the county residency requirements and whether the individual is eligible for enrollment in the LIHP under the MCE component of the program. If the individual is determined to be eligible, the Participating Entity will enroll the individual for the limited purpose of reporting allowable expenditures for services provided while the individual is admitted as an inpatient in an acute care hospital. The Participating Entity will not report expenditures for services provided to the individual that are not allowable for claiming.

K. Total Funds Expenditures of other Governmental Entities

Participating Entities may report the total funds expenditures incurred by other governmental entities, including a governmental entity with which a LIHP is affiliated, or any other eligible public entity that voluntarily incurs expenditures, in providing services under the LIHP to MCE

and HCCI enrollees for which the Participating Entity is responsible. The other governmental entity will submit a report of its total funds expenditure and the services provided under the LIHP, to the Participating Entity, along with an attestation signed by the entity's designated representative certifying that such costs are allowable and meet all federal requirements. The other governmental entity will report costs in a manner and format consistent with Attachment F and this Attachment as utilized by DPHs. The Participating Entity will submit a claim to DHCS that is accompanied by an attestation signed by the Participating Entity's designated representative that it has reviewed such costs, that to the best of its knowledge such costs are allowable and meet all federal requirements, and that the Participating Entity is relying on the other governmental entity's attestation.

IV. Interim Review and Reconciliation Process

The purpose of an interim review and reconciliation process is for DHCS to review LIHP program costs and payments for services provided to LIHP enrollees that may be claimed through the CPE process, to review the Participating Entity's expenditures to ensure that reported costs are accurate and allowable, and to reconcile the Participating Entity's expenditures under the HCCI to the Participating Entity's HCCI allocation. This interim computation of payments claimed as CPEs will be performed in a manner consistent with the instructions below. Costs that are claimed will be in a manner and form consistent with the contract terms and conditions, and be accompanied by an attestation signed by the Participating Entity's designated representative that the costs being claimed are allowable and meet all federal requirements.

Participating Entities must maintain and provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees. Revenue offsets to account for other revenues received for services furnished, and any other applicable non-patient care revenues that were not previously offset or accounted for, must be provided to DHCS. (*e.g.*, revenue paid by or on the behalf of the patient).

A. DPH-Based LIHPs

DPH-Based LIHPs and DHCS will reconcile the interim costs for LIHP enrollees based on each DPH's filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. DHCS will adjust, as necessary, the total interim payments based on the total costs under the interim reconciliations. If, at the end of the interim reconciliation process, DHCS determines that the Participating Entity received an overpayment, DHCS will recover the overpayment from the Participating Entity and report the appropriate credit to CMS through the quarterly federal reporting process.

B. Non DPH-Based LIHPs

At the end of each LIHP program quarter, for those Participating Entities that have provided services to LIHP enrollees, DHCS will review the Participating Entity's quarterly utilization,

expenditures, and other information submitted by the Participating Entity to ensure proper claiming, and reconcile the HCCI expenditures with the interim quarterly payment and the Participating Entity's allocation under the HCCI. Upon completion of the interim quarterly review and reconciliation, DHCS will adjust the interim quarterly payment accordingly.

After the end of each LIHP program year, for those Participating Entities that have provided services to LIHP enrollees, DHCS will review the Participating Entity's final expenditure data, and reconcile the expenditure data with the quarterly interim payments made to the Participating Entity. For Non-DPH Based LIHPs, an interim reconciliation will only be necessary for those services not provided through a subcontract but that were provided through the Participating Entity's own hospital or other facility

V. Final Reconciliation and Settlement, and Payment/Recovery, for the Expenditure Year

The purpose of a final reconciliation and settlement and payment/recovery is to finalize the LIHP program costs and payments for services provided to LIHP enrollees that may be claimed through the CPE process. DHCS will perform the final computation of payments claimed as CPEs in a manner consistent with the instructions below. Costs that are claimed must be in a manner and form consistent with the terms and conditions of the LIHP Contract and LIHP-MH Contract (if mental health services are provided through a carved-out delivery system that is separate from the LIHP) and must be accompanied by a certification signed by the Participating Entity's designated representative that the costs being claimed are allowable and meet all federal requirements. For Non-DPH Based LIHPs, a final reconciliation will only be necessary for those services not provided through a subcontract but that were provided through the Participating Entity's own hospital or other facility.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees, revenue offsets to account for other revenues received for services furnished, and any other applicable non-patient care revenues that were not previously offset or accounted for.

DHCS will perform the final reconciliation after the claiming period using the final cost determinations for the services provided, and other information submitted by the Participating Entity. For those Participating Entities providing services to LIHP enrollees at a hospital (including a DPH) operated by the Participating Entity, DHCS will perform a final reconciliation and settlement, and payment/recovery, after the claiming period using the hospital's Medi-Cal 2552-96 cost report for that same spending year as finalized by A&I for the purposes of Medicaid reimbursement.

DHCS will reconcile the Participating Entity's interim quarterly payments for services provided to MCE and HCCI enrollees to the final determination of the Participating Entity's costs for such

services. If, at the end of the final reconciliation process, DHCS determines that the Participating Entity has been underpaid for services provided to LIHP enrollees, DHCS will claim for reimbursement of the additional amount due to the Participating Entity. If, at the end of the final reconciliation process, DHCS determines that the Participating Entity received an overpayment, DHCS will recover the overpayment from the Participating Entity and will return the overpayment to CMS on the CMS-64 form within the required timeframe.

VI. Impact of Safety Net Care Pool (SNCP) and Uncompensated Care Cost Computations

The costs of services provided to LIHP enrollees that are not covered by LIHP may be considered uncompensated care costs. Costs for hospital services may be eligible for reimbursement as disproportionate share hospital (DSH) payments and Safety Net Care Pool (SNCP) payments. (Note however that certain hospital costs are only allowed for SNCP and not allowed for DSH purposes, in accordance with Attachment D; therefore, any uninsured costs to be claimed for DSH payments must be adjusted accordingly to arrive at DSH eligible costs only.) The non-hospital costs may be eligible for reimbursement through SNCP payments.

In the event that a Participating Entity's costs of providing HCCI program services to HCCI enrollees exceed the amount of the Participating Entity's allocation for its HCCI program, those costs may be considered uncompensated care costs. Costs for hospital services may be eligible for reimbursement as DSH payments and SNCP payments. (Note however that certain hospital costs are only allowed for SNCP and not allowed for DSH purposes, in accordance with Attachment D; therefore, any uninsured costs to be claimed for DSH payments must be adjusted accordingly to arrive at DSH eligible costs only.) The non-hospital costs may be eligible for reimbursement through SNCP payments for uncompensated care costs. Total HCCI program costs will be reduced by the total HCCI claim allocable to the appropriate services setting and the net uncompensated care costs will be included, as appropriate, in the DSH and the SNCP payment calculations.

With respect to a Participating Entity that is a county, is not a DPH-Based LIHP, and which is affiliated with a DPH that is operated by a hospital authority (Alameda County), if the Participating Entity's costs of providing HCCI program services to HCCI enrollees exceed the amount of the Participating Entity's allocation for its HCCI program, the costs in excess of the allocation may be considered uncompensated care costs and may be reported in the Workbook for the DPH that is operated by the hospital authority affiliated with the county (Alameda County Medical Center) as eligible SNCP CPEs incurred by a governmental entity affiliated with the DPH.

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

Local Low Income Health Program: Participating Entity Claiming Protocol

CONTRACTOR NAME

Purpose: STC 43(a)(iii) requires the State of California to submit individual funding and claiming protocols to the Centers for Medicare and Medicaid Services (CMS) with respect to each county participating in the LIHP program. The purpose of this document is to fulfill the requirement set forth is Paragraph 43 (a)(iii) of the Special Terms and Conditions (STCs) of California's Section 1115(a) Bridge to Reform Demonstration (Demonstration) and describe how the LIHP will receive payment and how federal reimbursement will be claimed under the program. All claiming should be consistent with Attachments G and J, as authorized under the STCs of the Demonstration.

1. PROGRAM DESCRIPTION

The LIHP is a:

☐ Designated Public Hospital-Based LIHP (DPH-Based LIHP)

☐ Non-Designated Public Hospital-Based LIHP (Non DPH-Based LIHP)

The LIHP will claim payment for the covered services rendered to enrollees in accordance with the STCs of the Demonstration and the following claiming protocols:

- Attachment G,
- Supplement 1 to Attachment G: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims Based on Certified Public Expenditures, and/or

☐ The LIHP will claim payment for administrative activities under Attachment J of the STCs of the Demonstration.

2. ELIGIBILITY: POPULATION SERVED

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

The LIHP will cover the following population(s) indicated below (the MCE population will be claimed separately from the HCCI population):

MCE: ☐ Existing MCE ☐ New MCE

HCCI: ☐ Existing HCCI ☐ New HCCI

3. BASIS FOR CLAIMING

The LIHP will use the identified claiming protocols for claiming payment for the services rendered (Check all that apply):

LIHP Services	Attachment G Protocol for Claiming Supplement 1 = Cost Basis (CPEs)
a. Health Care Services	
☐ MCE	☐ Supp 1
☐ HCCI	☐ Supp 1
b. Substance Abuse Services	
☐ MCE	☐ Supp 1
☐ HCCI	☐ Supp 1

Limited Service Populations-enrollees determined eligible by DHCS and who are only eligible while admitted as hospital inpatients.

☐ MCE ☐ Supp 1

Limited Service Populations-enrollees determined eligible by the participating entity and who are only eligible while admitted as hospital inpatients.

☐ MCE ☐ Supp 1

HIV/AIDS/Ryan White - Services provided to enrollees who meet the requirement in the definition of eligible individuals in Part B of the Ryan White Care Act, section 2616 (b)(1) of the Public Health Service Act (42 U.S.C. 300ff-26(b)(1).

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

Out-of-Network Emergency and Post-Stabilization Services
☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

Other Excluded Services (if applicable)

_____ ☐ Supp 1
Description of Other Service

Mental Health Services
a. ☐ LIHP mental health services are provided through a carved out delivery system that is separate from the LIHP.
☐ MCE ☐ Supp 1

☐ HCCI ☐ Supp 1

OR

b. ☐ LIHP mental health services are provided through the LIHP.
☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

4. SOURCES OF LOCAL NON-FEDERAL SHARE
(Check all that apply.)

a. ☐ The LIHP will use public county funds, including county general funds, patient care revenue, and other provider revenue as the non-federal share.

b. ☐ As authorized by Paragraph 63.g. of the STCs, out-of-network emergency and post-stabilization services will be funded in part with provider fee revenues that comply with § 1903(w) of the Social Security Act. (See § 14169.7.5 of the Welfare & Institutions Code).

c. ☐ Other public entities will provide part of the non-federal share. Please include the name of each public entity that will provide part of the non-federal share and describe the LIHP's arrangement with the other public entity, as requested below. If you need additional space to describe the contributions of other public entities, please attach supplemental pages to the end of this protocol.

(1). Name of Other Public Entity: (Insert Name)

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

The Other Public Entity will provide the non-federal share, based on:

☐ CPEs

☐ IGTs

Describe the nature of the arrangement through which the other public entity will contribute the non-federal share and receive payment. The other public entity must certify that the non-federal share is from permissible sources as identified in Paragraph 39 of the STCs.

(Insert Description)

(2). Name of Other Public Entity: (Insert Name)

The Other Public Entity will provide the non-federal share, based on:

☐ CPEs

☐ IGTs

Describe the nature of the arrangement through which the other public entity will contribute the non-federal share and receive payment. The other public entity must certify that the non-federal share is from permissible sources as identified in Paragraph 39 of the STCs.

(Insert Description)

***This Participating Entity Claiming Protocol will be amended to allow for claiming under Attachment G – Supplement 2 upon CMS approval of that protocol.**

SUPPLEMENT 1A: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims for Payments for Federally Qualified Health Centers (FQHCs) Owned by Participating Entities

The purpose of this Attachment G—Supplement 1A is to set forth the cost claiming guidelines and payment process for services provided by FQHCs owned or operated by the Participating Entity under the Low Income Health Program (LIHP), when the claim for federal financial participation (FFP) is based on intergovernmental transfers (IGTs).

1. Payment Expenditures for FQHCs Owned by the Participating Entity

Expenditures for payments for services provided by FQHCs owned or operated by the Participating Entity, whether or not hospital-based, will be expenditures incurred by the State, and will not be included in allowable costs for purposes of the LIHP certified public expenditure (CPE) claiming by the Participating Entity pursuant to Attachment G – Supplement 1. Payments to the Participating Entity for services provided by its FQHCs will be made by the State, with the nonfederal share of the payments funded by intergovernmental transfers made by the Participating Entity.

2. Establishing FQHC Payment Amount

The FQHC will be paid a rate either at its projected costs or the prospective payment system (PPS) rate established pursuant to Section 1902(bb) of the Social Security Act. The payment rate for FQHC visits for LIHP enrollees during the DY is defined as the greater of the FQHC PPS amount applicable for the DY or the projected per visit cost of services amount. The determination of the FQHC's payment rate will be made at the start of the applicable Demonstration Year (DY), or as soon thereafter as possible.

A. Determining Projected Costs

A projected per visit amount for the costs of services provided by the FQHC to LIHP enrollees will be determined using the most recently available cost data from the Workbooks completed and submitted in accordance with Attachment F of the STCs that are trended through the applicable DY. For FQHCs owned by the Participating Entity that are hospital-based, the costs of services are reflected in the hospital's records and included on the hospital's filed Medi-Cal 2552-96 cost report as hospital outpatient costs. DPH-Based LIHPs will include the costs of services provided to LIHP enrollees in hospital-based FQHCs in the Workbook schedules for hospital outpatient costs pursuant to Attachment F of the STCs. For FQHCs owned by the Participating Entity that are not hospital-based, the costs of services are captured in the clinic records at each individual FQHC site, and the cost per visit is established through a clinic cost report in accordance with the methodology set forth in Attachment F-Supplement 2 of the STCs. Clinic cost report data will be entered on the clinic cost finding forms that have been approved by CMS to establish the clinic rate and determine cost.

B. Determining the PPS Rate

SUPPLEMENT 1A: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims for Payments for Federally Qualified Health Centers (FQHCs) Owned by Participating Entities

In the determination of the FQHC's payment rate, the FQHC's most recently determined Medicaid PPS rate will be used. When the FQHC's Medicaid PPS rate has not yet been established for the DY or a revised PPS rate for the DY is pending at the time the comparison to projected costs is made, the interim PPS rate will be used for this purpose, and payments subsequently will be adjusted, if necessary, based upon the FQHC's final Medicaid PPS rate for the DY. No subsequent adjustment will be made based on final costs of services for the DY.

3. Payment Process

The Participating Entity will provide the State with a quarterly invoice for services provided by each of the Participating Entity's FQHCs, which identifies the visit count separately for HCCI and MCE enrollees, and the applicable payment rate. Within 14 days of when the invoice is submitted, the Participating Entity or its affiliated governmental entity will make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to draw the federal funding for the FQHC payments. The State will draw the federal funding and pay both the nonfederal and federal shares of the FQHC's payment rate to the Participating Entity. The federal and nonfederal share of the payments will be reflected on the accounting records applicable to the operations of the FQHC as payment for services rendered.

If the intergovernmental transfer is made within the appropriate 14 day timeframe, the FQHC payment will be disbursed within 7 days, otherwise the payment will be disbursed within 14 days of when the transfer is made, or as soon thereafter as possible, but in no case later than 30 days of when the intergovernmental transfer of funds is made.

4. Priority of FQHC Payment Expenditures Under HCCI Allocations

The FQHC payment expenditures under this Supplement with respect to services provided to HCCI enrollees shall be prioritized over all other eligible HCCI expenditures for purposes of the applicable Participating Entity's HCCI allocation established pursuant to paragraph 47 of the STCs and described in Attachment G.

Attachment H - Accounting Procedures

The following Accounting Procedures have been developed to ensure that no over claiming of expenditures occur and to provide for accurate reporting of mandated reports as required by CMS for the Demonstration. The Safety Net Financing Division's (SNFD) Hospital Contracts Unit (HCU), within the Inpatient Contract and Monitoring Section (ICMS), is responsible for preparing quarterly and annual reconciliation of program expenditures.

I. STATE-ONLY PROGRAMS - Reserved for State submission of accounting procedures for DY 6-10 DSHPs per paragraph 20.

II. CERTIFIED PUBLIC EXPENDITURES

CPEs are expenditures certified by counties, university teaching hospitals, or other governmental entities within a state, as having been spent on the provision of covered services to Medi-Cal beneficiaries and uninsured individuals. CPEs are eligible for reimbursement at the federal medical assistance percentage in effect on the date the service is provided.

Cost Submission

At least annually, designated public hospitals (DPHs) send to SNFD an estimate of their CPEs for the project (current) year, accompanied by an attestation of the costs. The CPEs are derived from the Medi-Cal 2552-96 cost report, a Workbook developed by SNFD, and other documentation to support the estimated CPEs. These CPEs are used to establish an interim per diem rate of reimbursement for the costs of providing inpatient care to Medi-Cal beneficiaries, and to determine DSH payments, and payments from the SNCP. In addition, the data is used as the basis of a tentative settlement made for inpatient services rendered to Medi-Cal beneficiaries.

1. Review Process
   SNFD reviews all data submitted for accuracy and compliance with established procedures, and performs tests for reasonableness. If discrepancies or inconsistencies are identified, SNFD works directly with the DPH staff to resolve issues and correct data.

2. Interim Payment Process

   Establish Inpatient Interim Rates
   SNFD establishes the inpatient interim rate for each DPH based on the most current filed Medi-Cal 2552-96 and Workbook. SNFD instructs Provider Enrollment Division (PED) to update the Provider Master File (PMF) to reflect the new interim rates. The new interim rates are not retroactive and are applied to all claims for services rendered effective with the update.

   Determine Interim Payment
   SNFD reviews the most current filed Medi-Cal 2552-96 cost report and Workbook filed by each DPH for the purpose of determining a tentative settlement. The tentative settlement is made to settle on an interim basis all claims paid to date to reflect the difference between the

interim rate paid and actual costs. The actual claims paid are based on the most current Medi-Cal claims payment data generated by California's fiscal intermediary. Based on the review and application of the current payment data, SNFD generates a notice of tentative settlement to each DPH that includes schedules supporting the calculation and a copy of the payment data. A copy of the notice is forwarded to A&I for preparation of an action notice authorizing California's fiscal intermediary to pay or recover the tentative settlement amount. California's fiscal intermediary will prepare a Statement of Account Status which will inform the hospital of the date of payment or instructions for repayment.

3. Final Reconciliation Process
   The final audit report of the Medi-Cal 2552-96 cost report generated by A&I will be used as the basis for final determination and settlement of the CPEs. SNFD will instruct A&I to prepare an action notice informing California's fiscal intermediary of the final settlement. California's fiscal intermediary will issue a Statement of Account Status which will incorporate the previous tentative settlement and inform the DPH of any further payment or recovery.

III. INTERGOVERNMENTAL TRANSFERS (IGTs)

IGTs are transfers of public funds between governmental entities, such as from a county to the State. One source of the funding used for the transfer is local tax dollars. SNFD reviews the source of funding for each IGT that is proposed by a governmental entity to ensure that it meets state and federal requirements for permissible transfers.

Pre-Transfer

For IGTs used as the non-federal share of DSH payments, DHCS and the State Treasurer's Office (STO) are notified by the county or governmental entity, prior to the transfer of funds to ensure all arrangements are complete.

For IGTs used as the non-federal share of the supplemental payments under the provisions of section 14166.12 of the California Welfare and Institutions (W&I) Code, DHCS, the California Medical Assistance Commission (CMAC), and STO are notified by the county, or governmental entity, prior to the transfer of funds to assure that all arrangements are complete.

Transfer

1. IGTs used as the non-federal share of DSH payments.
   The amounts of the IGTs are determined by the data submitted to DHCS by the DPHs. Staff of the DSH Payment Unit will coordinate the amount and timing of transfers from the DPHs to STO.

2. IGTs used as the non-federal share of the supplemental payments.
   CMAC coordinates with HCU on the amount and timing of IGTs to the STO under the provisions of section 14166.12 of the W&I Code.

Post-Transfer

For all IGTs, the county, or governmental entity, notifies DHCS after the transfer is complete. The transfer is verified and documented, and DHCS deposits the transferred amount into the appropriate funds for payments.

IV. SAFETY NET CARE POOL PAYMENTS

DPHs receive SNCP payments for hospital and clinic costs associated with health care services provided to uninsured individuals.

Payment Processes

The SNFD Program payment computation includes automated verification that the federal SNCP allotment, quarterly interim payments and the total SNCP funding level are not exceeded.
The payment process includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation occurs based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.

(ii) Record data on an internal spreadsheet, (including amount, date paid and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

V. DISPROPORTIONATE SHARE HOSPITAL PROGRAM

DHCS disburses $1.0325 billion of the federal DSH allotment to eligible DPHs and non-designated public hospitals (NDPHs) annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines DPHs and NDPHs, specifies the funding level, and describes the distribution methodology.

The non-federal share of DSH payments to DPHs is comprised of CPEs and IGTs. DPHs use CPEs to claim DSH funding for up to 100 percent of their uncompensated care costs, and use IGTs to claim DSH funding for up to 175 percent of their uncompensated care costs, as permitted by the Omnibus Budget Reconciliation Act of 1993. By contract, the nonfederal share of DSH payments to NDPHs is the State General Fund.

Annually, the DSH Share Hospital Eligibility Unit submits a DSH Program audit report to CMS as required by the Social Security Act. The DSH Share Hospital Payment Unit (DSHPU) performs a final reconciliation of total DSH hospital-specific payments to ensure that funding provided during and after the project year does not exceed appropriate funding levels established by actual hospital uncompensated care costs, as required by the State Plan.

The DSH Program payment computations include automated verification that the federal DSH allotment, appropriate IGT funds invoiced for DSH payments, and the total DSH Program funding level are not exceeded.

The DSHPU protocol and procedures include quality audits to ensure that correct data is used appropriately and that correct amounts are disbursed to the appropriate hospitals.

A. DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source.

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. For payments using IGTs as the non-federal share of the payments, the

PAN provides Accounting with authorization to use the federal DSH allotment and IGT funds from the Medicaid Inpatient Adjustment Fund. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for DPHs includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation is based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

EDS prepares the check write computer file for submission to SCO.

B. NON-DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal DSH allotment).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the General Fund and federal DSH allotment. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for NDPHs includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information.

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover any overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

C. PRIVATE HOSPITALS

DHCS disburses approximately $465 million of DSH replacement funding to eligible private hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the State Plan, are eligible to receive DSH replacement funding. The State Plan defines private hospitals, specifies the funding level, and describes the funding distribution methodology. In addition to the DSH replacement funding, DSH-eligible private hospitals receive their pro rata share of payments from a defined pool within the annual DSH allotment.

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal Medicaid funding).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the State General Fund and federal Medicaid funds. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for private hospitals includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

VI. PRIVATE HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi-Cal patients. Eligible private hospitals receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Private Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VII. NON-DESIGNATED PUBLIC HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the SPCP to provide acute inpatient hospital care to Medi-Cal patients. Eligible NDPHs receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Non-designated Public Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VIII. DISTRESSED HOSPITAL FUND PAYMENTS

CMAC negotiates contract amendments with participating SPCP hospitals that meet criteria for distressed hospitals. These hospitals must serve a substantial volume of Medi-Cal patients, be a critical component of the Medi-Cal program's health care delivery system, and be facing a

significant financial hardship that may impair ability to continue their range of services for the Medi-Cal program.

The non-federal share of distressed hospital fund payments is funded by State Treasury funds that are 20% of the July 2005 balance of the prior supplemental funds (PFSs), accrued interest on the PFSs, and any additional amounts appropriated by the Legislature.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for payments from the Distressed Hospital Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request, and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

IX. CONSTRUCTION/RENOVATION REIMBURSEMENT PROGRAM (SB 1732)

In 1989, Senate Bill (SB) 1732 was enacted to establish the Construction/Renovation Reimbursement Program (also known as the SB 1732 program) (Welfare and Institutions Code 14085.5). Under this program, reimbursement is provided to eligible hospitals for the debt service costs incurred on revenue bonds used to finance eligible hospital construction project(s).

Invoice Submission

Invoices are submitted by participating hospitals to HCU no more than twice each year. The invoices consist of the following:

(i) A cover letter from the hospital's Chief Financial Officer, or other appropriate representative.
(ii) A reimbursement request that includes bond debt service payment (principal and/or interest).
(iii) Support documents verifying payment by the hospital to the debt holder.

Review Process

HCU verifies inclusion and accuracy of all required documents in the invoice package.

Payment Process

HCU calculates reimbursement amounts on a spreadsheet by:

(i) Determining the amount of debt service paid.
(ii) Deducting interest earned in the hospital's SB 1732 account.
(iii) Calculating the reimbursable amount based on the eligible portion of the construction project and the Medi-Cal Utilization Rate percentage.

HCU prepares a reimbursement payment package, which is reviewed and approved by the ICMS Chief, and submits it to California's fiscal intermediary. .

HCU sends a notification letter to each eligible hospital and a copy of the notification letter is forwarded to CMAC.

California's fiscal intermediary forwards payment requests to SCO and sends copies of the payment requests to HCU.

SCO mails the payment to the hospital.

X. SELECTIVE PROVIDER CONTRACTING PROGRAM

The SPCP was established in 1982 and operated under a two-year section 1915(b) waiver until August 31, 2005. On September 1, 2005, CMS approved the continuation of a restructured SPCP under California's new five-year section 1115 Medi-Cal Hospital/Uninsured Care Demonstration. The SPCP allows DHCS to selectively contract with acute care hospitals to provide inpatient hospital care to Medi-Cal beneficiaries. Under the SPCP, CMAC negotiates contract terms and conditions and per diem rates with participating hospitals on behalf of DHCS. This program has resulted in millions of dollars of savings each year which offset expenditures in this Demonstration to assist in achieving budget neutrality.

The non-federal share of SPCP payments is funded by amounts from the State General Fund.

Contract Process

CMAC forwards proposed contract(s)/amendment(s) to HCU for review. After review, final proposed contracts/amendments are presented at a CMAC meeting for approval by the Commissioners. The approved contracts/amendments are signed by authorized hospital representatives and submitted by CMAC to HCU for processing. The HCU analyst prepares contract/amendment packages for processing and obtains the signature of DHCS's delegated Contract Officer (SNFD Chief) to fully execute the contracts/amendments.

Notification Process

HCU notifies PED of new per diem rates and/or new Current Procedural Terminology codes, revenue codes, and Health Care Procedure Coding System codes, to update the Provider Master File with the hospital- specific information. This file is used by California's fiscal intermediary to process and pay claims submitted by all Medi-Cal providers, including those participating in the SPCP.

Distribution Process

HCU distributes fully executed contracts/amendments to the following:

(i) Contracted hospital
(ii) CMAC Executive Director
(iii) Medi-Cal Field Office
(iv) A&I

i. CMS-64 QUARTERLY EXPENSE REPORT

After the end of every quarter, Accounting summarizes all payments and claims made relating to the Demonstration during the quarter and sends the summary to SNFD to verify the payment period, amount and funding source. After the confirmation, Accounting prepares and submits the CMS-64 Quarterly Expense Report to CMS.

Attachment I

Quarterly Report Guidelines

In accordance with Section, paragraph 20, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of California Bridge to Health Reform Demonstration 11-W-00193/9)

Title Line Two - Section 1115 Quarterly Report
Demonstration Reporting Period:
Example:
Demonstration Year: 6 (9/1/10 - 12/31/10)

Introduction:
Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:
Please complete the following table that outlines current enrollment in each HCCI program under the Demonstration. The State should indicate "N/A" where appropriate.
Note:
Monthly enrollment data during the quarter and Demonstration Year to Date by:

i. County of participation the number of persons in the Medicaid Coverage Expansion Program ([MCE]) who are new recipients and existing recipients by FPL;
ii. County of participation the number of persons in the HCCI program ([SNCP – HCCI]) who are new recipients and existing recipients by FPL;
iii. County of participation the number of persons enrolled in the SPD program ([Existing SPD] or [Mandatory SPD]);
iv. County of participation the number of persons enrolled in the California Children Services Program based on Medi-Cal eligibility ([CCS – State Plan]) and DSHP ([CCS – DSHP]); and
v. County of participation the number of persons participating in DSHP receiving FFP.
vi. Monthly eligible member-month totals for [LIHP], [Existing SPD], [Mandatory SPD], [CCS – State Plan], and [Families],

Attachment I

Quarterly Report Guidelines

Member-Months: To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

Demonstration Programs	**Mont h 1**	**Mont h 2**	**Mont h 3**	**Quarte r**	**Current Enrollees** (to date)
169.					

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Attachment I

Quarterly Report Guidelines

Date Submitted to CMS:

Low Income Health Program (LIHP)
Attachment J Administrative Cost Claiming Protocol

Preface

In addition to all other amounts otherwise payable by the Centers for Medicare and Medicaid Services (CMS) to the Department of Health Care Services (DHCS) under the Demonstration, CMS will provide Federal Financial Participation (FFP) to DHCS at the regular 50 percent match rate for administrative costs, including start up, implementation and close out costs associated with the approved Low Income Health Program (LIHP) Administrative Cost Claiming Protocol incurred on or after November 1, 2010 through December 31, 2014, subject to the limitations outlined below.

This protocol is applicable to the LIHPs in two categories:

- Legacy LIHPs which implemented their programs prior to December 31, 2011: Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties.
- New LIHPs which implemented their programs after December 31, 2011: County Medical Services Program (CMSP), Monterey, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Santa Cruz and Tulare counties/consortia.

I. General Conditions

Under the LIHP Administrative Cost Claiming Protocol, DHCS must:

A. Obtain prior approval for the methodology used to capture administrative costs associated with the program for each LIHP.

B. Comply with OMB Circular A-87, which contains the requirements regarding documentation for compensation of salary and wages and acceptable mechanisms for allocating such costs. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

C. Describe how it will offset other revenue sources for administrative expenditures associated with the LIHP.

D. Provide the oversight and monitoring to oversee administrative claiming for the LIHP. In addition, the State will:

   1. monitor the implementation process for each LIHP including, but not limited to, review of training materials, observation of training, interviews with time study participants, and review and verification of the claims submitted; and

   2. monitor the implementation of the time study to assure proper use of the time study codes by each LIHP and proper application of the methodology. The State agrees to provide summary reports to the CMS Regional Office, on a quarterly basis, detailing the results and issues/concerns identified in the monitoring process.

E. Obtain prior approval for any new categories of administrative expenditures to be claimed under the LIHP.

F. Agree that any regulations or national guidelines issued by CMS, relating to the use of time study codes, methodologies for conducting time studies or other elements of claims for administrative activities will be incorporated into the LIHP based on the effective date of the applicable policy change.

G. Agree to permit CMS to review any forms and/or documents that are subsequently developed for use by this program, prior to modification or execution. These would include, but are not limited to, the time study training materials and the time study forms in use by the applicable LIHP staff.

H. Agree to submit all changes to the administrative claiming protocol to CMS for review and approval prior to implementation.

II. Allowable Administrative Activities Categories

The allowable LIHP administrative costs are associated with the following categories of administrative activities:

1. LIHP outreach that provides information about services; and encourages eligible low-income persons to apply.
2. Development of screening and enrollment processes interface and systems to identify and facilitate the enrollment of eligible low-income persons for receipt of services and/or the development of enrollment system interface with DHCS data systems.
3. Planning to develop strategies to deliver, monitor and oversee program LIHP services.
4. Enrollment of eligible low-income, adults into the LIHP, including contracts for staff support and systems development associated with transition from LIHP as required by DHCS or CMS.
5. Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses.
6. Data collection and analyses of reports, studies, or surveys required by DHCS or CMS.
7. Developing, monitoring and administering contracts or other arrangements with private and or other public entities for delivery of services.
8. Operations of the LIHP administrative functions, e.g. accounting, data management, staff supervision and personnel management, etc.
9. Case management of eligible low income persons receiving LIHP services

Case management services for some local LIHPs will be considered health care services costs in the following situations only. These costs will be claimed pursuant to Attachment G, Supplement 1, Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims based on Certified Public Expenditures.

a) LIHPs with approved capitation rates.
b) LIHPs with case management services approved as add on services in their programs.
c) LIHPs that incorporate case management services into health care services subcontracts.
d) LIHPs that reimburse for case management services to network providers that are medical homes for LIHP enrollees.

The costs incurred by a LIHP for case management services in any other arrangement will be considered administrative activities costs and subject to this protocol. Each LIHP will retain the necessary documentation to support the approved claiming protocol utilized for receiving reimbursement of its allowable costs for providing case management services.

A. Direct Costs

Of the nine above-stated administrative activities categories, the costs associated with the following administrative activities categories may be claimed directly, with the costs captured through a time study methodology. The costs of LIHP specific subcontracts for the administrative activities may be claimed directly and not through a time study. The administrative activities include:

1. Program outreach
2. Development of screening and enrollment processes and systems
3. Program development and planning costs
4. Enrollment of eligible adults into the LIHP
5. Case management of eligible low-income persons receiving LIHP services

The associated costs for the administrative activities categories 1-5 above are captured through time studies with the exception of allowable costs reimbursed through LIHP specific subcontracts. Subcontractors are not subject to time studies. The number of time study participants and the corresponding frequency of the time studies are as follows. Most LIHPs are in the first group of time study participants.

0-99 participants: Each Work Day, Continuous
100-199 participants: 20 Consecutive Work Days, Per Month for 5 months
200-399 participants: 10 Consecutive Work Days, Per Month for 5 months
400 + participants: 5 Consecutive Work Days, Per Month for 5 months

In the event that a LIHP does not complete a time study for a month, an average of two completed previous time studies and one new study period will be used to calculate the payment amount for the missing time study month.

B. Indirect Costs

OMB Circular A-87, Attachment A, Section F, states in part, that indirect costs are those incurred for a common or joint purpose benefiting more than one cost objective, and not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. Amounts not recoverable as indirect costs or administrative costs under one Federal award may not be shifted to another Federal award, unless specifically authorized by Federal legislation or regulation.

The allowable indirect costs are associated with the following categories of administrative activities:

1. Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses.

2. Data collection and analyses of reports, studies, or surveys required by the Department of Health Care Services or CMS.

3. Developing, monitoring and administering contracts or other arrangements with private and or other public entities for delivery of services.

4. Operations of the LIHP administrative functions of the Legacy LIHPs and New LIHPs, e.g. accounting, data management, staff supervision and personnel management, etc.

DHCS must utilize the cognizant agency approved indirect cost rate to identify allowable administrative cost categories associated with the allowable indirect cost categories above. LIHPs would be allowed to directly allocate any costs that can be specifically identified and documented as LIHP only costs. For example, if the participating entity has entered into a contract for administrative services that are provided exclusively to the LIHP, those costs need not be subject to the cognizant agency rate. With respect to those remaining overhead costs that cannot be directly allocated to the LIHP, at its option, the local LIHP could develop the cognizant agency rate to be used for LIHP or could apply an alternative 10% cognizant agency rate.
Additional costs outside of the indirect cost rate will not be recognized by CMS and are not eligible for FFP.

III. LIHP Reimbursement Using Capitation Rates
The capitation rates approved for certain LIHPs for reimbursement of their program health care costs will include an administrative component that compensates for the administrative costs that are directly related to the provision of services. This administrative component of the capitation rates will include the following costs that fall generally within the categories 1-9 of Administrative Activities.

- LIHP administrative functions such as accounting, data management, staff supervision and personnel management (excluding such functions as they relate to eligibility or program development);
- The administration, oversight, and management of contracts or other arrangements related to the provision of LIHP services.
- Data collection and analyses of reports, studies, or surveys required by the State or CMS; and
- The development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses.

LIHPs approved for capitated rates follow the process described in Section II, Allowable Administrative Activities Categories, for the remaining categories of allowable administrative expenditures that will be claimed outside the capitation rate.

IV. LIHP Time Study Methodology
The State must develop and submit to CMS for approval an Implementation Plan that provides the time study methodology to accurately capture and allocate costs for the allowable administrative activities. This implementation plan will include, but not be limited to:

A. Claiming For Administrative Personnel Costs Under The Time Study Methodology:

Allowable county administrative personnel costs associated with the LIHP, except those incurred under LIHP-Specific Subcontracts, are computed in accordance with a sampling time study methodology which is used to determine the percentage of staffs' claimable time for each time-study period. The LIHP Percentage will be applied in accordance with the California Low Income Health Program Administrative Cost Claiming Protocol Implementation Plan.
B. Claiming For Administrative Costs Excluded From The Time Study Methodology:
Allowable county administrative costs, consisting of operating, capital equipment, and travel costs associated with the LIHP, and LIHP-Specific Subcontract costs, each of which are recorded and documented as having been incurred throughout each LIHP quarter, are not subject to the sampling time study methodology, and may be computed and claimed separately from personnel costs claimed under the time study methodology described in Section V, Prior Period Cost Claiming Methodologies.

V. Prior Period Cost Claiming Methodologies
This section describes the period of time prior to the commencement of the LIHP time study and submission of administrative costs, and the methodologies for claiming administrative costs which were incurred during these periods. Submission of administration costs for the period prior to the implementation of the time study will be in accordance with pertinent sections in Subpart A, starting at section 95.1 of Part 95 of Title 45 of the Code of Federal Regulations. The claimable LIHP administrative activities for all quarters (for which LIHP administrative costs may be claimed) will be those administrative activities identified and approved by this protocol for claiming for the time-study periods.
A. Legacy Transition Period:

Legacy LIHPs may claim under the Attachment J and Implementation Plan developed for the prior Demonstration for expenditures incurred through September 30, 2011. These claims will include administrative expenditures incurred in transitioning from a Coverage Initiative to a LIHP.
B. New LIHPs Non-Time Study Start Up Period:

New LIHPs may claim start-up costs for 12 months prior to the implementation date of the LIHP as follows: CMSP, Riverside, San Bernardino, and Santa Cruz.(January 1, 2011 – December 31, 2012); Sacramento (November 1, 2011 – October 31, 2012); San Joaquin (June 1, 2011 – May 31, 2012); Placer (August 1, 2011 – July 31, 2012); Monterey (March 1, 2012 – February 28, 2013); and Tulare (March 15, 2012 – March 14, 2013)
C. LIHP Time Study Period:

1. Legacy LIHPs would utilize time survey results for the appropriate time study periods according to the California Low Income Health Program Administrative Cost Claiming Protocol Implementation Plan from October 1, 2013 – December 31, 2013. The results of these time studies will be used for reimbursement of allowable administrative costs for the period of October 1, 2011 – December 31, 2013.

2. All new LIHPs would utilize time study results for the appropriate time study periods according to the California Low Income Health Program Administrative Cost Claiming Protocol Implementation Plan from October 1, 2013 – December 31, 2013. The results of these time studies will be used for reimbursement of allowable administrative costs for the period of January 1, 2012 – December 31, 2013.

D. Prior Period Non-Time Study Costs:

The methodology described in Section IV above for computing non-time-study costs will be used to compute such costs for all LIHP quarters in the Prior Period from October 1, 2010 through June 30, 2011 for Legacy LIHPs and 12 months prior to implementation date for New LIHPs.

E. Time Study Costs - Backcasting Period:

Backcasting is the method used to apply results of a future time study to a period of time in the past for which a time study was not conducted.

The methodology described in Section IV, LIHP Time Study Methodology, for computing administrative personnel costs subject to the time study methodology will be used to compute such costs during the backcasting period, except that the percentages of staff' claimable time for each of the activity codes for each quarter of this period will be based on the ratio of the total hours of time recorded by county staff for each activity code for a time-study period divided by the total hours staff worked for that period. This ratio will be computed from the aggregated totals of staff' recorded time for the time study period described above for time studies performed by the LIHP counties. This backcasting methodology will be applicable for all LIHP quarters in the entire backcasting period, from October 1, 2011 – September 30, 2013. The backcasting period for the legacy LIHPs begins October 1, 2011, and ends September 30, 2013. The backcasting period for the new LIHPs begins January 1, 2012, and ends September 30, 2013.

F. New LIHPs Time Study Costs - Start-Up Period:

The methodology described in Section IV, LIHP Time Study Methodology, for computing administrative personnel costs subject to the time-study methodology will be used to compute such costs during the Start-Up Period except that, for counties with acceptable quarterly records and documentation of staff time worked on allowable administrative activities, DHCS shall have the option to use such records to compute the percentages of staffs' claimable time for each quarter in the Start-Up Period in place of the sampling methodology used for other periods. Acceptable documentation of staff time shall consist of: (i) daily logs or recordings of time worked by activity, including (ii) descriptions of administrative activities of sufficient specificity to determine whether the activity is a protocol-approved claimable activity. For counties which DHCS determines do not have acceptable documentation of staff time worked on allowable administrative activities during the Start-Up Period, the backcasting methodology described in paragraph E. above, will be used to compute administrative personnel costs during the Start-Up Period. The option described in this paragraph shall be limited to the Start-Up Periods described for New LIHPs above.

G. LIHP Close-Out and ACA Transition Costs

All LIHPs will be able to claim allowable administrative costs described in Section II, Allowable Administrative Activities Categories incurred during a program close-out period of 12 months (January 1, 2014 – December 31, 2014). The methodology described in Section IV. LIHP Time Study Methodology, for computing administrative personnel costs subject to the time-study methodology will be used to compute such costs during the Close-Out Period except that, for counties with acceptable quarterly records and documentation of staff time worked on allowable administrative activities, DHCS shall have the option to use such records to compute the percentages of staffs' claimable time for each quarter in the Close-Out Period in place of the sampling methodology used for other periods. Allowable costs will include, but not be limited to: personnel costs related to enrollee transition issues, LIHP data transfer, provider claim resolution and payment, preparation of supplemental and final invoices for health care costs, payment reconciliations required by DHCS and CMS, and evaluation and transition data reporting. Acceptable documentation of staff time shall consist of: (i) daily logs or recordings of time worked by activity, including (ii) descriptions of administrative activities of sufficient specificity to determine whether the activity is a protocol-approved claimable activity. For counties which DHCS determines do not have acceptable documentation of staff time worked on allowable administrative activities during the Close-Out Period, the backcasting methodology described in paragraph E. above, will be used to compute administrative personnel costs during the Close-Out Period.

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER PMPM								
MEGS	CMS-64 reporting form (if applicable)	Trend Rates	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups								
Family – COHS		**5.30%**	$171.68	$180.78	$190.36	$199.61	$206.82	
	Family – COHS	*5.30%*	*$171.68*	*$180.78*	*$190.36*	*$202.66*	*$215.41*	
	Expansion Family COHS	*5.30%*				*$165.52*	*$176.30*	
Family - TPM/GMC		**5.30%**	$150.40	$158.37	$166.76	$177.02	$182.66	
	Family - TPM/GMC	*5.30%*	*$150.40*	*$158.37*	*$166.76*	*$177.81*	*$189.25*	
	Expansion Family TPM/GMC	*5.30%*				*$155.30*	*$165.55*	
SPD – COHS		**7.40%**	$1,069.73	$1,148.89	$1,233.91	$1,660.90	$1,750.03	
	Existing SPD's – COHS	*7.40%*	*$1,069.73*	*$1,148.89*	*$1,233.91*	*$1,704.12*	*$1,815.28*	
	Expansion SPDs – COHS	*7.40%*				*$889.15*	*$959.28*	
	Expansion SPDs - Humboldt PACE	*7.40%*				*$889.15*	*$950.10*	
SPD - TPM/GMC		**7.40%**	$730.43	$784.48	$842.53	$801.95	$864.87	
	Existing SPD's - TPM/GMC	*7.40%*	*$730.43*	*$784.48*	*$842.53*	*$801.93*	*$864.41*	
	Special Populations-SPD's	*7.40%*	*$730.43*	*$784.48*	*$842.53*	*$801.93*	*$864.41*	
	Expansion SPDs - TPM/GMC	*7.40%*				*$805.96*	*$869.94*	
Special Populations-Spec. Needs Child.		**3.28%**	$1,390.66	$1,436.27	$1,483.38	$1,532.04	$1,582.29	
Duals – COHS		**2.47%**				$428.67	$439.25	
	Existing Duals - COHS	*2.47%*				*$428.67*	*$439.25*	
	Expansion Duals - COHS	*2.47%*				*$428.67*	*$439.25*	
	Expansion Duals - Humboldt PACE	*2.47%*				*$428.67*	*$439.25*	
Duals – TPM/GMC		**3.28%**				$114.23	$117.97	
	Existing SPD's - TPM/GMC	*3.28%*				*$114.23*	*$117.97*	
	Special Populations-SPD's	*3.28%*				*$114.23*	*$117.97*	
Cal-Medi-Connect – COHS		**1.61%**				$642.42	$652.77	
MLTSS Duals – COHS		**1.61%**				$642.42	$652.77	
MLTSS Family - COHS		**5.30%**				$202.99	$213.75	
MLTSS SPDs – COHS		**7.40%**				$1,892.75	$2,032.81	
Cal-Medi-Connect - TPM/GMC		**3.40%**				$724.71	$749.35	
MLTSS Duals - TPM/GMC		**3.40%**				$724.71	$749.35	
MLTSS Family - TPM/GMC		**5.30%**				$178.35	$187.81	
MLTSS SPDs - TPM/GMC		**7.40%**				$978.60	$1,051.02	

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER PMPM									
	MEGS	CMS-64 reporting form (if applicable)	Trend Rates	DY06	DY07	DY08	DY09	DY10	5 Year Total
Hypothetical Populations									
	MCE		5.00%	$300.00	$315.00	$330.75	$347.29		
	ECM		3.16%	$10.00	$10.00	$10.00	$10.00	$10.00	
	CBAS		3.16%	$888.53	$916.60	$945.57	$975.45	$1,130.95	
	DMC-ODS							$735.42	

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER Member Month Projections							
	MEGS	CMS-64 reporting form (if applicable)	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups								
	Family – COHS		7,456,116	7,530,677	7,605,984	8,368,969	3,790,793	
		Family – COHS	*7,456,116*	*7,530,677*	*7,605,984*	*7,682,044*	*2,958,240*	
		Expansion Family COHS				*686,925*	*832,553*	
	Family - TPM/GMC		36,909,574	37,278,670	37,651,457	39,418,058	7,571,976	
		Family - TPM/GMC	*36,909,574*	*37,278,670*	*37,651,457*	*38,027,971*	*5,465,995*	
		Expansion Family TPM/GMC				*1,390,087*	*2,105,981*	
	SPD – COHS		1,064,064	1,074,705	1,085,452	3,418,738	2,882,407	
		Existing SPD's - COHS	*1,064,064*	*1,074,705*	*1,085,452*	*3,237,442*	*2,662,677*	
		Expansion SPDs - COHS				*181,294*	*219,717*	
		Expansion SPDs – Humboldt PACE				*2*	*14*	
	SPD - TPM/GMC		1,773,473	4,061,876	5,500,366	7,350,927	2,810,274	
		Existing SPD's - TPM/GMC	*1,745,286*	*1,762,739*	*1,780,366*	*3,592,302*	*1,306,161*	
		Special Populations-SPD's	*28,187*	*2,299,137*	*3,720,000*	*3,720,000*	*1,445,596*	
		Expansion SPDs - TPM/GMC				*38,625*	*58,518*	
	Special Populations-Spec. Needs Child.		1,356,036	1,396,717	1,438,619	1,481,777	1,526,230	
	Duals – COHS					2,000,209	1,384,623	
		Existing Duals - COHS				*1,796,558*	*1,137,798*	
		Expansion Duals - COHS				*203,631*	*246,571*	
		Expansion Duals - Humboldt PACE				*20*	*254*	
	Duals – TPM/GMC					1,393,966	878,004	
		Existing SPD's - TPM/GMC				*1,377,663*	*853,305*	
		Special Populations-SPD's				*16,303*	*24,699*	
	Cal-Medi-Connect – COHS					19,969	331,130	
	MLTSS Duals – COHS					243,477	636,797	
	MLTSS Family - COHS					-	4,800,624	
	MLTSS SPDs – COHS					-	640,368	
	Cal-Medi-Connect - TPM/GMC					36,262	2,543,271	
	MLTSS Duals - TPM/GMC					182,770	3,085,998	
	MLTSS Family - TPM/GMC					-	32,942,256	
	MLTSS SPDs - TPM/GMC					-	5,277,609	
Hypothetical Populations								

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER Member Month Projections								
	MEGS	CMS-64 reporting form (if applicable)		DY06	DY07	DY08	DY09	DY10	5 Year Total
	MCE			2,996,500	3,918,500	4,610,000	2,535,500		
	ECM			0	21,000	84,000	84,000	14,000	
	CBAS			0	84,000	336,000	336,000	56,000	
Total Member Months				**51,555,763**	**55,366,145**	**58,311,877**	**66,870,623**	**71,172,361**	

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER Projected Without Waiver Expenditures							
MEGS	CMS-64 reporting form	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups							
Family – COHS		$1,280,074,346	$1,361,397,469	$1,447,887,050	$1,670,547,659	$784,030,813	$6,543,937,337
	Family – COHS	*$1,280,074,346*	*$1,361,397,469*	*$1,447,887,050*	*$1,556,848,631*	*$637,248,200*	
	Expansion Family COHS				*$113,699,028*	*$146,782,614*	
Family - TPM/GMC		$5,551,199,601	$5,903,867,312	$6,278,940,002	$6,977,766,932	$1,383,079,319	$26,094,853,166
	Family - TPM/GMC	*$5,551,199,601*	*$5,903,867,312*	*$6,278,940,002*	*$6,761,882,877*	*$1,034,441,632*	
	Expansion Family TPM/GMC				*$215,884,054*	*$348,637,687*	
SPD – COHS		$1,138,263,784	$1,234,720,257	$1,339,350,452	$5,678,188,911	$5,044,286,987	$14,434,810,391
	Existing SPD's - COHS	*$1,138,263,784*	*$1,234,720,257*	*$1,339,350,452*	*$5,516,990,007*	*$4,833,503,624*	
	Expansion SPDs - COHS				*$161,197,125*	*$210,770,536*	
	Expansion SPDs – Humboldt PACE				*$1,778*	*$12,826*	
SPD - TPM/GMC		$1,295,390,692	$3,186,450,077	$4,634,216,959	$5,895,084,857	$2,429,552,842	$17,440,695,426
	Existing SPD's - TPM/GMC	*$1,274,802,175*	*$1,382,828,912*	*$1,500,009,834*	*$2,880,774,672*	*$1,129,058,570*	
	Special Populations-SPD's	*$20,588,516*	*$1,803,621,165*	*$3,134,207,125*	*$3,382,915,652*	*$3,649,382,298*	
	Expansion SPDs - TPM/GMC				*$31,130,585*	*$50,906,634*	
Special Populations-Spec. Needs Child.		$1,885,785,024	$2,006,067,936	$2,134,022,973	$2,270,139,494	$2,414,938,072	$10,710,953,498
Duals - COHS					$857,422,170	$608,201,639	$1,465,623,809
	Existing Duals - COHS				*$770,123,916*	*$499,782,759*	
	Expansion Duals - COHS				*$87,289,895*	*$108,307,529*	
	Expansion Duals - Humboldt PACE				*$8,359*	*$111,351*	
Duals – TPM/GMC					$159,226,109	$103,579,753	$262,805,862
	Existing SPD's - TPM/GMC				*$157,363,885*	*$100,665,944*	
	Special Populations-SPD's				*$1,862,225*	*$2,913,808*	
Cal-Medi-Connect - COHS					$12,828,540	$216,150,328	$228,978,868
MLTSS Duals - COHS					$156,415,166	$415,679,280	$572,094,446
MLTSS Family - COHS						$1,026,129,747	$1,026,129,747
MLTSS SPDs - COHS						$1,301,748,715	$1,301,748,715
Cal-Medi-Connect - TPM/GMC					$26,279,441	$1,905,801,013	$1,932,080,454
MLTSS Duals - TPM/GMC					$132,455,284	$2,312,493,680	$2,444,948,963
MLTSS Family - TPM/GMC						$6,186,757,627	$6,186,757,627
MLTSS SPDs - TPM/GMC						$5,546,853,612	$5,546,853,612

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITHOUT WAIVER Projected Without Waiver Expenditures							
	MEGS	CMS-64 reporting form	DY06	DY07	DY08	DY09	DY10	5 Year Total
Hypothetical Populations								
	MCE		$898,950,000	$1,234,327,500	$1,524,757,500	$880,547,456	$0	$4,538,582,456
	ECM		$0	$210,000	$840,000	$840,000	$140,000	$2,030,000
	CBAS		$0	$76,994,808	$317,711,377	$327,751,057	$56,351,332	$778,808,574
Other below the line adjustments								
	Public Hospital IP UPL		$2,596,361,467	$2,763,307,510	$2,940,988,182	$3,205,705,972	$3,504,932,961	$15,011,296,092
Adjustment for 1115A savings (per STC 159)						TBD	TBD	
TOTAL WITHOUT WAIVER CEILING			**$14,646,024,914**	**$17,767,342,869**	**$20,618,714,496**	**$28,251,199,047**	**$35,240,707,718**	**$116,523,989,044**

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER PMPM								
MEGS	CMS-64 reporting form (if applicable)	Trend Rates	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups								
Family - COHS			$150.49	$156.89	$163.55	$171.40	$178.43	
	Family - COHS		*$150.49*	*$156.89*	*$163.55*	*$172.71*	*$182.09*	
	Expansion Family COHS					*$156.72*	*$165.42*	
Family - TPM/GMC			$120.22	$125.33	$130.66	$138.13	$144.00	
	Family - TPM/GMC		*$120.22*	*$125.33*	*$130.66*	*$138.42*	*$146.34*	
	Expansion Family TPM/GMC					*$130.34*	*$137.92*	
SPD - COHS			$946.99	$989.60	$1,034.14	$1,074.67	$1,122.72	
	Existing SPD's - COHS		*$946.99*	*$989.60*	*$1,034.14*	*$1,085.18*	*$1,138.48*	
	Expansion SPDs - COHS					*$886.98*	*$931.36*	
	Expansion SPDs – Humboldt PACE					*$5,392.89*	*$5,635.57*	
SPD - TPM/GMC			$497.00	$528.75	$563.53	$596.29	$639.35	
	Existing SPD's - TPM/GMC		*$496.94*	*$519.30*	*$542.67*	*$571.60*	*$601.79*	
	Special Populations-SPD's		*$500.93*	*$536.00*	*$573.51*	*$618.17*	*$665.80*	
	Expansion SPDs - TPM/GMC					*$784.65*	*$824.43*	
Special Populations-Spec. Need Children			$1,390.66	$1,436.27	$1,469.02	$1,487.82	$1,506.86	
Duals - COHS						$470.94	$487.99	
	Existing Duals - COHS					*$476.92*	*$498.38*	
	Expansion Duals - COHS					*$417.86*	*$436.66*	
	Expansion Duals - Humboldt PACE					*$3,619.66*	*$3,782.54*	
Duals – TPM/GMC						$113.16	$117.98	
	Existing SPD's - TPM/GMC					*$113.34*	*$118.44*	
	Special Populations-SPD's					*$97.70*	*$102.10*	
Cal-Medi-Connect - COHS						$621.79	$649.77	
MLTSS Duals - COHS						$621.79	$649.77	
MLTSS Family - COHS						$172.99	$180.78	
MLTSS SPDs - COHS						$1,261.95	$1,318.74	
Cal-Medi-Connect - TPM/GMC						$711.18	$743.18	
MLTSS Duals - TPM/GMC						$711.18	$743.18	
MLTSS Family - TPM/GMC						$138.82	$145.07	
MLTSS SPDs - TPM/GMC						$793.72	$829.44	
Hypothetical Groups								

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER PMPM										
	MEGS	CMS-64 reporting form (if applicable)		Trend Rates	DY06	DY07	DY08	DY09	DY10	5 Year Total
	MCE				$300.00	$315.00	$330.75	$347.29		
	ECM				$10.00	$10.00	$10.00	$10.00	$10.00	
	CBAS				$888.53	$916.60	$945.57	$975.45	$1,006.27	

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER Member Month Projections							
	MEGS	CMS-64 reporting form (if applicable)	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups								
	Family - COHS		7,456,116	7,530,677	7,605,984	8,368,969	3,790,793	
		Family - COHS	*7,456,116*	*7,530,677*	*7,605,984*	*7,682,044*	*2,958,240*	
		Expansion Family COHS				*686,925*	*832,553*	
	Family - TPM/GMC		36,909,574	37,278,670	37,651,457	39,418,058	7,571,976	
		Family - TPM/GMC	*36,909,574*	*37,278,670*	*37,651,457*	*38,027,971*	*5,465,995*	
		Expansion Family TPM/GMC				*1,390,087*	*2,105,981*	
	SPD - COHS		1,064,064	1,074,705	1,085,452	3,418,738	2,882,407	
		Existing SPD's - COHS	*1,064,064*	*1,074,705*	*1,085,452*	*3,237,442*	*2,662,677*	
		Expansion SPDs - COHS				*181,294*	*219,717*	
		Expansion SPDs – Humboldt PACE				*2*	*14*	
	SPD - TPM/GMC		1,773,473	4,061,876	5,500,366	7,350,927	2,810,274	
		Existing SPD's - TPM/GMC	*1,745,286*	*1,762,739*	*1,780,366*	*3,592,302*	*1,306,161*	
		Special Populations-SPD's	*28,187*	*2,299,137*	*3,720,000*	*3,720,000*	*1,445,596*	
		Expansion SPDs - TPM/GMC				*38,625*	*58,518*	
	Special Populations-Spec. Needs Child.		1,356,036	1,396,717	1,438,619	1,481,777	1,526,230	
	Duals - COHS					2,000,209	1,384,623	
		Existing Duals - COHS				*1,796,558*	*1,137,798*	
		Expansion Duals - COHS				*203,631*	*246,571*	
		Expansion Duals - Humboldt PACE				*20*	*254*	
	Duals – TPM/GMC					1,393,966	878,004	
		Existing SPD's - TPM/GMC				*1,377,663*	*853,305*	
		Special Populations-SPD's				*16,303*	*24,699*	
	Cal-Medi-Connect - COHS					19,969	331,130	
	MLTSS Duals - COHS					243,477	636,797	
	MLTSS Family - COHS					-	4,800,624	
	MLTSS SPDs - COHS					-	640,368	
	Cal-Medi-Connect - TPM/GMC					36,262	2,543,271	
	MLTSS Duals - TPM/GMC					182,770	3,085,998	
	MLTSS Family - TPM/GMC					-	32,942,256	
	MLTSS SPDs - TPM/GMC					-	5,277,609	
Hypothetical Populations								

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER Member Month Projections								
	MEGS	CMS-64 reporting form (if applicable)		DY06	DY07	DY08	DY09	DY10	5 Year Total
	MCE			2,996,500	3,918,500	4,610,000	2,535,500		
	ECM			0	21,000	84,000	84,000	14,000	
	CBAS			0	84,000	336,000	336,000	56,000	
Total Member Months				**51,555,763**	**55,366,145**	**58,311,877**	**66,870,623**	**71,172,361**	

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER Population Expenditures							
MEGS	CMS-64 reporting form (if applicable)	DY06	DY07	DY08	DY09	DY10	5 Year Total
State Plan Groups							
Family - COHS		$1,122,070,897	$1,181,456,499	$1,243,985,084	$1,434,455,198	$676,386,895	$5,658,354,572
	Family - COHS	*$1,122,070,897*	*$1,181,456,499*	*$1,243,985,084*	*$1,326,800,312*	*$538,668,729*	
	Expansion Family COHS				*$107,654,886*	*$137,718,166*	
Family - TPM/GMC		$4,437,269,019	$4,672,111,482	$4,919,382,982	$5,444,967,082	$1,090,328,018	$20,564,058,583
	Family - TPM/GMC	*$4,437,269,019*	*$4,672,111,482*	*$4,919,382,982*	*$5,263,783,143*	*$799,880,543*	
	Expansion Family TPM/GMC				*$181,183,940*	*$290,447,475*	
SPD - COHS		$1,007,657,967	$1,063,532,602	$1,122,505,484	$3,674,031,737	$3,236,124,582	$10,103,852,372
	Existing SPD's - COHS	*$1,007,657,967*	*$1,063,532,602*	*$1,122,505,484*	*$3,513,216,947*	*$3,031,412,577*	
	Expansion SPDs - COHS				*$160,804,004*	*$204,635,924*	
	Expansion SPDs – Humboldt PACE				*$10,786*	*$76,080*	
SPD - TPM/GMC		$881,422,139	$2,147,720,511	$3,099,627,857	$4,383,266,489	$1,796,751,778	$12,308,788,774
	Existing SPD's - TPM/GMC	*$867,302,425*	*$915,394,344*	*$966,152,961*	*$2,053,363,703*	*$786,034,839*	
	Special Populations-SPD's	*$14,119,714*	*$1,232,326,166*	*$2,133,474,896*	*$2,299,595,339*	*$962,473,545*	
	Expansion SPDs - TPM/GMC				*$30,307,448*	*$48,243,394*	
Special Populations-Spec. Need Children		$1,885,779,146	$2,006,061,683	$2,113,353,886	$2,204,616,960	$2,299,821,139	$10,509,632,812
Duals - COHS					$941,974,414	$675,684,976	$1,617,659,389
	Existing Duals - COHS				*$856,814,441*	*$567,057,360*	
	Expansion Duals - COHS				*$85,089,389*	*$107,668,741*	
	Expansion Duals - Humboldt PACE				*$70,583*	*$958,875*	
Duals – TPM/GMC					$157,737,137	$103,587,396	$261,324,533
	Existing SPD's - TPM/GMC				*$156,144,324*	*$101,065,695*	
	Special Populations-SPD's				*$1,592,812*	*$2,521,701*	
Cal-Medi-Connect - COHS					$12,416,491	$215,157,941	$227,574,432
MLTSS Duals - COHS					$151,391,155	$413,770,819	$565,161,973
MLTSS Family - COHS						$867,853,194	$867,853,194
MLTSS SPDs - COHS						$844,479,402	$844,479,402
Cal-Medi-Connect - TPM/GMC					$25,788,809	$1,890,108,142	$1,915,896,951
MLTSS Duals - TPM/GMC					$129,982,369	$2,293,451,994	$2,423,434,362
MLTSS Family - TPM/GMC						$4,778,786,924	$4,778,786,924
MLTSS SPDs - TPM/GMC						$4,377,460,494	$4,377,460,494
Hypothetical Groups							

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER Population Expenditures							
MEGS	CMS-64 reporting form (if applicable)	DY06	DY07	DY08	DY09	DY10	5 Year Total
MCE		$898,950,000	$1,234,327,500	$1,524,757,500	$880,547,456	$0	$4,538,582,456
ECM		$0	$210,000	$840,000	$840,000	$140,000	$2,030,000
CBAS		$0	$76,994,808	$317,711,377	$327,751,057	$56,351,332	$778,808,574
TOTAL POPULATION EXPENDITURES		**$10,233,149,167**	**$12,382,415,084**	**$14,342,164,170**	**$19,769,766,353**	**$25,616,245,024**	**$82,343,739,799**

WITH WAIVER Hospital Expenditures							
Description	Trend Rates	DY06	DY07	DY08	DY09	DY10	5 Year Total
Public Hospital Payments	6.43%	$2,196,242,461	$2,315,498,426	$2,418,075,006	$2,525,195,729	$2,637,061,900	$12,092,073,523
Mental Health Supplements		$3,754,220	$3,995,616	$4,252,534	$4,525,972	$4,816,992	$21,345,336
TOTAL HOSPITAL EXPENDITURES		**$2,199,996,681**	**$2,319,494,043**	**$2,422,327,541**	**$2,529,721,702**	**$2,641,878,893**	**$12,113,418,858**

Attachment K – Budget Neutrality Projections and Allotment Neutrality Requirements

WITH WAIVER Waiver Savings Expenditures							
	Description	DY06	DY07	DY08	DY09	DY10	5 Year Total
	Existing Uncompensated Care	$1,172,000,000	$1,172,000,000	$1,172,000,000	$1,172,000,000	$1,172,000,000	$5,860,000,000
	Proposed Uncompensated Care	$461,486,827	$822,000,000	$497,000,000	$276,000,000	$100,000,000	$2,156,486,827
	Coverage Initiative (134%-200%)	$184,000,000	$214,000,000	$263,000,000	$154,000,000	$0	$815,000,000
	Investment/Incentive Pool	$1,006,880,349	$1,300,000,000	$1,400,000,000	$1,400,000,000	$1,400,000,000	$6,506,880,349
	HIV Transition Incentive Program	$0	$0	$110,000,000	$55,000,000	$0	$165,000,000
	IHS Uncompensated Care	$0	$0	$15,461,000	$17,011,000	$1,550,000	$34,022,000
	TOTAL SNCP EXPENDITURES	**$2,824,367,176**	**$3,508,000,000**	**$3,457,461,000**	**$3,072,461,000**	**$2,672,000,000**	**$15,537,389,176**

WITH WAIVER Total Expenditures						
	DY06	DY07	DY08	DY09	DY10	5 Year Total
Total With Waiver Expenditures	$15,257,513,024	$18,209,909,127	$20,221,952,711	$25,373,499,055	$30,931,673,917	$109,994,547,833
Total Net Waiver Expenditures	**$15,257,513,024**	**$18,209,909,127**	**$20,221,952,711**	**$25,373,499,055**	**$30,931,673,917**	**$109,994,547,833**

SUMMARY					
	DY06	DY07	DY08	DY09	DY10
Annual Budget Neutrality Margin	**-$611,488,110**	**-$442,566,258**	**$396,761,785**	**$2,877,699,993**	**$4,309,033,802**
Cumulative Budget Neutrality Margin	**-$611,488,110**	**-$1,054,054,368**	**-$657,292,583**	**$2,220,407,410**	**$6,529,441,211**

Attachment L – Managed Care Enrollment Requirements

		Included State Plan Populations								
Prior authority/ 1115 transition group	**County Included**	Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP [a]	BCCPT * Program	Children with accelerated eligibility
HIO Waiver 1915(b)	**Santa Cruz**	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Monterey	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Merced	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Orange	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Solano	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Napa	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Sonoma	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Yolo	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
HPSM 1915(b)	**San Mateo**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
SBSLORHA 1915(b)	**Santa Barbara**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
	San Luis Obispo	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
Two-Plan/GMC Waiver 1915(b)	**Alameda**	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Contra Costa	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Fresno	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kern	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kings	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Los Angeles	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Madera	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Riverside	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Sacramento	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Bernardino	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Diego	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Francisco	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Joaquin	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Santa Clara	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Stanislaus	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Tulare	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
2011 Managed Care Expansions	**Marin**	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Mendocino	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Ventura	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
2013 Managed Care Expansion County Organized Health System (COHS) Health Insuring Organization (HIO)±	**Del Norte**	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Humboldt	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lake	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Lassen	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Modoc	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Shasta	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Siskiyou	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]
	Trinity	All Populations Required to enroll in managed care					Req	Req	Req	Req[b]

Attachment L – Managed Care Enrollment Requirements

		Included State Plan Populations								
Prior authority/ 1115 transition group	**County Included**	Section 1931 Children	Section 1931 Adults/ New Adult Group	Blind/ Disabled Adults	Blind/ Disabled Children	Aged & Related Populations	Foster Care Children	Title XXI CHIP [a]	BCCPT * Program	Children with accelerated eligibility
2013 managed care expansion Regional[z]	**Alpine**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Amador	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Butte	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Calaveras	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Colusa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	El Dorado	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Glenn	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Inyo	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mariposa	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Mono	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Nevada	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Placer	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Plumas	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sierra	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Sutter	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tehama	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Tuolumne	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
	Yuba	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion Imperial[z]	**Imperial**	Req	Req	Req	Req	Req	Vol	Req	Vol	Req[b]
2013 managed care expansion San Benito[z]	**San Benito**	Vol					Vol	Vol	Vol	Vol[b]

Notes:
Vol=Voluntary
Req=Required

[a] Required CHIP enrollment is subject to the transition requirements of STC 105 and all other requirements in section VIII. E of the demonstration's STCs.
[b] New eligible children after January 1, 2013 that meet CHIP and enrollment requirements as set forth by above designation [a]

* BCCPT - Breast and Cervical Cancer Prevention Treatment Program

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013
[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment L – Managed Care Enrollment Requirements

		Populations that may be excluded from enrollment in managed care									
Prior authority/ 1115 transition group	**County Included**	Dual Eligibles	Preg. Women	Other Insurance	Nursing Facility or ICF/MR Resident	Enrolled in Another Managed Care Program	Less than 3 Months Eligibility	HCBS Waiver-Enrolled	Special Needs Children (State Defined)	CHIP Title XXI	Retro Eligibility
HIO Waiver 1915(b)	**Santa Cruz**					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM 1915(b)	**San Mateo**					X				X[h]	
SBSLORHA 1915(b)	**Santa Barbara**					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver 1915(b)	**Alameda**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
2011 Managed Care Expansion	**Marin**					X				X[h]	
	Mendocino					X				X[h]	
	Ventura					X				X[h]	
2013 Managed Care Expansion County Organized Health	**Del Norte**					X				X[h]	
	Humboldt					X				X[h]	
	Lake					X				X[h]	
	Lassen					X				X[h]	
	Modoc					X				X[h]	
	Shasta					X				X[h]	
	Siskiyou					X				X[h]	

System (COHS) Health Insuring Organization (HIO)±	**Trinity**					X				X[h]	
2013 Managed Care Expansion Regional[z]	**Alpine**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Amador	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Butte	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Calaveras	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Colusa	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	El Dorado	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Glenn	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Inyo	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mariposa	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mono	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Nevada	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Placer	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Plumas	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sierra	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sutter	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tehama	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tuolumne	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Yuba	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion Imperial,[z]	**Imperial**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion San Benito[z]	**San Benito**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	

Notes:

[c] State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;

[d] Beneficiaries with incomes above 138 percent up to and including 213percent of FPL receive pregnancy-related services only, and are therefore excluded from mandatory managed care;

[e] State excludes individuals that have a share of cost or are ineligible for full-scope services;

[f] State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;

[g] Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program

[h] State only Healthy Families;

[i] Except for non-Healthy Families children in the Percent of Poverty program.

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013

[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment L – Managed Care Enrollment Requirements

		Populations that may be excluded from enrollment in managed care									
Prior authority/ 1115 transition group	**County Included**	Dual Eligibles	Preg. Women	Other Insurance	Nursing Facility or ICF/MR Resident	Enrolled in Another Managed Care Program	Less than 3 Months Eligibility	HCBS Waiver-Enrolled	Special Needs Children (State Defined)	CHIP Title XXI	Retro Eligibility
HIO Waiver 1915(b)	**Santa Cruz**					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM 1915(b)	**San Mateo**					X				X[h]	
SBSLORHA 1915(b)	**Santa Barbara**					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver 1915(b)	**Alameda**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera**	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[C]	X[d]	X[ef]	X	X[g]	X			X[i]	X
2011 Managed Care Expansion	**Marin**					X				X[h]	
	Mendocino					X				X[h]	
	Ventura					X				X[h]	
2013 Managed Care Expansion County Organized Health	**Del Norte**					X				X[h]	
	Humboldt					X				X[h]	
	Lake					X				X[h]	
	Lassen					X				X[h]	
	Modoc					X				X[h]	
	Shasta					X				X[h]	
	Siskiyou					X				X[h]	

System (COHS) Health Insuring Organization (HIO)±	**Trinity**					X				X[h]	
2013 Managed Care Expansion Regional[z]	**Alpine**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Amador	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Butte	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Calaveras	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Colusa	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	El Dorado	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Glenn	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Inyo	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mariposa	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Mono	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Nevada	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Placer	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Plumas	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sierra	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Sutter	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tehama	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Tuolumne	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
	Yuba	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion Imperial,[z]	**Imperial**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	
2013 managed care expansion San Benito[z]	**San Benito**	X[C]	X[d]	X[e,f]	X	X[g]	X			X[i]	

Notes:

[c] State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;

[d] These beneficiaries receive pregnancy related services only;

[e] State excludes individuals that have a share of cost or are ineligible for full-scope services;

[f] State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;

[g] Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program

[h] State only Healthy Families;

[i] Except for non-Healthy Families children in the Percent of Poverty program.

± Part of the 2013 Managed Care Expansion, COHS Model, to begin no sooner than September 1, 2013

[z] Part of the 2013 Managed Care Expansion, non-COHS Model, to begin no sooner than November 1, 2013

Attachment M – Geographic Distribution and Delivery System Model

Prior authority/ 1115 transition group	Counties Included	Delivery System Model	Managed Care Organizations Participating
HIO Waiver 1915(b)	**Santa Cruz**	MCO/HIO	Central Coast Alliance
	Monterey	MCO/HIO	Central Coast Alliance
	Merced	MCO/HIO	Central Coast Alliance
	Orange	MCO/HIO	CalOPTIMA
	Solano	MCO/HIO	Partnership HealthPlan of California
	Napa	MCO/HIO	Partnership HealthPlan of California
	Sonoma	MCO/HIO	Partnership HealthPlan of California
	Yolo	MCO/HIO	Partnership HealthPlan of California
HPSM 1915(b)	**San Mateo**	MCO	Health Plan of San Mateo
SBSLORHA 1915(b)	**Santa Barbara**	MCO/HIO	CenCal
	San Luis Obispo	MCO/HIO	CenCal
Two-Plan/ GMC Waiver 1915(b)	**Alameda**	MCO	Alameda Alliance for Health , Anthem Blue Cross Partnership Plan
	Contra Costa	MCO	Contra Costa Health Plan, Anthem Blue Cross Partnership Plan
	Fresno	MCO	Health Net Community Solutions, Anthem Blue Cross Partnership Plan
	Kern	MCO	Kern Family Health, Health Net Community Solutions
	Kings**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Los Angeles *	MCO	L.A. Care Health Plan, Health Net Community Solutions
	Madera**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Riverside *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	Sacramento	MCO; medical PAHP; dental	Anthem Blue Cross, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Bernardino *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	San Diego	MCO	Care First, Community Health Group, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Francisco	MCO	San Francisco Health Plan, Anthem Blue Cross Partnership Plan
	San Joaquin	MCO	Health Plan of San Joaquin, Health Net
	Santa Clara	MCO	Santa Clara Family Health Plan, Anthem Blue Cross Partnership Plan
	Stanislaus	MCO	Health Plan of San Joaquin, , Health Net Community Solutions
	Tulare	MCO	Anthem Blue Cross Partnership Plan, Health Net Community Solutions
2011 Managed Care Expansions	**Kings**	MCO	Anthem Blue Cross, CalViva
	Madera	MCO	Anthem Blue Cross, CalViva
	Marin	MCO/HIO	Partnership HealthPlan of California
	Mendocino	MCO/HIO	Partnership HealthPlan of California
	Ventura	MCO/HIO	Gold Coast Health Plan
2013 Managed Care Expansion County Organized Health	**Del Norte**	MCO/HIO	Partnership HealthPlan of California
	Humboldt	MCO/HIO	Partnership HealthPlan of California
	Lake	MCO/HIO	Partnership HealthPlan of California
	Lassen	MCO/HIO	Partnership HealthPlan of California
	Modoc	MCO/HIO	Partnership HealthPlan of California
	Shasta	MCO/HIO	Partnership HealthPlan of California

System (COHS) Health Insuring Organization (HIO)±	**Siskiyou**	MCO/HIO	Partnership HealthPlan of California
	Trinity	MCO/HIO	Partnership Health Plan of California
2013 Managed Care Expansion Regional±	**Alpine**	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Amador	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Butte	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Calaveras	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Colusa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	El Dorado	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Glenn	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Inyo	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mariposa	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Mono	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Nevada	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Placer	MCO	Anthem Blue Cross, California Health and Wellness Plan, Kaiser
	Plumas	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sierra	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Sutter	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tehama	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Tuolumne	MCO	Anthem Blue Cross, California Health and Wellness Plan
	Yuba	MCO	Anthem Blue Cross, California Health and Wellness Plan
2013 Managed Care Expansion Imperial±	**Imperial**	MCO	California Health and Wellness Plan, Molina Healthcare
2013 Managed Care Expansion San Benito±	**San Benito**	MCO	Anthem Blue Cross (Note: beneficiaries in this county will also have a choice of FFS because only one plan is available)

Note:
* These counties allow beneficiaries in certain zip codes to enroll on a voluntary basis
Planned Expansions:

- **In March 2011, Kings and Madera County, Two Plan Expansion - authority as approved by the Tri-Country 1915b approval
- ***In July, 2011, Marin, Mendocino and Ventura counties plan to begin operation using an HIO model

± Part of the 2013 Managed Care Regional Expansion effective September 1, 2013 for COHS counties and November 1, 2013 for non-COHS counties.

Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	Services for children under 21 to treat autism spectrum disorder as articulated in the state plan.	X[10]	X[10]	X[10]	X[10]	X[10]	X[10]
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X	X	X	X
California Children Services (CCS)	Service is not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			X[6]			
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provide services within the scope of their practice.	X	X	X	X	X	X
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X	X	X	X
Child Health and Disability Prevention (CHDP) Program		A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X[4]	X	X	X

Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)		A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.						
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X	X	X	X
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 95.	X	X	X			

Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X	X	X	X
Dental Services (Covered under Denti-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.						
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.						
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X	X	X	X
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X	X	X	X
Erectile Dysfunction Drugs		FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.						

Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.						
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	**X**[1,3]	**X**[1,3]	**X**[1,3]	**X**[1,3]	**X**[1,3]	**X**[1,3]
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).	**X**	**X**	**X**	**X**	**X**	**X**
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	**X**	**X**	**X**	**X**	**X**	**X**
Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.						

Attachment N – Capitated Benefits Provided in Managed Care

(X = covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X	X	X	X
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X	X	X	X
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X	X	X	X
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X	X	X	X
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			X[7]			

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.			X			
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services	.	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X[5]	X[5]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/ID-N) are covered subject to prior authorization by the Department for the ICF/ ID-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/ID-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X	X	X	X
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.						
Long Term Care (LTC)		Care in a facility for longer than the month of admission plus one month. Medically necessary care in a facility covered under managed care health plan contracts	**X**[5,9]	**X**[5,9]	**X**	**X**[5]	**X**[5]	**X**[5]
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	**X**	**X**	**X**	**X**	**X**	**X**

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.	X	X	X	X	X	X
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.	X[9]	X[9]	X[9]			
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X	X	X	X
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management	X[2]	X[2]	X[2]	X[2]	X[2]	X[2]
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.						
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.						
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	**X**[5]	**X**[5]	**X**	**X**[5]	**X**[5]	**X**[5]
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.	**X**[9]	**X**[9]	**X**[9]			
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	**X**	**X**	**X**	**X**	**X**	**X**
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	**X**	**X**	**X**	**X**	**X**	**X**

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	X	X	X	X	X
Prosthetic and Orthotic Appliances	Prosthetic and Orthodic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X	X	X	X
Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X[1,2*]	X[1,2]	X[1,2*]	X[1,2]	X[1,2]	X[1,2]
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			X[8]			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X	X	X	X
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X	X	X	X
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.						

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.						
Skilled Nursing Facility Services,	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X	X	X	X
Specialty Mental health services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.						
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[5]	X[5]	X	X[5]	X[5]	X[5]
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X	X	X	X
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5,9]	X[5,9]	X	X[5]	X[5]	X[5]

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in 2-Plan	COHS	Regional	Imperial	San Benito
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.						
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.						
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	X	X	X	X	X
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.						

[1] Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.

[2] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

[3] Fabrication of optical lenses only covered by CenCal Health.

[4] Not covered by CenCal

[5] Only covered for the month of admission and the following month

[6] Not Covered by CalOptima, Central California Alliance for Health, Partnership HealthPlan of California (Sonoma County Only) and CenCal (San Luis Obispo County Only)

[7] Only covered in Health Plan of San Mateo and CalOptima

[8] Only covered in Health Plan of San Mateo

[9] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Alameda, Los Angeles, Orange, San Bernadino, San Diego, San Mateo, Santa Clara, and Riverside

[10] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT program.

Attachment O – County Listing for SPD Enrollment

County Name	Plan Model						Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	Regional	Imperial	San Benito	
Alameda	X						X
Alpine				X			X
Amador				X			X
Butte				X			X
Calaveras				X			X
Colusa				X			X
Contra Costa	X						X
Del Norte			X				
El Dorado				X			X
Fresno	X						X
Glenn				X			X
Humboldt			X				
Imperial					X		X
Inyo				X			X
Kern	X						X
Kings	X						X
Lake			X				
Lassen			X				
Los Angeles	X						X
Madera	X						X
Marin			X				
Mariposa				X			X
Mendocino			X				
Merced			X				
Modoc			X				
Mono				X			X
Monterey			X				
Napa			X				
Nevada				X			X
Orange			X				
Placer				X			X
Plumas				X			X
Riverside	X						X
Sacramento		X					X
San Benito							
San Bernardino	X						X

San Diego		X					X
San Francisco	X						X
San Joaquin	X						X
San Luis Obispo			X				
San Mateo			X				
Santa Barbara			X				
Santa Clara	X						X
Santa Cruz			X				
Shasta			X				
Sierra				X			X
Siskiyou			X				
Solano			X				
Sonoma			X				
Stanislaus	X						X
Sutter				X			X
Tehama				X			X
Trinity			X				
Tulare	X						X
Tuolumne				X			X
Ventura			X				
Yolo			X				
Yuba				X			X

I. Review Process

A. DHCS Review Process

The California Department of Health Care Services (DHCS) will review all 5-year SNCP Delivery System Reform Incentive Pool (DSRIP) proposals prior to submission to CMS for final approval according to the following timeline:

1. By February 18, 2011, each Designated Public Hospital (DPH) system will submit a 5-year DSRIP proposal to DHCS for review. Each proposal will address Categories 1, 2 and 4.

2. DHCS shall review each proposal to verify that the proposal conforms to the requirements for Categories 1, 2 and 4 as described in Section II Key Elements of Proposed Plans. By March 1, 2011, DHCS will complete its review of the proposal, and will respond to the DPH system in writing with any questions, concerns or problems identified.

3. By March 1, 2011, DHCS will take action on the proposal, and will approve each proposal and submit it to CMS for final review and approval as described in I.B.1.

4. By April 15, 2011, each DPH system will submit to DHCS an addendum to its 5-year DSRIP proposal to address Category 3.

5. DHCS shall review each proposal addendum to verify that it conforms to the requirements for Category 3 as described in Section II Key Elements of Proposed Plans. By April 30, 2011, DHCS will complete its review of the proposal addendum, and will respond to the DPH system in writing with any questions, concerns or problems identified in the addendum.

6. The DPH system will respond to DHCS' questions and concerns in writing within 3 business days of notification by DHCS.

7. By May 15, 2011, DHCS will approve each DPH system's proposal addendum for Category 3 and submit it to CMS for final review and approval as described in section B. B. CMS Review Process

The following review process for designated public hospital (DPH) system proposals that have been reviewed and approved by California DHCS will result in approval by CMS within 30 days of receipt from DHCS.

1. CMS will review each DPH system's 5-year DSRIP proposal for Categories 1 2 and 4 upon receipt of the proposal as approved by DHCS pursuant to I.A.3. CMS' review will assess whether each 5-year DSRIP proposal as approved by DHCS has the following elements

    a. The proposal is in the format described in the DSRIP program description described within these special terms and conditions.

    b. Category 1 and 2 projects must clearly identify goals, milestones and expected results, and their relationship to anticipated Category 3 population-focused

improvements. Plans must identify, by year, the applicable milestones in accordance with the descriptions and examples identified in Attachment Q – on the (Category 1 & 2 superset).

c. Plans must identify Category 4 milestones for the 2 required interventions and clearly identify the 2 additional interventions selected from the superset described in Attachment Q – on Category 4.

2. By March 18, 2011, CMS will complete a review of each DPH system's proposal for Categories 1, 2 and 4 and will either:

   Approve the proposal; or

   Notify DHCS and the DPH system if approval will not be granted for a component of the DPH system's proposal for Categories 1, 2 and 4. Notice will be in writing and will include any questions, concerns or problems identified in the application.

   DHCS and the DPH system will respond to the CMS notice within 3 business days.

3. If CMS finds that a component of a DPH system's Category 1 or 2 project is inconsistent with the overall goals of the DSRIP, CMS will request additional information from the DPH system and may request a revision or replacement project. If CMS does not grant approval for a component of a DPH system's 5-year proposal for Categories 1, 2 and 4, by March 18, 2011 pursuant to the above, CMS will approve the DPH system's 5-year proposal, request that the DPH system provide additional information and may request that the DPH system revise or replace the project component.

4. If CMS does not approve a component of a DPH system's project as described in I.B.3, CMS will still permit full DY 6 payment by March 31, 2011, in accordance with the expedited DY6 process under Section III. Expedited DY 6 Reporting & Reimbursement, while the DPH system develops an acceptable revision or replacement project or component. The DPH system will submit the revised/replacement project to CMS by April 15, 2011. CMS will consider and approve any revised/replacement project by May 1, 2011 if it is achievable within the applicable timeframes.

   a. Upon approval and submission from DHCS pursuant to I.A.7., CMS will complete an initial review of each DPH system's addendum to its proposal related to Category 3.

   b. By May 31, 2011, CMS will respond to DHCS and the DPH system in writing with any questions, concerns or problems identified in the addendum.

c. Within 3 business days of notification by CMS, DHCS and the DPH system will provide responses to CMS regarding any questions or concerns raised.

d. By June 15, 2011, CMS will approve each DPH system's addendum for Category 3.

II. Key Elements of Proposed Plans

1. DPH systems will submit 5-year DSRIP plansthat include projects or interventions for each of the 4 following categories. The DPH system plan will describe how the projects and interventions included in the plan are related to each other and how, taken together, they support broad delivery system reform relevant to the patient population.

2. Each DPH system 5-year DSRIP plan will include an Introduction that includes, but is not limited to the following sections:

   a. A Background section on the DPH system(s) covered by the 5-year DSRIP plan that includes an overview of the patients served by the DPH system(s); and

   b. An Executive Summary section for the 5-year plan that summarizes the high-level challenges the DSRIP plan is intended to address and the 5-year target goals and objectives included in the plan.

3. The DPH system 5-year plan will include sections on each of the 4 categories as specified in Attachment Q.

4. Category 1 - Infrastructure Development (Category 1)

   a. Category 1 Infrastructure Development is investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services.

   b. Each DPH system plan must select at least 2 projects for Category 1 for at least DY 6, DY 7 and DY 8 in accordance with the *Categories 1-2 Projects in Attachment Q*, which lists the acceptable projects, measures, metrics, and data sources.

   c. For each project selected for Category 1, DPH system plans must include a narrative that includes the following subsections:

      i. The Goal(s) for the project, which describes the challenges of the DPH system and the major delivery system solution identified to address those challenges by implementing the particular project; the starting point of the DPH system(s) related to the project and based on that, the 5-year target goal and the significance of that goal to the DPH system(s) and its patients. As part of this subsection, each DPH system will provide its reasons for selecting the project, milestones, and metrics based on relevancy to the DPH system's population and circumstances, community need, and DPH system priority and starting point; and

ii. The Relation to Other Categories for the project, which describes how this project supports, reinforces, enables, and is related to other projects and interventions within the DPH system plan.

d. Category 1 - Milestones and Metrics Table:

i. All projects must include milestones based on projects, measures, metrics, and data sources in accordance with the *Categories 1-2 Projects in Attachment Q*.

ii. The milestones shall be designated by project by year in table format.

iii. For each project, the DPH system plan must include at least 1 milestone based on a Process Measure and at least 1 milestone based on an Improvement Measure over the 5-year period in accordance with the *Categories 1-2 Projects in Attachment Q*.

iv. For each milestone, the DPH system plan must include the metric(s) in accordance with the *Categories 1-2 Projects in Attachment Q*.

v. For each project, the table must list the other inter-related projects and interventions included in the DPH system's overall 5-year plan.

5. Category 2 - Innovation and Redesign (Category 2)

a. Category 2 Innovation and Redesign is investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management.

b. Each DPH system plan must select at least 2 projects for Category 2 in accordance with the *Categories 1-2 Projects in Attachment Q*. For each project selected for Category 2, DPH system plans must include a narrative that includes the following subsections:

i. *The Goal(s) for the pro*ject, which describes the challenges of the DPH system and the major delivery system solution identified to address those challenges by implementing the particular project; the starting point of the DPH system(s) related to the project and based on that, the 5-year target goal and the significance of that goal to the DPH system(s) and the patients, including how the selected Category 2 projects can refine innovations, test new ways of meeting the needs of target populations, and disseminate learnings in order to spread promising practices. As part of this subsection, each DPH system will provide the reasons for selecting the project, milestones, and metrics based on relevancy to the DPH system's population and circumstances, community need, and DPH system priority and starting point; and

ii. The Relation to Other Categories for the project, which describes how this project supports, reinforces, enables, and is related to other projects and interventions within the DPH system plan.

c. Category 2 Milestones and Metrics Table:

   i. All projects must include milestones based on projects, measures, metrics, and data sources in accordance with the *Categories 1-2 Projects in Attachment Q*.

   ii. The milestones shall be designated in table format by project by year.

   iii. For each project, the DPH system plan must include at least 1 milestone based on a Process Measure and at least 1 milestone based on an Improvement Measure over the 5-year period in accordance with the *Categories 1-2 Projects in Attachment Q*.

   iv. For each milestone, the DPH system plan must include the metric(s) in accordance with the *Categories 1-2 Projects in Attachment Q*,

   v. For each project, the table must list the other inter-related projects/interventions included in the DPH system's plan.

6. Category 3: Population-focused Improvement (Category 3)

   a. Category 3: Population-focused Improvement is the reporting of measures of care delivery for high burden conditions in DPH systems specific to the population in question.

   b. Each DPH system plan must include reporting of all measures listed for all 4 domains, pursuant to *Category 3 Superset of Measures in Attachment Q*.

   c. Category 3 Milestones and Metrics Table:

      i. For Category 3, a milestone is the reporting of a particular measure.

      ii. Each DPH system plan would include Category 3 milestones for DY 7-10, in accordance with *Category 3 Superset of Measures in Attachment Q*.

      iii. The milestones shall be designated by domain by year.

   d. Each domain will constitute a bundle.

7. Category 4 Urgent Improvement in Care (Category 4):

   a. Category 4 Urgent Improvement in Care is broad dissemination of top-level performance on a set of interventions where there is deep evidence, including evidence from within the safety net, that major improvement in care is possible within 5 years, measurable and meaningful for almost all hospital populations such as those served by DPH systems.

   b. Each DPH system plan must include 2 common interventions for all DPH systems participating in DSRIP.

c. Each DPH system plan must include an additional 2 interventions from within the superset of Category iv interventions *in Attachment Q*. Plans must indicate the reasons for choosing the 2 interventions selected, including their significance for the DPH system and its patients. ,

d. For its 2 additional interventions, a DPH system is precluded from choosing an intervention for which it has achieved top performance for at least 4 consecutive quarters, in aggregate in all process and outcomes measures within the intervention, as defined by *Category 4 – Urgent Improvement in Quality & Safety: Superset of Interventions found in Attachment Q*.

e. Improvement Targets will be established for each required measure within the Category 4 interventions, as pursuant to *Category 4 – Urgent Improvement in Quality & Safety: Superset of Interventions in Attachment Q*.

f. The DPH system 5-year plan will include the following subsections for each Category 4 intervention selected:

    i. A Key Challenge(s) subsection that describes the key challenge(s) the intervention is designed to address;

    ii. A Major Delivery System Solution(s) subsection that describes the intervention selected by the DPH system and the 5-year target goals and objectives; and

    iii. A Milestones and Metrics table that includes the milestones per intervention per year based on the measures specified in or otherwise in accordance with *Category 4 – Urgent Improvement in Quality & Safety: Superset of Interventions in Attachment Q*.

g. Category 4 Milestones and Metrics Table:

    i. All projects must include milestones based on interventions, measures, metrics, data sources, and improvement targets in accordance with the *Category 4 – Urgent Improvement in Quality & Safety: Superset of Interventions in Attachment Q*.

    ii. The milestones shall be designated by project by year.

III. Expedited DY 6 Reporting & Reimbursement

1. As described in Section I.A. above, each designated public hospital system will submit a draft 5-year DSRIP proposal addressing Categories 1, 2 and 4 to DHCS by February 18, 2011. The DY6 component of the proposal will contain projects and milestones related to DSRIP Categories 1 & 2, and one preparation/process milestone for each Category 4 intervention project. Plans for DY 6 will not be required to include Category 3 milestones.

2. On March 2, 2011, public hospital systems will submit a report to DHCS and CMS (using an approved standardized report form) on the achievement of their DY 6

milestones through March 1, 2011. This report will serve as the basis for permitting payment of the applicable total computable DY6 incentive amount in a DPH system's plan on or by March 31, 2011. These payment amounts will be based on the achievement of the DY6 milestones in accordance with the criteria established in Section VI (Disbursement of Pool Funds) in Attachment P.

3. Following plan approval and submission of the DY 6 report by the public hospital system, DHCS will issue a request to the designated public hospital system for an intergovernmental transfer in the amount of the necessary nonfederal share of the applicable incentive payment amount by March 7, 2011. Each DPH system or its affiliated governmental entity will make an intergovernmental transfer of funds to DHCS in the amount specified within 7 days of receiving the DHCS request.

4. By March 18, 2011, CMS will provide approval of the plans to permit payment for DY6.

5. Upon receipt of the intergovernmental transfer, DHCS will draw the federal funding and pay both the non-federal and federal shares of the DY 6 payment to the designated public hospital system or other affiliated governmental provider as applicable. If the intergovernmental transfer is made within the appropriate timeframe, the incentive payment will be paid within 14 days of when the transfer is made, but in no event shall the payment be made later than March 31, 2011. In the event federal approval is not obtained, DHCS must return immediately the IGT funds to the public hospital system.

6. On May 15, 2011, public hospital systems may submit a second report to DHCS and CMS (using the approved standardized report form) on the achievement of their DY 6 milestones through May 1, 2011. The report will include, if applicable, the achievement of revised/replacement projects approved by CMS as described in I.B.4. This report will serve as the basis for permitting additional payment of the applicable total computable DY6 incentive amount in a DPH system's plan on or by June 30, 2011. These payment amounts will be based on the achievement of the DY6 milestones in accordance with the criteria established in Section VI (Disbursement of Pool Funds) in Attachment P and will take into account payments already received in March 2011.

7. Following submission of the second DY 6 report by the public hospital system, DHCS will issue a request to the designated public hospital system for an intergovernmental transfer in the amount of the necessary nonfederal share of the applicable incentive payment amount by May 15, 2011. Each DPH system or its affiliated governmental entity will make an intergovernmental transfer of funds to DHCS in the amount specified within 7 days of receiving the DHCS request.

8. Upon receipt of the intergovernmental transfer, DHCS will draw the federal funding and pay both the nonfederal and federal shares of the DY 6 payment to the designated public hospital system or other affiliated governmental provider as applicable. If the intergovernmental transfer is made within the appropriate timeframe, the incentive payment will be paid within 14 days of when the transfer is made, but in no event shall the payment be made later than June 30, 2011. In the event federal approval is not obtained, DHCS must return immediately the IGT funds to the public hospital system.

9. DY 6 payments made under the expedited process will be subject to reconciliation using the metrics and other reportable elements for DY 6 as required by the designated public hospital system's final approved 5-year plan, and based upon the July 31, 2011 report submitted pursuant to Section IV (Reporting, Assessment & Modification Process) in Attachment P

10. . If, after the reconciliation process it is determined that DY 6 funding was overpaid, the overpayment will be properly credited to the federal government or will be withheld from the next DSRIP payment for the hospital system.

11. Unexpended DY 6 funding:
    a. A designated public hospital system may carry forward available incentive pool funding associated with DY 6 milestones and metrics that either were not claimed pursuant to the expedited process, or were returned pursuant to the reconciliation to final approved plan, for claiming in a subsequent period in accordance with Section VII (Carry-Forward/Reclamation/ Reallocation) in Attachment P.
    b. The Department may reallocate unexpended DY 6 funding under conditions specified and in accordance with Section VII (Carry-Forward/Reclamation/ Reallocation) in Attachment P.

IV. Reporting, Assessment and Modification Process

A. Reporting

1. Semi-annual reporting for payment

    a. Twice a year, the hospital systems seeking payment under the DSRIP must submit reports to the State demonstrating progress, measured by category specific metrics. The reports must include the incentive payment amount being requested for the progress achieved in accordance with payment mechanics. (see section VI "Disbursement of Pool Funds").

    These reports will be due as indicated below after the end of each 6-month period reporting period:

        i. Reporting period of July 1 through December 31st. The report and request for payment is due March 31st, with payment occurring by April 30th.

        ii. Reporting period of January 1st through June 30th. The report and request for payment is due September 30th, with payment occurring by October 31st.

    The report must include submission of the data for the each of the milestones for which the DPH system has achieved progress and seeks payment under the DSRIP.

    b. The semi-annual report must be submitted using the standardized reporting form approved by CMS.

c. The State must use this documentation in support of DSRIP claims made on the MBES/CBES 64.9 Waiver form.

d. Prior to issuing payment, the DHCS DSRIP Analyst will conduct an administrative review of the semi-annual reports for technical issues.

e. Prior to submitting the first semi-annual reports to CMS, the DHCS Clinical Quality Officer and other clinical staff will conduct a review of the reports for clinical issues using the DSRIP Semi-Annual Report Review Table, a checklist for review approved by CMS.. The DHCS DSRIP Analyst will also complete a review of the first semi-annual reports for administrative issues using the DSRIP Semi-Annual Report Review Table.

f. The DHCS DSRIP Analyst will complete a review of the second semi-annual reports for administrative issues.

2. Hospital System Annual Report

a. Hospital systems must submit an annual report by October 31st following the end of the Demonstration year.

b. These reports will include the information provided in the 2 semi-annual reports previously submitted for the Demonstration year, including data on the progress made for all milestones.

c. Additionally, the hospital systems will provide a narrative description of the progress made, lessons learned, challenges faced and other pertinent findings.

d. A section of the DPH system's annual report will describe the DPH system's participation in shared learning.

e. Hospital systems must complete and submit the DSRIP Review Table with their annual report.

f. The hospital system must have available for review by State or CMS, upon request, all supporting data and back-up documentation.

g. DHCS shall in a timely manner review each DSRIP annual report by adhering to the following steps in the review process:

i. The DHCS DSRIP Analyst will conduct an administrative review of the reports and ensure the administrative portion of the DSRIP Review Table has been completed.

ii. The DHCS Clinical Quality Officer (QO) and other clinical staff will concurrently review reports for clinical issues and ensure the clinical portion of the DSRIP Review Table has been completed.

iii. The DHCS QO briefs the DHCS Medical Director on quality and other clinical issues that are identified in the reports. A second review of selected reports is conducted by the DHCS Medical Director, when indicated.

iv. Reviews will be issued to hospital systems and they will be given a reasonable time period, not less than fourteen (14) days, in which to respond to issues and revise reports if needed.

v. The DSRIP Analyst, QO and other clinical staff will review revisions and the DSRIP Analyst will coordinate any further revisions with the hospital system if needed, and will update and involve the DHCS Medical Director, as indicated.

vi. The DSRIP Analyst will submit such annual reports, as revised if necessary, to CMS for review and approval.

3. Aggregate Public Hospital System Annual Report

a. Annually, the State must compile reports documenting progress made, metric reporting, outcome data, if applicable, detailing system change supported by the DSRIP. The aggregate report should also include information about the shared learning activities that occurred during the Demonstration year.

b. The State, in collaboration with the participating DPH systems, may utilize the California Association of Public Hospitals/Safety Net Institute (CAPH/SNI) to assist in the development and management of the annual DPH aggregate progress report to be submitted to CMS within 60 days of receipt of approval from CMS of all the annual reports as set forth above in Section IVA.2. of this Attachment P. .

c. As part of the aggregate report, CAPH/SNI shall submit a table that shows system wide performance in Category IV. This table shall include baseline rates, improvement targets, interventions and current status of Category IV interventions.

d. The State will review the annual DPH aggregate report before it is submitted to CMS. The DHCS DSRIP Analyst will review the report for any organizational or technical issues. The DHCS Clinical Quality Officer and other clinical staff will review the report for any clinical issues.

e. Per CMS' review, the DSRIP Analyst will coordinate and submit any further revisions required in the annual DPH aggregate report.

B. Mid-Point Assessment

a. During the first 6 months of DY8, CMS, the State and the California Association of Public Hospitals will review the progress made in each category for each system. This review will provide opportunity to modify projects and/or metrics in consideration of learning and new evidence be taken into account and incorporated in to plans. Revisions to a DPH system's plan as justified by the results of the midpoint assessment will be agreed to by CMS, the State and the DPH system, be reflective of the plan's overall goals, and must be both practicable and achievable in the remaining time period of the waiver.

1. *Categories i-ii:* Based on learnings and new evidence, a hospital may modify its DY9-10 milestones in an effort to update its plan to potentially make more progress toward improvements on the plan's goals and objectives.

2. *Category iv:* At the start of DY8, CMS, the State of California, in collaboration with the participating DPH systems, will establish a 90-day period to review the superset of Category iv interventions for DY9-10, including whether an intervention or metric should be removed, updated, or added to the superset, including specifically whether a Medicaid obstetric measure should be added. The intent of this review period is to ensure the achievement of the goals for Category iv, not to completely revise the DPH's plan for Category iv, unless necessitated as described below. DPH systems will have the opportunity to revise their Category iv plans if needed, for example, if it seeks to revise the target units or populations in order to achieve more significant improvement, or if new data or evidence emerges that encourages revision of strategies or metrics. If a DPH system has achieved top performance, as defined below in this in Attachment Q, in aggregate on all process and outcomes measures included in the superset for an intervention for at least 4 consecutive quarters, then it may be required to replace the intervention with another intervention from the superset (4 consecutive quarters at a minimum is standard clinical practice for measuring improvement).

3. DPH systems that make changes to their plans as a result of the Mid-Point Assessment will submit addendums to their plans specific to DY9-10, and for Category iv that reflect the decisions made in the 90-day review period and could include replacement of an intervention on the superset with another intervention. The same timeline for the State and CMS to review the plans that is delineated in the Waiver terms and conditions will apply.

b. Due to the recognition that the diabetes composite measure in category iii is nascent as of March 2011 and the best practice is evolving, the composite measure will be defined at the Mid-Point Assessment to be able to take into account a more refined, tested composite measure. At the start of DY8, CMS, the State of California, in collaboration with the participating DPH systems, will determine the diabetes composite measure based on industry refinement of the measure, to be reported by

DPH systems in DY9-10. Accordingly, DPH systems will update their 5-year proposals to reflect this determination.

c. Based on learnings and potential changes to plans made during the mid-point assessment, the standardized reporting form utilized for the semi-annual reports may also be modified through a process developed by CMS, the State of California and the participating DPH systems.

C. Plan Modification Process

1. Consistent with the recognized need to provide DPH systems some flexibility to evolve their plans over time and take into account evidence and learning from their own experience and from the field, as well as for unforeseen circumstances, a DPH system may request modifications to its plan prior to and/or beyond those built into the Mid-Point Assessment as described above, including instances in which plans require additional data in order to identify problems and develop strategies. For those Category iv interventions for which there is no external dataset available to use for benchmarking and setting Improvement Targets, a DPH system will submit a request for a modification once it has established sufficient baseline data to set Improvement Targets, as pursuant to *Category iv – Urgent Improvement in Quality & Safety: Superset of Interventions*. A DPH system must submit a request for modification to the State. Requests for modification must describe the basis for the proposed modification. The same timeline for the DHCS to review and forward the requests for modification to CMS that is delineated in the Waiver terms and conditions for the plans will apply. In the event that DHCS does not approve a modification to a DPH's proposal, the DPH system my seek redress by requesting a meeting with the DHCS Director to resolve any issues. The meeting shall take place in a timely manner. The same timeline for CMS to review the requests for modification that is delineated in the Waiver terms and conditions for the plans will apply.

2. Any modified plans will be required to contain all plan elements required in the Waiver terms and conditions. In no case will a plan modification for Demonstration Years 9 or 10, beyond the modifications done during the Mid-Point Assessment, include plans to establish new projects in categories 1 or 2 that are unrelated to other projects in the 5-year plan.

3. If total available funding for designated public hospital system plans under the DSRIP is less than the limits indicated in STC 35(c)(v) entitled General Overview of Payments, the plans will need to be modified to reflect the reduced funding available.

V. Eligible Hospital Systems to Receive Funds

The DPH systems (which include their affiliated governmental providers), are eligible to receive incentive payments from the pool, subject to each DPH system establishing a 5-year set of system transformation milestones set forth in an approved plan. Incentive funds shall be disbursed solely to eligible DPH systems, unless pursuant to STC 35(c)(vii) a sub-pool/pools for private and/or non-designated public hospitals is established and approved by CMS. A specified amount of incentive funding will be available annually to each eligible hospital system based on

the milestones approved for that hospital. The actual receipt of funds will be conditioned on reporting by the entity of progress towards and achievement of the specified milestones as laid out below.

VI. Disbursement of Pool Funds

1. Each DPH system will be individually responsible for progress towards and achievement of its milestone bundles in all categories in order to receive its potential incentive funding from the pool. Every 6 months, eligible DPH systems will be able to receive incentive payments related to achievement within milestone bundles.

2. In order to receive incentive funding related to any milestone bundle, the DPH system must submit the required Semi-Annual Report as described above in section III(A)(1).

3. Categories i and ii:

   Given the varied nature of the projects and the hospital systems, the incentive payment amounts for Categories 1 and 2 will be determined by each specific DPH system in its plan submission. The submission will describe the factors that were considered in assigning the incentive payment amounts to and among these projects, such as relative effort/starting point or patient/community need. The incentive payment amounts identified by the DPH system for each category shall be approved if they are consistent with the following guidelines:

   A. *Category 1 Incentive Amount Guidelines:*

      1. The amount of a hospital system's incentive funding for a particular Demonstration year that is allocated for Category 1 projects cannot exceed the following percentages of the total incentive payment amount for that system for that Demonstration year:

         a. DY6: 47 percent

         b. DY7: 35 percent

         c. DY8: 30 percent

         d. DY9: 15 percent

         e. DY10: 5 percent

      2. For Demonstration years 6, 7 & 8, a hospital system must have at least two Category 1 projects. DPH systems are encouraged and allowed to include more than the minimum number of projects, however the maximum Category 1 funding available to the DPH system will remain limited by the same percentages identified above for the 2 project minimum.

3. For Demonstration years 6, 7, & 8, the amount of Category 1 incentive funding allocated to a single Category 1 bundle in that Demonstration year cannot be more than 50 percent of the total Category 1 incentive funding for the particular year.

B. *Category 2 Incentive Amount Guidelines:*

1. The amount of a hospital system's incentive funding for a particular Demonstration year that is allocated for Category 2 projects cannot exceed the following percentages of the total incentive payment amount for that system for that Demonstration year:

   a. DY6: 47 percent

   b. DY7: 35 percent

   c. DY8: 30 percent

   d. DY9: 15 percent

   e. DY10: 10 percent

2. For Demonstration years 6, 7, & 8, a hospital system must have at least two Category 2 projects in each Demonstration year. DPH systems are encouraged and allowed to include more than the minimum number of projects, however the maximum Category 2 funding available to the DPH system will remain limited by the same percentages identified above for the 2 project minimum.

3. For Demonstration years 6, 7, & 8, the amount of Category 2 incentive funding allocated to a single Category 2 bundle in a Demonstration year cannot be more than 50 percent of the total Category 2 incentive funding for the particular year.

As discussed in Section 1 all projects will include milestones that are measurable. Milestones would be bundled by improvement project by year. In the case where an improvement project only has 1 milestone in a given year, then the milestone will be considered a bundle.

4. Category iii:

   a. For each domain that is identified consistent with a CMS approved Category 3 *Superset of Measures,* the incentive payment amount will be determined using a formula where a base amount is multiplied by factors to determine the total dollars for that domain. The dollars will then be allocated within a plan among each of the 4 years (DY7-DY10) based on a set percentage laid out below.

   b. Incentive Payment Formula:

      a. Calculation of 4-Year Per Domain Incentive Amount

1) 4-Year Base Amount Per Domain: $6.5 million (total computable)
2) The base amount will be multiplied by a size factor that takes into account the DPH system's cost and patient count related to low-income individuals (See Table 1 below with size multiplier amounts for each of the 17 DPH systems)
3) The result from steps 1 and 2 will be multiplied by a factor of 1.1 for all teaching hospital systems (Table 1 indicates those systems that will have the teaching factor applied)
4) The result from the above steps can be adjusted by up to 10 percent by each individual system to account for the following factors: differences in quality infrastructure, differences in external supports for improvement work, and differences in patient populations.
5) The result from steps 1 – 4 will determine the total 4-year amount per domain.

b. Allocation of 4-Year Per Domain Incentive Amount to Each Demonstration Year
The 4-year per domain incentive payment amount will be allocated to each Demonstration year based on the following percentages:

a. DY6: 0 percent
b. DY7: 15 percent
c. DY8: 20 percent
d. DY9: 30 percent
e. DY10: 35 percent

c. The per-year, per-domain incentive amounts determined according to the formula above will then serve as the "bundled" payment amount for all milestones related to that domain for that Demonstration year for purposes of the payment mechanics/processes.

Example of Category iii Domain Payment Formula
At-Risk Population Domain
Base Amount of $6,500,000
x Size Factor = 3.0
x Medical Education (IF APPLICABLE) = 1.1
(OPTIONAL ADJUSTMENT +/- 10 percent) X up to +/- 10 percent
Total Dollars For Year 4 years For At-Risk Population= $ 21,450,000
Total Dollars Per Demonstration Year:
DY6 = $0
DY7 = $3,217,500
DY8 = $4,290,000
DY9 = $6,435,000
DY10 = $7,507,500

Table 1:

Public Hospital System	Size Factor	Teaching?
Alameda County Medical Center	3.1	yes
Arrowhead Regional Medical Center	3.6	yes

Contra Costa Regional Medical Center	3.2	yes
Kern Medical Center	2.5	yes
Los Angeles County System	23.5	yes
Natividad Medical Center	1.0	yes
Riverside County Regional Medical Center	3.9	yes
San Francisco General Hospital	4.2	yes
San Joaquin General Hospital	1.9	yes
San Mateo Medical Center	1.3	no
Santa Clara Valley Medical Center	5.9	yes
UC Davis	3.5	yes
UC Irvine	2.1	yes
UC Los Angeles	2.9	yes
UC San Diego	2.1	yes
UC San Francisco	2.9	yes
Ventura County Medical Center	2.3	yes

5. *Category iv:*

   a. Category iv must comprise 20-30 percent of the total aggregate DSRIP funding for the 5-year Demonstration period within the DPH system's plan. Each intervention's incentive payment amount will be determined using a formula where a base amount is multiplied by factors to determine the total dollars for that intervention. The dollars will then be allocated within a plan among each of the 5 years based on a set percentage laid out below.

   b. Incentive Payment Formula:

      a. Calculation of 5-Year Per Intervention Incentive Amount

      1) 5-Year Base Amount Per Intervention: $5.5 million (total computable)
      2) The base amount will be multiplied by a size factor that takes into account the DPH system's cost and patient count related to low-income individuals (See Table 1 above with size multiplier amounts for each of the 17 DPH systems)
      3) The result from steps 1 and 2 will be multiplied by a factor of 1.1 for all teaching hospital systems (Table 1 indicates those systems that will have the teaching factor applied)
      4) The result from the above steps can be adjusted by up to 10 percent by each individual system to account for the following factors: differences in quality infrastructure, differences in external supports for improvement work, and differences in patient populations.
      5) The result from steps 1 – 4 will determine the total 5-year amount per intervention.

      b. Allocation of 5-Year Per Intervention Incentive Amount to Each Demonstration Year

The 5-year per intervention incentive payment amount will be allocated to each Demonstration year based on the following percentages:

i. DY6: 5 percent
ii. DY7: 10 percent
iii. DY8: 20 percent
iv. DY9: 30 percent
v. DY10: 35 percent

C. The per-year, per-intervention incentive amounts determined according to the formula above will then serve as the "bundled" payment amount for all milestones related to that intervention for that Demonstration year for purposes of the payment mechanics/processes.

Example of Category iv Intervention Payment Formula

Sepsis Intervention
Base Amount of $5,500,000
x Size Factor = 3.0
x Medical Education (IF APPLICABLE) = 1.1
(OPTIONAL ADJUSTMENT +/- 10 percent) X up to +/- 10 percent
Total Dollars For Year 5 years For Sepsis Intervention= $ 18,150,000
Total Dollars Per Demonstration Year:
DY6 = $907,500
DY7 = $1,815,000
DY8 = $3,630,000
DY9 = $5,445,000
DY10 = $6,352,500

6. *Achievement Value for Milestone Bundle (For All Categories)*

i. The amount of the incentive funding paid to a DPH system will be based on the amount of progress made within each specific bundle. For each milestone within the bundle, the DPH system will include in the semi-annual report the progress achieved toward that milestone's target. Based on the progress reported, each milestone will be categorized as of the following to determine the total achievement value for the milestone bundle:

- Full achievement (achievement value=1)
- At least 75 percent achievement (achievement value=.75)
- 50percent to less than 75 percent achievement (achievement value=.5)
- At least 25 percent achievement (achievement value=.25)
- Less than 25 percent achievement (achievement value=0)

The achievement values for each milestone in the bundle will be summed together to determine the total achievement value for the milestone bundle. The DPH system is then eligible to receive an amount of incentive funding for that milestone bundle determined by multiplying the total amount of funding related to that bundle by the result of dividing the total possible achievement value by the reported achievement value. If a DPH system has previously reported progress in a bundle and received partial funding, only the additional amount it is eligible for will be disbursed. (See example below of disbursement calculation)

Within 14 days after the due dates of the semi-annual report to the State, the DPH system or its affiliated governmental entity will make an intergovernmental transfer of funds equal to the nonfederal share that is necessary to draw the federal funding for the incentive payment related to the milestone achievement that is reported. The State will draw the federal funding and pay both the nonfederal and federal shares of the incentive payment to the DPH system or other affiliated governmental provider as applicable. If the intergovernmental transfer is made within the appropriate 14 day timeframe, the incentive payment will be disbursed within 7 days, otherwise the payment will be disbursed within 14 days of when the transfer is made.

Example of disbursement calculation

Milestone Bundle A (5 milestones = maximum achievement value of 5; Total funding related to Bundle $30 million)

Hospital system reports the following progress at 6 months:

Milestone 1: 100 percent achievement (achievement value = 1)
Milestone 2: 85 percent achievement (achievement value = .75)
Milestone 3: 40 percent achievement (achievement value = .25)
Milestone 4: 25 percent achievement (achievement value = .25)
Milestone 5: 10 percent achievement (achievement value = 0)

Total achievement value at 6 months = 2.25
Disbursement at 6 months = $30M x (2.25/5) = $13.5M

DPH system reports the following progress at 12 months

Milestone 1: 100 percent achievement (achievement value = 1)
Milestone 2: 100 percent achievement (achievement value = 1)
Milestone 3: 90 percent achievement (achievement value = .75)
Milestone 4: 80 percent achievement (achievement value = .75)
Milestone 5: 60 percent achievement (achievement value = .5)

Total achievement value at 6 months = 4.0
Total eligible disbursement at 12 months = $30M x (4/5) = $24M
Minus 6 months disbursement of $13.5M
Total actual disbursement amount at 12 months = 24M – 13.5M = $10.5M

Progress & Payment Reconciliation

As noted above in Section (IIV)(A)(2), each DPH system will be required to submit an annual report after the end of a Demonstration year. This report will include the data

reported in the semi-annual reports related to the milestone progress achieved by the system. If, upon review of the annual report, it is determined that the DPH system has received an overpayment, the Department will collect the overpayment from the DPH system by withholding the amount of the overpayment from the next DSRIP payment. Alternatively, if the DPH system would prefer to repay the funding prior to the next DSRIP payment, the Department would, upon request, issue a letter requesting repayment within an agreed upon number of days but no later than the next DSRIP payment. If the review of the report determines that actual progress exceeded the progress previously reported and paid for, and the actual progress would have resulted in increased payment (up to the maximum allocated for the bundle) the DPH system will be able to transfer the appropriate IGT in order to receive the appropriate additional payment.

VII. Carry-Forward/Reclamation/Reallocation

A. Categories i-ii

If a DPH system does not fully achieve a milestone bundle that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding associated with that milestone bundle until the end of the following Demonstration year during which the DPH system may complete the milestone bundle and receive full payment.

If after the end of that additional Demonstration year, a DPH system has not fully achieved a milestone bundle, it will no longer be able to claim that funding related to its completion of that milestone bundle.

A 90-day process will begin on January 1, 2014 during which time 90 percent of any amounts determined to be unclaimed for DY6 & 7 will be made available to the DPH system that did not claim the amounts. An additional 90-day process will begin on July 1, 2014 during which time 90 percent of any amounts determined to be unclaimed for DY8 will be made available to the DPH system that did not claim the amounts. In order to claim such funding, the DPH systems would be required to develop additional project or data milestones in population health or patient safety, or milestones associated with other hospital initiatives that are achieving significant impacts in population health or patient safety. These additional milestones must be applicable to the remaining Demonstration years. Requests for additional milestones must be approved by the State and CMS. If a DPH system is unable to propose sufficient additional milestones to claim the full 90percent of its own funding, such funding will be made available to other DPH systems for additional milestone plans.

The 10 percent of the unclaimed amounts related to DY6, 7, and 8, any of the 90 percent from those years that is not allocate during the 90-day process, and 100 percent of the unclaimed amounts related to DY9 and 10 will either remain unclaimed or using the authority in STC paragraph #37 entitled "Restricted Use of SNCP Funds" could be rolled over for use in other SNCP categories subject to CMS approval.

B. Category iii

If a DPH system fails to achieve a milestone bundle that was specified in its plan for completion in a particular year, that funding will be forfeited and either remain unclaimed or could be rolled over for use in other SNCP categories subject to CMS approval, using the authority in STC #37 Restricted Use of SNCP Funds.

C. Category iv

If a DPH system does not fully achieve a milestone bundle that was specified in its plan for completion in a particular year, it will be able to carry forward the available incentive funding

associated with that milestone bundle until the end of the Demonstration during which the hospital system may complete the milestone bundle and receive full payment.
Any funding related to Category iv milestone bundles that is not claimable due to less than full achievement of the related milestones will be forfeited and either remains unclaimed or using the authority in STC #37 entitled Restricted Use of SNCP Funds, could be rolled over for use in other SNCP categories subject to CMS approval.

D. Reallocation of DSRIP to other SNCP categories

By January 1, 2015, the State will have identified unclaimable amounts from the DSRIP that it is seeking to roll-over for use in other SNCP categories. The State will propose for CMS approval the particular Demonstration year and dollar amounts being sought for roll-over and will specify which SNCP category the funding would be rolled into and will request CMS approval for roll-over prior to the expiration of the Demonstration.

VIII. Support for DSRIP Evaluation

Pursuant to paragraph 25 (f) of the Special Terms and Conditions (STCs), the state will submit a complete evaluation plan for the DSRIP components of the demonstration to CMS for approval, by no later than October 1, 2013, in accordance with the requirements of STC 27. By no later than October 1, 2014, the state will submit interim evaluation findings to CMS, pursuant paragraph 25 (g) of the STCs in accordance with the requirements of STC 28 and 42 C.F.R. 431.424. Designated Public Hospitals (DPHs) participating in DSRIP are required to reimburse the department up to $500,000, distributed on a pro rata basis, in DY 9 , through DY 10 for the cost of evaluating the DSRIP program in DY 6 through DY 10. The pro rata distribution is based on each DPH's DY 9 and DY 10 DSRIP allocation. DHCS will use the reimbursement as the non-federal share to claim matching federal funds, and will use the reimbursement and matching federal funds to pay for the evaluation, as permitted under the state plan.

If the selected contractor for the external evaluation elects to certify their own expenditures for any portion of the non-federal share of the cost of the evaluation, DHCS will reduce the DPH's reimbursement by the amount of the non-federal share of the payment that is received via the Certified Public Expenditure (CPE) process from the selected contractor. DHCS will use the CPEs from the selected contractor as the non-federal share to claim matching federal funds, and will use the CPEs and the matching federal funds to pay for the DSRIP evaluation, as permitted under the state plan.

Attachment P – Supplement 1
DSRIP Category 5 HIV Transition Projects

The purpose of this Attachment P–Supplement 1 is to set forth the mechanics for each DPH system that chooses to participate in DSRIP Category 5 HIV Transition Projects (Category 5). All components of this Supplement are specific to only those DPHs that participate.

I. Review Process

A. DHCS Review Process

For each DPH system that chooses to participate in Category 5 of the DSRIP, the DHCS will review their proposed modifications to their 5-year SNCP Delivery System Reform Incentive Pool (DSRIP) plan prior to submission to CMS for final approval according to the following timeline:

7. By **November 15, 2012**, each DPH system that has chosen to participate in Category 5, will submit a proposed modification to their 5-year DSRIP plan to DHCS, which includes the Category 5 projects, related performance measures, and shared learning objectives for review. The DSRIP Plan Modification Guidelines provide guidance on documentation formatting for submission.

8. DHCS shall review each proposed plan modification to verify that it conforms to the requirements for Category 5, as described in Section II of this Attachment P - Supplement 1, Key Elements of Proposed Plans. Included in the DHCS review will be a state-level stakeholder review of the local stakeholder engagement process. By **November 21, 2012**, DHCS will complete its review of each proposed plan modification, and will respond to each DPH system in writing with any questions, concerns or problems identified.

9. The DPH system will respond to DHCS' questions and concerns in writing by **November 28, 2012.**

10. By **December 3, 2012**, DHCS will approve each DPH system's proposed plan modification for Category 5 and submit it to CMS for final review and approval as described in section I.B of this Attachment P – Supplement 1.

B. CMS Review Process

The following review process for DPH system proposed modifications that have been reviewed and approved by California DHCS will result in approval by CMS within 30 days of receipt from DHCS.

5. CMS will review each DPH system's plan modifications to their 5-year DSRIP plan for Category 5 upon receipt of the proposed modifications as approved by DHCS pursuant to I.A.4 of this Attachment P Supplement 1. CMS' review will assess whether each proposed modified 5-year DSRIP plan as approved by DHCS has the following elements:

    c. The proposed modification is in the format as described in the applicable DSRIP program description within these special terms and conditions.
    d. Category 5 projects must clearly identify goals, milestones and expected results. Plans must identify, by six-month period, the applicable milestones in accordance with the descriptions and examples identified in Attachment Q - Supplement 1.

6. By **January 4, 2013**, CMS will complete a review of each DPH system's proposal for DSRIP Category 5 HIV Transition Projects and will either notify DHCS of approval of the proposed DSRIP Category 5 HIV Transition Project plan (HIV Transition Project plan) or that approval will not be granted for the proposed plan. Notice will be in writing.

If approval has not been granted, the notice will include any questions, concerns or problems identified in the proposed plan. DHCS will collaborate with the DPH system and respond to the CMS notice within 3 business days.

II. Key Elements of Proposed Plans

8. Participating DPH systems will submit modifications to their 5-year DSRIP plans that include projects for Category 5. The DPH system submission will describe how the projects included in the modifications to their plan are related to each other and how, taken together, they support delivery system reform relevant to the applicable patient population.

9. Each modified DPH system 5-year DSRIP plan will include an Introduction that includes, but is not limited to, the following sections:

    a. A Background section on the DPH system(s) covered by modifications to the 5-year DSRIP plan that includes an overview of the applicable patients served by the DPH system(s); and

    b. An Executive Summary section for modifications to the 5-year plan that summarizes the high-level challenges the DSRIP plan is intended to address and target goals and objectives included in the plan.

    c. A description of their stakeholder engagement process

10. The DPH system modified 5-year plan will include sections on Category 5 as specified in Attachment Q - Supplement 1.

11. Category 5– HIV Transition - Category 5a – Improvements in Infrastructure and Program Design

    a. Each plan will include projects and milestones that are designed to improve how care is delivered to HIV patients with an emphasis on ensuring efficient coordination of services among providers.
    b. Each DPH system plan must select three (3) and only three (3) projects for Category 5(a) in accordance with the Category 5a Projects in Attachment Q - Supplement 1, which lists the acceptable projects, measures, metrics, and data sources, provided that some milestones must be achieved in DY 8 and some must be achieved in the first half of DY 9.
    c. For each project selected for Category 5a, DPH system plans must include a narrative that includes the following subsections:
        i. The Goal(s) for the project, which describes the challenge(s) faced by the DPH system and the major delivery system solution(s) identified to address those challenge(s) by implementing the particular project; the starting point of the DPH system(s) related to the project and based on that, the target goal and the significance of that goal to the DPH system(s) and its patients. As part of this subsection, each DPH system will provide its reasons for selecting the project, milestones, and metrics based on relevancy to the DPH system's population and circumstances, community need, and DPH system priority and starting point; and
    d. Category 5a. - Milestones and Metrics Table:
        i. All projects must include milestones based on projects, measures, metrics, and data sources in accordance with the Category 5a Projects in Attachment Q - Supplement 1.
        ii. The milestones shall be designated by project in six (6) month intervals in table format.

12. Category 5 HIV Transition - Category 5b – Improvements in Clinical and Operational Outcomes

a. Each DPH system plan must include the six (6) required Category 5b core clinical performance measures set forth in Group 1, Category 5b in Attachment Q - Supplement 1.
b. Each DPH system plan must include an additional four (4) and only four (4) performance measures from within the superset of Category 5b performance measures in Groups 2 and 3, and the Medical Case Management Group, Category 5b in Attachment Q - Supplement 1. Plans must indicate the reasons for choosing the four (4) additional performance measures selected, including their significance for the DPH system and its patients.
c. Improvement Targets will be established for each required measure within the Category 5b activities, as pursuant to Category 5b in Attachment Q - Supplement 1.
d. The DPH system plan will include the following subsections for each Category 5b performance measure selected:
    i. A Key Challenge(s) subsection that describes the key challenge(s) the project is designed to address;
    ii. A Major Delivery System Solution(s) subsection that describes the performance measure selected by the DPH system and the target goals and objectives; and
    iii. A Milestones and Metrics table that includes the milestones per measure per six-month period based on the measures specified in or otherwise in accordance with Category 5b in Attachment Q - Supplement 1.
e. Category 5 Milestones and Metrics Table:
    i. All projects must include milestones based on projects, measures, metrics, data sources, and improvement targets in accordance with the Category 5b in Attachment Q - Supplement 1.

III. Reporting, Assessment and Modification Process

During the term of Category 5, all of the reporting and plan modification requirements set forth in section IV of Attachment P shall be applicable for Category 5, excluding Section IV.B. – Midpoint Assessment, which is not applicable to Category 5 reporting requirements.

IV. Disbursement of Category 5 Pool Funds

4. Each DPH system will be individually responsible for progress towards and achievement of its milestones in Category 5 in order to receive its potential incentive funding from the pool. Every 6 months, eligible DPH systems will be able to receive incentive payments related to achievement within milestones.

5. In order to receive incentive funding related to any milestone, the DPH system must submit the required Semi-Annual Report as described above in Attachment P section IV(A)(1).

6. Available Funding – Coinciding with the term of the LIHP component of the Demonstration, a total of $110 million (total computable) in DSRIP Category 5 HIV Transition project payments will be available for SFY 2012-13, and $55 million (total computable) will be available for the July 1, 2013-December 31, 2013, six (6) month period. The total available payments will be consistent with the Demonstration budget neutrality limit.

7. The available DSRIP Category 5 funding for each of the two (2) periods will be allocated to DPH systems based on the relative numbers of HIV patients who will be transitioned and the necessary extent of delivery system reform efforts to be undertaken by an LIHP within the DPH county (using the estimated amounts of AIDS Drugs Assistance Program expenditures as a proxy, adjusted by the income eligibility limit of the county's LIHP program as of July 1, 2012). The

allocation of the available funding in this manner will ensure that dollars rewarded reflect the impact of the transition of ADAP and Ryan White services to the LIHP in a DPH county.

8. Each DPH system's total allotment of funding will be allocated equally between Category 5a (50%) and Category 5b (50%).
9. As described in Attachment Q – Supplement 1, each participating DPH system is required to undertake three projects within Category 5a, and report data on ten performance measures within Category 5b. Projects within Category 5a will be equally weighted and projects within Category 5b will be equally weighted. Thus, each of the three Category 5a projects for a DPH system will be weighted such that full achievement of the particular project's milestones will result in incentive payments equal to one-sixth of the DPH system's total allocated Category 5 DSRIP amount. With respect to each of the ten (10) Category 5b performance measures for which it reports, a DPH system will receive an incentive payment equal to one-twentieth of its total allocated Category 5 DSRIP amount.
10. Payment amounts will be disbursed semi-annually, as set forth below.

    a. *Category 5a*

    All Category 5a projects will include milestones that are measurable. Given the varied nature of the projects and the hospital systems, the metrics will be determined by each specific DPH system in its HIV Transition Plan, consistent with the guidelines set forth in the DSRIP Category 5 sections in Attachment Q – Supplement 1. DPH system HIV Transition Project plans will specify the milestones by improvement project for each six-month period. Each DPH system will be individually responsible for progress towards and achievement of its milestones in order to receive its potential Category 5a incentive funding.

    Every six months, DPH systems will be able to receive incentive payments related to achievement of milestones. To receive funding related to any milestone, the DPH system must submit the required Semi-annual Report as described in section IV.A.1 of Attachment P. The amount of the incentive funding paid to a DPH system will be based on the amount of progress made toward each milestone, pursuant to the application of achievement values described in section VI.6 of Attachment P.

    b. *Category 5b*

    Category 5b activities consist of reporting data for the selected ten (10) performance measures, each of which are equally weighted for purposes of receiving incentive payments. The performance measures will be consistent with the guidelines set forth in the DSRIP Category 5 sections in Attachment 1 – Supplement 1. Data reporting and submission requirements as well as the incentive payment structure for Category 5b are set forth below in Table 1. DPH systems will be required to collect and report baseline performance data within six (6) months of the HIV Transition Project plan, and develop performance targets and report on progress in achieving performance targets, as further delineated in Table 1 below.

    Payment for Category 5b activities is available semi-annually, as set forth in Table 1. To receive funding, the DPH system must submit the required Semi-annual Report as described in section IV.A.1 of Attachment P.

Attachment P – Supplement 1
DSRIP Category 5 HIV Transition Projects

Table 1: Category 5b Milestones Data, Reporting and Payment Structure*

Milestone	**Incentive Plan Reporting Period**	**Dates of numerator**	**Dates of denominator**	**Date data submitted**	**Share of Incentive Payment (100% = total 5b funding *per metric* for all three reporting periods) with each six month period weighted equally in total incentive funding**
Report Baseline data to the State	Period 1: July 1, 2012 – December 31, 2012	Any continuous 12 months during calendar years 2011 and 2012	Same as numerator	12/31/2012 (claimed as completed milestone for incentive payment 3/31/2013)	100%/3/2 = 16.67%
Develop performance improvement target	Period 1: July 1, 2012 – December 31, 2012	n/a	n/a	3/31/2013 (with semi-annual report)	100%/3/2 = 16.67%
Report Interim data to the State	Period 2: January 1, 2013 – June 30, 2013	7/1/2012 – 6/30/2013	7/1/2012 – 6/30/2013 –	9/30/2013 (with semi-annual report)	100%/3 = 33.33%
Report Final data to the State to demonstrate achievement of performance improvement targets	Period 3: July 1, 2013 – December 31, 2013	1/1/2013 – 12/31/2013	1/1/2013 – 12/31/2013	3/31/2014 (with semi-annual report)	100%/3 = 33.33%

***Note: each of ten 5b metrics are weighted equally (1/10th of applicable payment due.)**

DSRIP Category 5 project payments are intended to support and reward DPH systems for improvements in their delivery systems that meet the special needs of enrollees diagnosed with HIV/AIDS. As such, the payments are not direct reimbursement for expenditures incurred by the DPH systems in implementing reforms, and are not reimbursement for health care services that are recognized under the Special Terms and Conditions or under the State Plan. The Category 5 project payments are not considered patient care revenue and should not be offset against the

certified public expenditures incurred by DPH systems for health care services, Disproportionate Share Hospital or administrative activities as defined under the STCs and/or under the State plan.

11. *Achievement Value for Milestone (For All Categories)*

    Achievement values for milestones for Category 5 shall be determined in accordance with all Categories in the aggregate as set forth in section VI.6. of Attachment P.

12. *Progress and Payment Reconciliation*

    Progress and Payment Reconciliation for Category 5 shall be determined in accordance with the terms set forth in section VI.6. of Attachment P.

13. *Category 5 Funding Impact on Funding for Other DSRIP Categories*

    Available funding to DPH systems for meeting Category 5 milestones shall be separate from and have no effect on the incentive payment formulas and guidelines set for in Attachment P Sections VI 3, 4 and 5.

VI. Carry-Forward/Reclamation/Reallocation

If a DPH system does not fully achieve a milestone that was specified in its plan for completion in a particular demonstration year, it will be able to carry forward the available incentive funding associated with that milestone until the end of the Demonstration during which the hospital system may complete the milestone and receive full payment.

Any funding related to Category 5 milestones that is not claimable due to less than full achievement of the related milestones will be forfeited and either remains unclaimed or, using the authority in STC #37 entitled Restricted Use of SNCP Funds, could be rolled over for use in other SNCP categories subject to CMS approval.

XIII. I. Introduction

The California Medicaid section 1115 Demonstration special terms and conditions state that the goal of the DSRIP is to "support California's public hospitals efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable and directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement." Through the DSRIP, designated public hospital (DPH) systems seek to transform their delivery systems to:

- Be integrated systems of care in which the elements of the system function together in a highly effective manner on an individual and population basis and where patients can receive the right care at the right time, in the right setting;
- Offer timely, proactive, coordinated medical home care from a multi-disciplinary team that is highly adept at managing chronic disease;
- Provide patients with positive health care experiences;
- Deliver proactive and planned prevention and primary care services for all patients, and expand the primary care workforce to increase capacity and enable increased patient access;
- Deliver high-quality care and be an engine for ongoing improvement in quality, safety, and efficiency; and
- Provide equitable care and an equitable opportunity for health that is tailored to patient-specific health care needs, desires and backgrounds in a respectful manner.

In order to achieve this vision, DPH systems' DSRIP plans include Population-Focused Improvement (Category 3) and Urgent Improvement in Care (Category 4). This work is enabled and bolstered by a broad array of projects related to Innovation and Redesign (Category 2) and Infrastructure Development (Category 1).

This document includes the improvement projects for DSRIP Categories 1-2, from which DPH systems may choose to include in their plans. The projects demonstrate the focus areas, milestones, and metrics represented by the DPH systems' plans. Each DPH system will provide the rationale for focusing on the particular projects, milestones and metrics most relevant to its population and circumstances. The measures are evidence-based and vetted by nationally recognized organizations where possible; in other cases where measures are remaining to be defined, DPH systems will serve as a learning laboratory to test and validate measures.[3]

The example milestones and metrics listed under projects included in this document are not meant to be adopted by every DPH that chooses that improvement project, but rather demonstrates the use of a "menu set" to arrive at a comprehensive array of potential improvement activities and ways to measure progress. However, it is important to note that the

[3] Please see Appendix A: *Evidence-Based Models Implemented by California Public Hospital Systems to Enhance Quality, Promote Coordinated Care, Build Medical Homes and Ensure Access*, below, which was also provided to CMS by the California Health Care Safety Net Institute on November 29, 2010.

overall undergirding of the interventions (i.e., the models and constructs) is similar across the DPH systems.
Together, these plans, and the delivery system transformation they describe, will position and prepare DPH systems for full implementation of health care reform.

Interconnection and Shared Orientation of Improvement Projects:
The diagram below demonstrates the interconnection of the improvement projects being pursued by DPH systems, with an overall goal of becoming more integrated, coordinated systems of care, by underscoring:

- While they are highly related projects, each improvement project is distinct;
- All of the proposed improvement projects are oriented to creating more integrated, coordinated delivery systems; and
- Being an integrated delivery system allows DPH systems to more fully enact improved patient experience, population health and cost control.

For purposes of space, the bullet points in the below diagram represent *select*, but not all, Categories 1-4 improvement projects to demonstrate that multiple, complementary initiatives will be occurring in the same facilities simultaneously, reinforcing each other in the transformation of care delivery:

The following pages include the comprehensive Categories 1-2 improvement projects, and Appendix B: Example DSRIP Categories 1-2 Plan samples how the projects will be presented in DPH system plans, which was also provided to CMS on 1/18/11.

II. Categories 1-2 Required Plan Elements

- Based on this Categories 1-2 project list and the *Incentive Pool – Review Process and Program Mechanics* in Attachment P, DPH systems will submit five-year DSRIP plans that describe: (1) the reasons for the selection of the projects, based on gaps, needs, and key challenges; (2) how the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population; and (3) the progression of the project year over year, including the specifics and exact data source needed per project per measure per metric per year.
- Categories 1-2 each include a menu set of several projects, from which the DPH system would select at its option (please see the following pages). Each DPH system would choose at least two projects in each of the two categories for at least DY 6, DY 7, and DY 8.
    - Each project includes multiple potential Process Measures (process-oriented) and Improvement Measures (results-oriented) from which a DPH system would choose at least one Process Measure and one Improvement Measure. It should be noted that although most Process Measures have one metric, several projects will likely be occurring in a given facility simultaneously, with the result that a series of related metrics will apply.

- For each project selected for Categories 1-2, DPH system plans must include a robust narrative that includes the following subsections:
  - The Goal(s) for the project, which describes: (1) the specific challenge(s) faced by the DPH system, such as a specific gap, need, or issue; (2) the major delivery system solution(s) identified to address the challenge(s) by implementing the particular project, including explaining how the project will work to fill the gap/need or solve the issue; (3) the starting point of the DPH system(s) related to the project, such as a benchmark, if one exists, and/or the baseline starting no earlier than July 2009 for the Improvement Measures; and (4) the overall target goal and the significance of that goal to the DPH system(s) and its patients. As part of this subsection, each DPH system will provide its reasons for selecting the project, milestones, metrics, improvements, and targeted goals based on relevancy to the DPH system's population and circumstances, community need, and DPH system priority and starting point.
  - Related DSRIP Projects, which describes how this project supports, reinforces, enables, and is related to other projects and interventions within the DPH system plan. For example, a plan may include the project to Expand Primary Care Capacity in Category 1, and the projects Expanding the Medical Home Model and Redesigning Primary Care in Category 2. The plan could describe how expanding primary care capacity was related to being able to expand the medical home model and redesign primary care, which be occuring in the same clinics, if applicable. Finally, in this component, the plan would, for example, describe how all of these projects in sum are critical to being able to improve preventive screening rates and improve chronic care outcomes, as measured in Category 3. This is because the capacity, access, and efficiency implemented in the primary care clinics – along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner – are foundational to being able to bring in the right patients at the right time to make sure planned, proactive and organized care is delivered.
  - Related Federal Projects, which describes how this project complements any related projects that are being funded by the Department of Health and Human Services (if applicable). Per OMB Circular A-87, to be allowable under Federal awards, costs must not be included as a cost or used to meet cost sharing or matching requirements of any other Federal award in either the current or a prior period, except as specifically provided by Federal law or regulation.

- In addition to the narrative, the plan will include a Milestones and Metrics Table for each Categories 1-2 project.
  - All projects must include specific, measurable milestones based on projects, measures, metrics, and data sources selected from or otherwise in accordance with this document.

- The milestones shall be designated by project by year in table format.
- For each milestone, the DPH system plan must include the metric(s) being selected from or otherwise in accordance with the Categories 1-2 Projects document.
- Even though the measure may be selected for more than one year, in each year, the milestone will be uniquely specified to include the particular improvement and specific data source(s) for that year.

III. Sample Project

The DPH system Categories 1-2 plans would resemble the sample project below, as well as the larger sample plan provided as Appendix B in this document:

Primary Care Redesign: Sample Project Narrative

- **Goal:** We currently have about 1,800 patients waiting for primary care medical home appointments. It may be difficult for the patient to get a primary care appointment in a timely manner due to traditional office hours and the practice of medicine structured around the physician, not around the patient. In order to address this challenge, Public Hospital System A will redesign primary care to achieve increased efficiencies to maximize the capacity we already have. This plan seeks to build upon work we have started to standardize clinic-level data across Public Hospital System A so that we can better understand cycle time, wait times for primary care, and patient satisfaction. In order to do this, we propose to: (1) Build internal capacity with the resources we already have through implemented efficiencies that will reduce primary care cycle times, patient no-show rates, and days to third next available appointments; and (2) Implement the Patient Centered Scheduling Model so that patients can get in to see their primary care team when needed and when it is convenient for the patient to enable expanded access to primary care. Historically at Public Hospital System A, patient appointment "no-show" rates have been as high as 30%.

- **Expected Result:** Patient "no-show" to appointment rate is less than 10% as a result of improved access when it is convenient for the patient, and due to establishing an ongoing relationship with his/her care team that reinforces continuity of care.

- **Relation to Category 3 Population-Focused Improvement:** With increased access to primary care, patients are better able to receive preventive, primary and ongoing care, developing a continuity of care with their primary care team.

Sample Project Milestones and Metrics Table: Primary Care Redesign					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
1. **Milestone:** Develop a plan to build capacity into primary care team schedules, including use of the Patient Centered Scheduling Model and resourcing and training staff in order to reduce patient appointment "no-show" rates • **Metric:** Documentation of the plan, including workplan and timeframes.	**2. Milestone:** Achieve at least a 25% or lower patient no-show rate for primary care medical homes[4] due to enhanced continuity of care and lasting relationships established between the provider and the patient • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	**3. Milestone:** Achieve at least a 12% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	**4. Milestone:** Achieve at least a 10% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	**5. Milestone:** Maintain 10% or lower patient no-show rate for primary care medical homes in order to demonstrate sustainability of the improvement for at least 4 consecutive quarters • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	• Improve Preventive Screening Rates (Cat. 3) • Improve Chronic Care Outcomes (Cat. 3) • Reduce Readmissions (Cat. 3)

[4] For this and other milestones using this measure, measurement is determined based on the percentage of the patients scheduled for each session who did not show up for their medical home visit. The rate is an average measured monthly. This measurement would be based on the most recent reporting month.

IV. Explanation of the Format of this Document

As illustrated above, the DPH system will follow the guidelines in this document and provide specificity in its plan. The following Categories 1-2 projects are laid out to include the following components, which provide instruction to the DPH system of what to include in the plan:

- **Goal of Project:** This component describes the purpose of the project. DPH system plans would include narrative description on this component that is specific to that DPH system's starting point, particular circumstances, and its and its patients' needs.

- **Potential Project Elements:** This component describes the types of high-level activities that the DPH systems may undertake in order to accomplish the described goals for the project in their plans.

- **Related Projects:** In order to demonstrate clearly the Interconnection and Shared Orientation of Improvement Projects (see page 2 above), this component describes how the project supports and reinforces other projects/interventions. This component underscores that the projects selected by the DPH system are inter-related and occurring simultaneously, often in the same facilities. This component will also describe how the Categories 1-2 projects selected are foundational to the success of work in Categories 3-4.

- **Key Measures:** This component includes the measures from which the DPH system would choose:

    - **Process Measures:** These measures are important process steps leading toward process results.

    - **Improvement Measures:** These measures are the process (as opposed to clinical) results of the project.

    - **Metric:** For the measure selected, the metric listed would be incorporated by the DPH system plans. However, the DPH system *in its plan* would include the specific targets of the metric.

        - The metric may vary over the life of the project; for example, the targeted patient appointment 'no-show' rate as a result of primary care redesign may be specified as 12% for DY 7 and less than 10% for DY 8 (the goal is to lower the rate).

        - The DPH system may tailor the metric, such as selecting an absolute number or a percentage, as appropriate.

    - **Data Source:** The data source often lists multiple sources that could be used for the data being measured. Please note that these options identify appropriate sources of information, but DPH systems may identify alternative sources that are more appropriate to their individual systems and that provide comparable or better information. The DPH system will specify the exact data source being used for the metric per year in the plan; for example, if the DPH system is expanding health care interpretation, in DY 6 the data source may be submission of the expansion plan, and in DY 7, the data source may be documentation of training 6 additional health care interpreters. In other words, the data source must be specific to the metric being used for that year.

- **Rationale/Evidence:** This describes why the metric is reasonable, including academic citations, descriptions of how widely used the metric is in the industry, and other reasons why the metric is seen as the appropriate data to meaningfully measure improvement.

Additional Measures

In an effort to avoid repetition, it is permissable for each project to include any one of the following as Measures, in addition to or in lieu of the other Measures listed. Each is in the spirit of continuous improvement, and applying and sharing learnings. If a plan elects to use one or more of these Measures, the DPH system plan would describe the related specifics for the measure, such as the metric and data source:

13. Process Measures:

    i. Participate in a collaborative (e.g., in DY 6, Join the Patient Safety First collaborative, as documented by the membership agreement)

    ii. Conduct a needs/gap analysis, in order to inform the establishment or expansion of services/programs (e.g., in DY6, conduct a gap analysis of high-impact specialty services to identify those in most demand by the local community in order to expand specialty care capacity targeted to those specialties most needed by patients)

    iii. Pilot a new process and/or program

    iv. Assess efficacy of processes in place and recommend process improvements to implement, if any (e.g., in DY 8, evaluate whether the primary care redesign methodology was as effective as it could be, by: (1) performing at least two team-based Plan-Do-Study-Act workshops in the primary care clinics; (2) documenting whether the anticipated metric improvements were met; (3) identifying opportunities, if any, to improve on the redesign methodology, as documented by the assessment document capturing each of these items)

    v. Redesign the process in order to be more effective, incorporating learnings (e.g., in DY 9, incorporate at least one new element into the process based on the assessment, using the process modification process to include the specificity needed as new learnings are discovered in DY 8)

    vi. Implement a new, improved practice piloted in one or more parts of the DPH system in other parts of the DPH system (e.g., in DY 10, implement improved practices across the Medical Center ambulatory care setting)

    vii. Share learnings from implementing process improvements, such as through presentations, reporting, etc. (e.g., in DY 8, present the results and findings from the redesign work to at least two peer organizations and/or convenings of peer organizations, as documented by the presentation delivered and the agenda)

    viii. Establish a baseline, in order to measure improvement over self

    ix. Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infastructure development or program/process redesign (e.g., in DY 6, complete a planning process for a care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care)

    x. Designate/hire personnel or teams to support and/or manage the project/intervention

    xi. Implement, adopt, upgrade, or improve technology to support the project

    xii. Develop a new methodology, or refine an existing one, based on learnings

xiii. Incorporate patient experience surveying

b. Improvement Measure: Report on / Improve patient satisfaction/experience (e.g., in DY 10, improve primary care clinic patient satisfaction scores as a result of redesigning clinic visits)

V. Categories 1-2 Projects

Please find the Categories 1-2 Projects listed by category below.

XIV. Proposed Category 1 Improvement Projects

Proposed Category 1 Improvement Projects

Per the California Section 1115 Waiver Terms and Conditions, the purpose of Category 1: Infrastructure Development is "investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services." Therefore, Category 1 would include infrastructure development, including investment in people, places, processes and technology. This category is foundational to the success of Categories 2-4. DPH system plans must describe how the infrastructure development will enhance capacity to conduct, measure and report on quality/performance improvement, expand access to meet demand, and/or enable improved care with strong emphasis on building coordinated systems that promote preventive, primary care.

The following improvement projects as specified would be acceptable for DPH systems to include in their Category 1 plans, using similar formatting as shown below in Appendix B: Example DSRIP Categories 1-2 Plan:

1. Expand Primary Care Capacity 354
2. Increase Training of Primary Care Workforce 357
3. Implement and Utilize Disease Management Registry Functionality 362
4. Enhance Interpretation Services and Culturally Competent Care 366
5. Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities 370
6. Enhance Urgent Medical Advice 373
7. Introduce Telemedicine 376
8. Enhance Coding and Documentation for Quality Data 378
9. Develop Risk Stratification Capabilities/Functionalities 382
10. Expand Capacity to Provide Specialty Care Access in the Primary Care Setting 384
11. Expand Specialty Care Capacity 387
12. Enhance Performance Improvement and Reporting Capacity 390

1. Expand Primary Care Capacity

- Goal of Project: Expand the capacity of primary care to better accommodate the needs of the patient population and community so that patients can receive the right care at the right time in the right setting

- Potential Project Elements:
    - Establish more primary care clinics
    - Expand primary care clinic space
    - Expand primary care clinic hours
    - Expand primary care clinic staffing
    - Expand primary care clinic staffing knowledge

- Related Projects (DPH system will specify all of those other category projects this project would feed into):
    - Reduce Readmissions (Cat. 3)
    - Improve Screening Rates (Cat. 3)
    - Improve Chronic Care Management and Outcomes (Cat. 3)
    - Expand Medical Homes (Cat. 2)
    - Redesign Primary Care (Cat. 2)
    - Integrate Physical-Behavioral Health Care (Cat. 2)
    - Redesign for Cost Containment (Cat. 2)
    - Other

- Key Measures:
    - **Process Measures:**
        i. Measure: Establish additional/expand existing/relocate primary care clinics
            1. Metric: Number of additional clinics or expanded hours or space
                a. Documentation of expansion
                b. Data Source: New primary care schedule or other hospital document
                c. Rationale/Evidence: It is well known the national supply of primary care does not meet the demand for primary care services. Moreover, it is a goal of health care reform to provide more preventive and primary care in order to keep individuals and families healthy and therefore

avoid more costly ER and inpatient care. DPH systems are in real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

ii. Measure: Implement/expand a community/school-based clinics program

1. Metric: Number of additional clinics or expanded hours or space

a. Documentation of expansion

b. Data Source: New primary care schedule or other hospital document

c. Rationale/Evidence: Providing clinics in the community and/or in schools has been shown to be effective because the health care is located conveniently for patients, and is in a setting that is familiar and may feel 'safe'.

iii. Measure: Implement/expand a mobile health clinic program

1. Metric: Number of additional clinics or expanded hours or space

a. Documentation of expansion

b. Data Source: New primary care schedule or other hospital document

c. Rationale/Evidence: Many DPH systems cover very large counties, including hundreds of miles. In some areas, it may take patients hours to drive to DPH system facilities. Therefore, a mobile clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively.

iv. Measure: Expand the hours of a primary care clinic, including both evening and/or weekend hours

1. Metric: Increased number of hours at primary care clinic over baseline

a. Data Source: Clinic documentation

b. Rationale/Evidence: Expanded hours can not only allow for more patients to be seen, but also provides more choice for patients.

v. Measure: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers

1. Metric: Documentation of completion of all items described by the DPH system plan for this measure.

a. Data Source: Hospital report, policy, contract or other documentation

vi. Measure: Implement a nurse triage software system to assist nurses in determining the acuity of patients

1. Metric: Documentation of vendor agreement

a. Data Source: Vendor agreement

vii. Measure: Establish a nurse advice line and/or primary care patient appointment unit

1. Metric: DPH system administrative reports

viii. Measure: Develop automated tracking system for measuring time to next available offered appointment at DPH system primary care medical homes for non-urgent needs

1. Metric: DPH system administrative records from patient scheduling system

ix. Measure: Develop and implement a plan for proactive management of adult medicine patient panels through a new Office of Panel Management, such that same-store panel capacity is increased and optimized going forward. This intervention will reopen and optimize use of available adult medicine panel capacity (must include at least one metric):

1. Metric: Documentation of Office of Panel Management plan, staff assignments, policies and procedures. Documentation of the panel status (open/ closed) and panel capacity at points in time.

2. Metric: Documentation of panel management dynamics (counts of additions, deletions, and total paneled patients) and results of initial panel "cleaning".

x. Measure: Expand episodic care capacity at primary care clinics.

- **Improvement Measures:**

i. Measure: Patient access to primary care by reducing days to third next-available appointment

a. Metric: Third Next-Available Appointment

i. The length of time in calendar days between the day a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be 7 calendar days (lower is better), but depending on the DPH system's starting point, that may not be possible within five years.

ii. Data Source: Practice management or scheduling systems

iii. Rationale/Evidence: This measure is an industry standard of patients' access to care. For example, the IHI definition white paper on whole system measures sites this metric.

ii. Measure: Increase primary care clinic volume

a. Metric: Number of visits, encounters or size of patient panels over baseline

i. Data Source: Registry, EHR, claims or other DPH source

ii. Rationale/Evidence: This measures the increased volume.

iii. Measure: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within X calendar days of request

iv. Measure: Achieve a call abandonment rate for the nurse advice line and patient scheduling unit

a. Metric: Automated data on call abandonment rate

2. Increase Training of Primary Care Workforce

- Project Goal: The 21 California DPH systems train 43% of new doctors in the state. As we move towards the implementation of health care reform in 2014, the nation will continue to face a major shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in California is a critical problem that we have the opportunity to begin addressing under the next waiver. California barely meets the nationally recognized standard for supply of primary care physicians. Over the last several years, it has become difficult for public hospitals to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in public hospital clinics. Expanding the primary care workforce will increase access and capacity, and help create an organized structure of primary care providers, clinicians and staff. Moreover, it will strengthen an integrated health care system and play a key role in implementing disease management programs. The new primary care workforce will also be trained to operate in patient-centered medical homes. A greater focus on primary care will be crucial to the success of an integrated health care system under health care reform. As more patients are covered under the Affordable Care Act, it will be essential to increase the number of primary care workforce personnel in order to meet the demands and needs of these newly covered patients. Furthermore, in order to effectively operate in a medical home model, there is a need for residency and training programs to enable expanded capabilities of primary care providers and other staff to effectively provide team-based care and manage population health. Therefore, the need to expand the responsibilities of primary care workforce members will be even more important. In summary, the goal for this project is to train more workforce members to serve as primary care providers, clinicians, and staff to help address the substantial primary care workforce shortage, *and* to update training programs to include more organized care delivery models. This project may apply to primary care physicians (including residents in training), nurse practitioners, physician assistants, and other clinicians/staff (e.g., health coaches, *promotoras*) in the following service areas: family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics.

- Potential Project Elements:
    - Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, and/or quality/performance improvement

- Increase the number of primary care residents (i.e., physicians)/trainees (i.e., nurse practitioners, physician's assistants and other clinicians/staff, such as health coaches and *promotoras*)
- Increase the number of residency/training program faculty/staff to support an expanded, more updated program
- Increase the number of residents/trainees *choosing* primary care as a career
- Establish/expand primary care training programs

- Related Projects:
  - Reduce Readmissions (Cat. 3)
  - Improve Screening Rates (Cat. 3)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Expand Medical Homes (Cat. 2)
  - Redesign Primary Care (Cat. 2)
  - Expand Primary Care Capacity (Cat. 1)
  - Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Expand primary care training, (must include at least one of the following metrics):
       a. Metric: Expand the primary care residency, mid-level provider (MLP – physician assistants and nurse practitioners), and/or other clinician/staff (e.g., health coaches, *promotoras*) training programs and/or rotations
          i. Documentation of applications and agreements to expand training programs
          ii. Data Source: Training program documentation
          iii. Rationale/Evidence: Increasing primary care training may help address the primary care workforce shortage.
       b. Metric: Hire additional precepting primary care faculty members
          i. Number of additional training faculty/staff members
          ii. Data Source: HR documents, faculty lists, or other documentation

iii. Rationale/Evidence: More faculty is needed to expand training programs.

ii. Measure: Expand positive primary care exposure for residents/trainees, (must include at least one of the following metrics):

a. Metric: Develop mentoring program with primary care faculty and new trainees

i. Documentation of program

ii. Data Source: Mentoring program curriculum and/or program participant list

iii. Rationale/Evidence: Mentoring programs have been found to foster primary care trainees' interest in pursuing primary care careers.

b. Metric: Train trainees in the medical home model, chronic Care Model and/or disease registry use / Primary care trainees participate in medical homes by managing panels

i. Documentation of program

ii. Data Source: Curriculum, rotation hours, and/or patient panels assigned to resident/trainee

iii. Rationale/Evidence: Training programs in primary care should reflect the evolving primary care delivery models.

c. Metric: Include trainees/rotations in quality improvement projects

i. Documentation of program

ii. Data Source: Curriculum and/or quality improvement project documentation/data

iii. Rationale/Evidence: Including primary care trainees in quality improvement has been linked to trainee satisfaction with primary care.

iii. Measure: Develop and implement a curriculum for residents to utilize their practice data to demonstrate skills in quality assessment and improvement

a. Metric: Documentation of curricular content in residency program training manuals

iv. Measure: Implement loan repayment program for primary care providers

a. Metric: Documentation of program

i. Data Source: Program materials

ii. Rationale/Evidence: Loan repayment programs can help to make primary care more attractive.

v. Measure: Create a primary care career pipeline program for secondary school students (optional – specifications to be provided in DPH system plan)

vi. Measure: Establish/expand a faculty development program

a. Metric: Enrollment of faculty staff into primary care education and training program

i. Data Source: Program documents

vii. Measure: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites

a. Metric: Clinical teaching tool

i. Submission of teaching tools

viii. Measure: Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents

a. Metric: Documentation of ACGME approval for residency position expansion

- **Improvement Measures:**

i. Measure: Increase primary care training and/or rotations (must select one of the following metric):

a. Metric: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline. Trainees may include physicians, mid-level providers (physician assistants and nurse practitioners), and/or other clinicians/staff (e.g., health coaches, *promotoras*).

i. Data Source: Documented enrollment by class by year by primary care training program

ii. Rationale/Evidence: As the goal is to increase the primary care workforce to better meet the need for primary care in the health care system by increasing training of the primary care workforce in California, the metric is a straightforward measurement of increased training.

b. Metric: Increase the number or primary care trainees rotating at the DPH system

i. Data Source: Student/trainee rotation schedule

c. Metric: Increase the number or percent of culturally-competent trainees eligible for existing California residency programs

d. Metric: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline or by absolute number

ii. Measure: Recruit/hire more trainees/graduates to primary care positions in DPH system

a. Metric: Percent change in number of graduates/trainees accepting positions in the DPH system over baseline

i. Data Source: Documentation, such as HR documents compared to class lists

ii. Rationale/Evidence: A measure of the success of the training program is how many graduates are choosing to practice primary care at the DPH system.

iii. Measure: Increase the number/proportion of primary care residency/trainee graduates choosing primary care as a career

a. Metric: Number of primary care residency/trainee graduates choosing primary care as a career

i. Numerator: Number of class year residency/trainee graduates choosing primary care as a career

ii. Denominator: Number of class year residency/trainee graduates

iii. Data Source: Program documentation

iv. Rationale/Evidence: Measures success of process measures.

iv. Measure: Increase the number of faculty staff completing educational courses

a. Metric: Number of staff completing courses

v. Measure: Increase primary care training in Continuity Clinics,[5] which may be in diverse, low-income, community-based settings, (must include at least one of the following metrics):

a. Metric: Add scheduled Continuity Clinic sessions

i. Data Source: Number of trainee office visits, such as from registry, EHR, claims data or other reports

ii. Rationale/Evidence: Residents/trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients.

b. Metric: Assign a Continuity Clinic patient panel to primary care residents

[5] Per the Accreditation Council for Graduate Medical Education (ACGME), "Setting for a longitudinal experience in which residents develop a continuous, long-term therapeutic relationship with a panel of patients." All internal medicine residents typically have continuity clinics. Categorical residents have it just one afternoon per week (often at the hospital-based primary care clinic). Primary care residents have continuity clinic more often during select months and usually have one continuity clinic at the hospital primary care clinic and another off-site (e.g., community or DPH clinic). For more information, please see http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf.

i. Data Source: Patient panel, registry or EHR

ii. Rationale/Evidence: Residents/trainees have the opportunity to treat patients in the clinic setting, offering the trainee an option to provide continuing care to his/her patients in order to build continuity with his/her patients.

c. Metric: Increase resident's patient clinic roster

3. Implement and Utilize Disease Management Registry Functionality

- Project Goal: Implement infrastructure that supports patient population health, panel management and coordination of care.

- Potential Project Elements:
  - Implement and utilize disease management registry functionalities
  - Enter patient data into the registry

- Related Projects:
  - Define the DPH System Population (Cat. 3)
  - Reduce Readmissions (Cat. 3)
  - Improve Quality (Cat. 3)
  - Reduce Harm from Medical Errors (Cat. 3)
  - Reduce Disparities (Cat. 3)
  - Improve Screening Rates (Cat. 3)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Expand Medical Homes (Cat. 2)
  - Expand Chronic Care Management Models (Cat. 2)
  - Conduct Medication Management (Cat. 2)
  - Implement/Expand Care Transitions Programs (Cat. 2)
  - Other

- Key Measures:
  - **Process Measures:**

i. Measure: Review current registry capability and assess future needs

   a. Metric: Documentation of review of current registry capability and assessment future registry system needs

ii. Measure: Develop cross-functional team to evaluate registry program

   a. Metric: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program

iii. Measure: Implement/expand a functional disease registry

   a. Metric: Disease management registry functionality is available in X% of the DPH system's sites and/or for an expanded number of targeted diseases or clinical conditions

      i. Potential Numerator: Number of sites with disease management registry functionality

      ii. Potential Denominator: Total number of sites

      iii. Registry includes total number of targeted diseases or clinical conditions

      iv. Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation

      v. Rationale/Evidence: Utilization of disease registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care. Having the functionality in as many sites as possible will enable care coordination for patients as they access various services throughout the system. Registry use can be targeted to clinical conditions/diseases most pertinent to the patient population (e.g., diabetes, hypertension, chronic heart failure).

iv. Measure: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status

   a. Metric: Registry automated report on file

      i. Data Source: Registry

      ii. Rationale/Evidence: To be meaningful for panel management and potentially for population health purposes, registry functionality should be able to produce reports for groups or populations of patients that identify clinical indicators.

      iii. Additional related components :

1. Expand registry report services to provide on-demand, operational, and historical capabilities, inclusive of reports to care providers, managers, and executives

2. Expand registry functionality to include electronic structured documentation and clinical decision support at the point of care

v. Measure: Conduct staff training on populating and using the registry function

a. Metric: Documentation of training programs and list of staff members trained, or other similar documentation

i. Data Source: HR or training program materials

ii. Rationale/Evidence: Staff need to be trained on appropriate use of the registry functions in order to optimize its use and efficacy.

vi. Measure: Making patient data in the registry more accurate

a. Metric: Updating patient data based on clinic visit

i. Numerator: Number of updated entries

ii. Denominator: Number of unique patients that are in the registry

iii. Data Source: Registry data report showing entry date

iv. Rationale/Evidence: Need accurate data to best measure patient care improvements

vii. Measure: Create/disseminate protocols for registry-driven reminders and reports for clinicians and providers regarding key health indicators monitoring and management in patients with targeted diseases (select at least one metric):

a. Metric: Documented protocols for the specified conditions and health indicators

i. Data Source: Protocols

b. Metric: Electronic process in place to correctly identify number or percent of screening tests that require additional follow-up

i. Data Source: Process or other reporting documentation

viii. Measure: Review future potential registry platforms and select registry platform

a. Metric: Documentation of review of registry platforms and selection of future registry platform

ix. Measure: Implement cross-functional team to staff registry program

a. Metric: Documentation of personnel (clinical, IT, administrative) assigned to staff registry program

x. Measure: Plan development of/implement tethered registry to capture patients enrolled in chronic disease management program

a. Metric: Documentation of plan / completion of implementation

- **Improvement Measures:**

i. Measure: Enter patient data into the registry

a. Metric: Number/percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition); below are potential specifications:

i. Numerator: Number of patients in registry

ii. Denominator: Number of patients assigned to this clinic for routine care (i.e., the clinic is the "medical home")

iii. Data Source: Registry or EHR

iv. Rationale/Evidence: Supports work of panel management. Establishes patient population for a medical home. (For measurement purposes, a clinic may remove patients from denominator who, once offered a medical home, choose to continue to receive care at multiple sites).

ii. Measure: Number of patient touches recorded in the registry

a. Metric: Total number of in-person and virtual (including email and web-based) visits, either absolute or divided by denominator

i. Numerator: Number of patient touches recorded in the registry

ii. Denominator: Number of targeted patients in the registry (“targeted” as defined by DPH system)

iii. Measure: Spread registry functionality throughout system

a. Metric: Implement disease management registry functionality in X% of the DPH sites providing continuity of care for the defined population

i. Numerator: Number of sites with disease management registry functionality

ii. Denominator: Total number of sites

iv. Measure: Generate registry-based reports for each provider/care team for the care delivered outside the office visit, which may include historical and peer comparisons for protocols

a. Metric: Increase or achieve number or reports sent out to number or percent of primary care providers over the 12-month period.

i. Data Source: Registry and/or EMR

v. Measure: Increase the number of providers/clinicians/staff using the registry

a. Metric: Number of staff using the registry

i. Data Source: Registry report

ii. Rationale/Evidence: The more staff that are using the registry, the most current it will be, and therefore most useful to monitor patients' conditions. Providers can also monitor their patients across the DPH system – primary care to the hospital.

4. Enhance Interpretation Services and Culturally Competent Care

- Project Goal: Patients have access to timely, qualified health care interpreter services in their primary language, thereby increasing the likelihood of safe and effective care, open communication, adherence to treatment protocols, and good outcomes.

- Potential Project Elements:
  - Identify language access needs and/or gaps in language access
  - Implement language access policies and procedures
  - Increase training related to language access and/or cultural competency/sensitivity
  - Expand language access

- Related Projects:
  - Reduce Disparities (Cat. 3)
  - All Categories 3-4 Projects/Interventions
  - Expand Medical Homes (Cat. 2)
  - Expand Chronic Care Management Models (Cat. 2)
  - Redesign Primary Care (Cat. 2)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Use Palliative Care Programs (Cat. 2)
  - Conduct Medication Management (Cat. 2)
  - Implement/Expand Care Transitions Programs (Cat. 2)

- Collect Accurate REAL Data (Cat. 1)
- Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Conduct an analysis to determine gaps in language access
       a. Metric: Gap analysis
          i. Report results of analysis
          ii. Data Source: Gap analysis
          iii. Rationale/Evidence: It is important to identify needs in order to address those needs/gaps.
    ii. Measure: Implement language access policies and procedures
       a. Metric: Submission of policies and procedures, for example based on *Straight Talk: Model Hospital Policies & Procedures on Language Access*
          i. Data Source: DPH system policies and procedures
    iii. Measure: Expand qualified health care interpretation technology
       a. Metric: Video or audio conferencing interpreter terminals and/or areas/units of the DPH system with access to health care interpretation technology, for example:
          i. Number of hospital departments/health system clinics with video or audio conferencing terminals over baseline
          ii. Number of total video or audio conferencing terminals over baseline
    iv. Measure: Upgrade hardware systems to function on a wireless network
    v. Measure: Train/certify additional health care interpreters
       a. Metric: Expand capacity of qualified health care interpretation workforce
          i. Numerator: Number of trained/certified interpreters
          ii. Denominator: Total number of trained/certified interpreters
          iii. Data Source: HR workforce training data, program materials
          iv. Rationale/Evidence: It is important to make sure staff are fully trained and have the proper certifications necessary to optimize their performance in order to increase language access

vi. Measure: Train number or proportion of providers and staff to appropriately utilize health care interpreters (via video, phone or in-person)

a. Metric: Expand language access utilization

i. Numerator: Number of trained providers/staff

ii. Denominator: Total number of relevant providers/staff (relevant as defined by DPH system)

iii. Data Source: HR workforce training data, program materials

iv. Rationale/Evidence: It is important to make sure that providers and staff know when and how to appropriately utilize the qualified health care interpretation services available in order to increase language access.

vii. Measure: Develop program to improve staff cultural competency and awareness

a. Example Metric: Number of champions/staff that are designated and trained in a population's culture and unique needs

i. Data Source: HR workforce training data, program materials

ii. Rationale/Evidence: Cultural competency and awareness can improve patient-provider/staff communication and help to build trust in order to provide equitable and appropriate health care.

viii. Measure: Generate prescription labels in a patient's primary language with easy-to-understand directions

a. Metric: Number of prescriptions labels translated

i. Data Source: Report

ii. Rationale/Evidence: Translation enables appropriate use of prescriptions, helping to prevent incorrect use of medications, which can result in serious health conditions. See *Medical Care* (June 2009).

- **Improvement Measures:**

i. Measure: Improve language access (must select at least one metric):

a. Metric: The number of qualified health care interpreter encounters per month,[6] based on one of the reporting months within the prior year

[6] "Qualified health care interpreter" is defined as one who has: 1) been trained in healthcare interpreting; 2) adheres to the professional code of ethics and protocols of healthcare interpreters; 3) is knowledgeable about medical terminology; and, 4) can accurately and completely render communication from one language to another. This definition can be found in the California Health Care Safety Net Institute's *Straight Talk* recommends hospital policies and procedures to access interpreters that reflect a commitment to language access, including lists of procedures requiring health care interpretation, a definition of qualified health care interpreter, and maximum wait

i. Average number of remote video/voice and/or in-person interpreter encounters recorded per month

ii. Data Source: Automated report (such as from Health Care Interpreter Network or Video Medical Interpretation and/or other encounter data report)

iii. Rationale/Evidence: Interpreter encounters per month is the current industry standard for how to measure language access. DPH systems know that as a result of high numbers of patients whose primary language is not English, the current provision of interpretations is not meeting the demand. Some DPH systems may have estimated the current need, but all know that more encounters are the targeted improvement. There may be other measures seemingly more meaningful, but these measures have not been directly linked to provision of health care interpretation and may instead be the result of that plus multiple environmental factors. Provision of interpreter services results in patients asking more questions, having a better understanding of treatment plans, and reporting higher patient satisfaction scores (Ku, *Health Affairs*, 2005).

b. Metric: The number of remote video/voice and/or in-person interpreter minutes recorded

ii. Measure: Increase number or percent visits by Limited English Proficient patients that are facilitated by qualified health care interpreters

a. Metric: Expand qualified health care interpretation workforce

i. Numerator: The number of visits by Limited English Proficient patients that are facilitated by qualified health care interpreters

ii. Denominator: Total number of visits by Limited English Proficient patients

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: The metric is one way to potentially measure whether demand and supply are aligned, allowing adjustments to be made so that language access is increased.

iii. Measure: Improve Limited English Proficient patients' satisfaction with care and interpreter services

a. Metric: Percent change in patient satisfaction scores over baseline

i. Data Source: Results of patient satisfaction survey

iv. Measure: Reduce wait time for interpretation encounters

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times for the interpretation encounter. Please see http://www.safetynetinstitute.org/content/Upload/AssetMgmt/Site/Publications/documents/StraightTalkFinal.pdf

a. Metric: The percentage of encounters where the patient wait time for an interpreter is 15 minutes or less, as specified in *Speaking Together* measures,[7]orAverage wait time for interpretation encounter, as measured by *Straight Talk: Model Hospital Policies & Procedures on Language Access*

i. Data Source: Interpreter services documentation

5. Collect Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities

- Project Goal: Develop the ability to and collect accurate patient demographic data in a structured format so that it may be stratified by quality/clinical data in order to identify health care process and clinical outcomes disparities.

- Potential Project Elements:
  - Implement a system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify potential health disparities and develop strategies to ensure equitable health outcomes
  - Collect accurate data on race, ethnicity, and language at the point of care
  - Analyze and report on quality outcomes by REAL data categories to identify potential areas of disparities
  - Develop improvement plans to address key factors contributing to the disparities
  - Target and improve identified health outcome disparities
  - Reduce disparities for target patient populations measured through improved rates of preventive care, patient experience, and/or health outcomes

- Related Projects:
  - Reduce Disparities (Cat. 3)
  - All Categories 3-4 Projects/Interventions
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Develop REAL data template and/or integrate it into data warehouse, electronic medical record (EMR), and/or registries

[7] http://www.rwjf.org/qualityequality/product.jsp?id=29660

a. Metric: Develop REAL data template

i. Print screen, report, printout or another source of documentation showing capability to integrate REAL data

ii. Data Source: REAL database, data warehouse, EMR or registry

iii. Rationale/Evidence: The need to collect REAL data is a widely-recognized best practice in the U.S. health care system (e.g., The Joint Commission, the Institute of Medicine, and others). Some extent of REAL data collection is included in both the EHR meaningful use and Affordable Care Act programs.

ii. Measure: Modify registration screens in order to increase the collection of consistent, valid and reliable data

a. Metric: Adequate registration screens in place

i. Submission of registration print-screen

ii. Data Source: Patient registration system

iii. Rationale/Evidence: Patient registration is the primary point of entry of patient REAL data.

iii. Measure: Train staff on the collection of consistent, valid and reliable data

a. Metric: Number or proportion of staff trained

i. Number or percent of staff trained over baseline

ii. Data Source: HR workforce training data

iii. Rationale/Evidence: Staff training is crucial to overcome discomfort at collecting REAL data[8]

iv. Measure: Develop and implement an organizational process to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify potential health disparities and develop strategies to ensure equitable health outcomes / Implement standardized policies and procedures to ensure the consistent and accurate collection of data

a. Metric: Description of elements of the system

i. Documentation of system/processes being implemented

ii. Data Source: Policies, procedures, or other similar sources

iii. Rationale/Evidence: In order to stratify quality and safety measures by REAL data, an organization first needs to establish processes to routinely conduct such review.

[8] See, for example, HRET Disparities Toolkit, http://www.hretdisparities.org

v. Measure: Establish REAL sources of accurate point of care data beginning with current Electronic Medical Record as baseline

vi. Measure: Develop a plan to propagate, establish, and document standard REAL data in all relevant patient care systems participating in enterprise standard registration approach.

- **Improvement Measures:**

i. Measure: Collect accurate REAL data fields as structured data

a. Metric: The number or percent of patients registered at the DPH system hospital and/or health centers

i. Numerator: Number of unique patients registered with designated REAL data fields

ii. Denominator: Number of total unique patients registered

iii. Data Source: Registry, electronic health record, or other registration system

iv. Rationale/Evidence: The capacity to stratify quality data by REAL data is foundational to being able to identify, address and eliminate health care disparities. DPH system hospitals are at the forefront of entering REAL structure data to be utilized to improve equity and quality of health care, and multiple DPH systems have begun the process of utilizing this approach.

ii. Measure: Analyze and report on quality outcomes by REAL data categories to identify potential areas of disparities, (e.g., such as utilization of preventive care, improving patient experience and/or various health outcomes)

a. Metric: REAL data analysis

i. Documentation of REAL data analysis

ii. Data Source: Data warehouse, EMR or registry

iii. Rationale/Evidence: Once accurate REAL data are collected on patients, they must be utilized for quality improvement purposes.[9] All DPH systems will have this as a target goal, but depending on starting point, it may not be possible to do this within five years.

iii. Measure: Develop improvement plans to address key factors contributing to the disparities

a. Metric: Identification of health care disparities and plans to address those that are targeted/prioritized

[9] See, for example, Disparities Solutions Center's Improving Quality and Achieving Equity: A Guide for Hospital Leaders, http://www2.massgeneral.org/disparitiessolutions/guide.html

i. Number of identified disparities and documentation of plans

ii. Data Source: REAL database, data warehouse, EMR or registry

iii. Rationale/Evidence: The purpose of identifying disparities is to ultimately eliminate them through effective quality improvement efforts. All DPH systems will have this as a target goal, but depending on starting point, it may not be possible to do this within five years.

6. Enhance Urgent Medical Advice

- Project Goal: Provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the ED can be reduced.

- Potential Project Elements:
  - Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care.

- Related Projects:
  - Improve Quality (Cat. 3)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Expand Medical Homes (Cat. 2)
  - Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Establish baseline and metrics

    a. Metric: TBD by DPH System

    ii. Measure: Establish clinical protocols

    a. Metric: Submission of complete protocols

    b. Rationale/Evidence: The nurse advice line would use the clinical protocols

    iii. Measure: Train nurses on clinical protocols

a. Metric: Number of nurses trained

iv. Measure: Expand nurse advice line

a. Metric: Nurse advice line

i. Numerator: Number of nurses staffing nurse advice line per shift

ii. Denominator: Number of patient calls per shift

iii. Data Source: Documentation of nurse advice line staffing levels.

iv. Rationale/Evidence: Patients will experience expanded access to medical advice and direction to the appropriate level of care as a result of a higher ratio of nurses to patient calls.

v. Measure: Expand access to nurse advice line

a. Metric: Nurse advice line

i. Number of enrolled patients who place calls to a nurse advice line

ii. Data Source: Nurse advice line call center reports

iii. Rational/Evidence: Patients will experience expanded access to medical advice and direction to appropriate care for perceived urgent medical problems as a result of being able to call a nurse 24 hours.

vi. Measure: Establish nurse advice line

a. Metric: Nurse advice line

i. Number of nurses designated to staff a nurse advice line

ii. Data Source: HR documents or other documentation demonstrating employed and/or contracted nurses to staff a nurse advice line.

iii. Rational/Evidence: Patients will experience expanded access to medical advice and direction to appropriate care for perceived urgent medical problems as a result of being able to call a nurse 24 hours.

vii. Measure: Inform and educate patients on the nurse advice line

a. Metric: Number or percent of targeted patients informed/educated

i. Numerator: Number of targeted patients informed/educated

ii. Denominator: Number of targeted patients (targeted as defined by DPH system)

iii. Data Source: Documentation in patient's paper or electronic medical record that patient was contacted and received information about accessing the nurse advice line and education about how to use the nurse advice line

iv. Rationale/Evidence: Patients who are informed on how to access and utilize a nurse advice line are less likely to seek care for non-emergent conditions in the Emergency Department.

viii. Measure: Develop/distribute a patient-focused educational newsletter with proactive health information and reminders based on nurse advice line data/generated report identifying common areas addressed by the nurse advice line

a. Metric: Number of newsletters sent to patients

i. Data Source: Mailer vendor invoice

ii. Rationale/Evidence: The nurse advice line can collect important data that may be representative of the types of concerns of the larger, general patient population. By monitoring the types of health care needs addressed through the nurse advice line, broader trends can be identified. Based on that, proactive health care guidance (e.g., when to get a screening test/immunization) can be disseminated to the larger patient population. In essence, this shares the learnings from the nurse advice line and disseminates preventive and other health care guidance to the broader patient population.

- **Improvement Measures:**

i. Measure: Increase in the number of patients that accessed the nurse advice line

a. Metric: Utilization of nurse advice line

i. Numerator: Number or percent of targeted patients that access the nurse advice line

ii. Denominator: Targeted patients (targeted as defined by DPH system)

iii. Data Source: TBD by DPH System, but could include Call Center phone and encounter records and appointment scheduling software records

iv. Rationale/Evidence: Targeted patients that access and utilize a nurse advice line are less likely to seek care for non-emergent conditions in the Emergency Department.

ii. Measure: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice and appointment line when needed

a. Metric: Number of urgent medical appointments scheduled via the nurse advice line

i. Numerator: Number of patients in defined population who were scheduled an urgent medical appointment via the nurse advice line

ii. Denominator: Total number of patients in defined population (defined by DPH system)

iii. Data Source: TBD by DPH System, but could include Call Center phone and encounter records and appointment scheduling software records

iv. Rationale/Evidence: Patients in defined population who utilize the nurse advice line and were given an urgent medical appointment when needed are less likely to see non-emergency care in the Emergency Department.

iii. Measure: Increase the number of patients that called the nurse advice line with intent to go to the ED for non-emergent conditions who were redirected to non-ED resources

a. Metric: Better utilization of health care resources

i. Numerator: Number of targeted patients that accessed the nurse advice line who reported intent to go to the ED, but were redirected to non-ED resources

ii. Denominator: Total number of targeted patients that accessed the nurse advice line who reported intent to go to the ED

iii. Data Source: TBD by DPH system, but could include Call Center phone and encounter records, appointment scheduling software records and Emergency Department medical records.

iv. Rationale/Evidence: Patients that access the nurse advice line who reported intent to go to the Emergency Department are being directed to appropriate medical resources.

iv. Measure: Increase patient satisfaction (this measure may be moved to Category 3, pending finalization of Category 3)

a. Metric: Increase surveyed patients who believed the advice provided was appropriate

i. Numerator: Number of surveyed patients who accessed the nurse advice line and reported finding it helpful

ii. Denominator: Total number of surveyed/respondents who accessed the nurse advice line

iii. Data Source: Survey Tool Results

iv. Rationale/Evidence: Patients who report they believed the advice they received was appropriate are more likely to not seek care in the Emergency Room for non-emergent conditions in the future.

7. Introduce Telemedicine

- Project Goal: Provide electronic health care services to increase patient access to health care.

- Potential Project Elements:

- Expand/establish telemedicine program to help fill significant gaps in services

- Related Projects:
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Increase Specialty Care Access/Redesign Referral Process (Cat. 2)
  - Other
- Key Measures:
  - **Process Measures:**

    i. Measure: Establish telemedicine program for selected medical service line(s)

    a. Metric: Telemedicine program for selected medical service line(s)

    i. Numerator: Number of telemedicine consults available for selected medical service lines

    ii. Denominator: Number of medical service lines

    iii. Data Source: Appointment scheduling software records

    iv. Rationale/Evidence: Establishing telemedicine consults for selected medical service lines expands access to clinicians.

    ii. Measure: Expand telemedicine program for selected medical service line(s)

    a. Metric: Telemedicine program for selected medical service line(s)

    i. Numerator: Number of telemedicine consults available for selected medical service lines

    ii. Denominator: Number of medical service lines

    iii. Data Source: Appointment scheduling software records

    iv. Rationale/Evidence: Establishing telemedicine consults for selected medical service lines expands access to clinicians.

    iii. Measure: Expand telemedicine program to additional clinics/service lines

    a. Metric: Telemedicine program to clinics

    i. Numerator: Number of clinics with telemedicine

    ii. Denominator: Number of clinics

    iii. Data Source: Appointment scheduling software records

iv. Rationale/Evidence: Expanding to additional clinics allows increased access.

iv. Measure: Conduct needs assessment to identify specialties most in need of telemedicine

a. Metric: Needs assessment

i. Submission of completed needs assessment

ii. Data Source: Needs assessment

iii. Rationale/Evidence: It is important to expand telemedicine to the most impacted areas in order to have optimal affect.

- **Improvement Measures:**

i. Measure: Increase number of e-consultations

a. Metric: Electronic consultations

i. Numerator: Number of patients referred to medical specialties electronically that have their referral resolved without being scheduled for an in-person visit

ii. Denominator: Number of patients referred to medical specialties electronically

iii. Data Source: Patient records from electronic referral processing system

iv. Rationale/Evidence: Increased e-consultations will result in the patient's issue being handled resolved more frequently without need for a face-to-face specialty care an in-person visit with the specialist.

ii. Measure: Reduce wait times in high-impact specialty for consult for patient's condition

a. Metric: Number of days until first available time for review and consult on patient's condition

i. Data Source: Appointment scheduling software and or electronic referral management software

ii. Rationale/Evidence: Patients are more likely to receive appropriate care when the wait time for review and consult of the condition for which they were referred is shortened.

8. Enhance Coding and Documentation for Quality Data, (to create a more robust administrative data set of patient safety and quality codes to use for performance improvement)

- Project Goal: Improve coding and documentation of clinical data so that it reflects a more accurate and specialized data set that can be stratified by quality indicators in order to better identify opportunities for quality improvement.

- Potential Project Elements:
    - Conduct data collection and reporting using ICD-9 codes linked to MS-DRGs
    - Implement HIPAA 5010 transaction sets and convert to ICD-10 codes
    - Implement processes and environmental changes to enhance coding and documentation of diagnoses, procedures, and process and outcome measures

- Related Projects:
    - All Categories 3-4 Projects/Interventions
    - Other

- Key Measures:
    - **Process Measures:**

        i. Measure: Determine whether current information systems that house ICD codes should be converted or upgraded

            a. Metric: Hospitals will conduct an impact analysis to identify touch points within the hospital system where ICD codes are used and stored. A structured risk assessment process will be conducted to quantify, order and rank the impact to identify whether information systems will be converted or upgraded.

                i. Submission of analysis

                ii. Data Source: Analysis

                iii. Rationale/Evidence: ICD codes are used in administrative, clinical and financial information systems. Ensuring accurate coding in these systems is critical to maintain hospital operations.

        ii. Measure: Implement HIPPA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions

            a. Metric: Hospitals will convert to the new HIPAA X12 standard that regulates the electronic transmission of specific health care transactions

                i. Documentation of conversion, such as print-out or report

                ii. Data Source: http://www.cms.gov/ICD10/

iii. Rationale/Evidence: This new standard is a required precursor to mandatory ICD-10 conversion.

iii. Measure: Develop/implement an education plan and/or curriculum for coding staff, clinical documentation specialists, physicians and other staff

a. Metric: Documentation of the education plan and curriculum

iv. Measure: Train staff on the changes in work flow

a. Metric: Identify staff to be formally trained on clinical workflow redesign.

i. Number of trained staff

ii. Data Source: HR or training program materials

iii. Rationale/Evidence: Environmental constraints contribute to coding errors.

v. Measure: Implement process to enhance coding and documentation of diagnoses, procedures, and process and outcome measures

a. Metric: Using a process improvement methodology, identify and rank impact of factors that impact the quality of clinical coding. This may include, but is not limited to, structural characteristics of coding unit, support provided to clinical coders through education, training and resources, and coding quality control mechanisms.

i. Data Source: Submission of ranked factors

ii. Rationale/Evidence: Evidence suggests organizational factors affect the quality of hospital clinical coding.

vi. Measure: Modify existing clinical documentation improvement tools for ICD-10

a. Metric: Documentation of updated tools

vii. Measure: Conduct data collection and reporting using ICD-9 codes linked to MS-DRGs

viii. Measure: Increase utilization of data quality reports to identify data improvement priorities

a. Metric: Review data reports quarterly and identify at least three data improvement priorities

i. Data Source: Internal data reports

ii. Rationale/Evidence: Continuous monitoring will allow hospitals to identify and correct data improvement opportunities.

ix. Measure: Determine a methodology to calculate costs per MS-DRG clinical conditions

a. Metric: Development, documentation and submission of a methodology to calculate costs per MS-DRG clinical conditions

x. Measure: Designate a project manager for coding/documentation

a. Metric: Submission of project manager role/position description, or HR documents

xi. Measure: Complete an audit of the clinical documentation improvement program

a. Metric: Number or percent of records audited to evaluate accuracy of coding in ICD-10

i. Numerator: Number of records audited

ii. Denominator: Total records

- **Improvement Measures:**

i. Measure: Implement ICD-10 conversion to be able to communicate with institutions that are able to receive such transactions

a. Metric: All internal information systems (administrative, financial, and clinical) using ICD-9 codes will either convert to ICD-10 or crosswalk old ICD-9 codes to ICD-10 codes.

i. Data Source: http://www.cms.gov/ICD10/

ii. Rationale/Evidence: Conversion to ICD-10 codes is mandated by CMS and will be required for reimbursement

ii. Measure: Implement improvement strategies to ensure accurate coding of patient safety indicators

a. Metric: Reduce coding errors

i. Percent change in coding errors over baseline

ii. Data Source: Random chart audits or other coding quality control mechanisms

iii. Rationale/Evidence: Accurate coding has important patient care delivery, clinical and reimbursement/financial impacts.

iii. Measure: Use accurate coding to identify high utilizers of services or high risk patients and then develop and implement clinical pathways to more effectively deliver needed care.

a. Metric: Demonstrate utilization of clinical pathways or document clinical pathway in policy and procedure manual as a metric.

i. Data Source: Random chart audits or other coding quality control mechanisms

ii. Rationale/Evidence: Accurate coding can reveal patterns in utilization that can then help drive improvement efforts that have direct impact on delivery of patient care, clinical outcomes, and reimbursement/financial benefits. Accurate coding has important patient care delivery, clinical and reimbursement/financial impacts.

9. Develop Risk Stratification Capabilities/Functionalities

- Project Goal: To develop the capability to target high-risk patients by collecting accurate patient data and stratifying by health risk indicators.

- Potential Project Elements:
  - Develop criteria to better identify those patients that would benefit from disease management and other special programs
  - Conduct risk stratification for patients with the targeted chronic conditions
  - Apply the risk stratification methodology, produce risk scores for the patients, and assign them to the appropriate medical home and disease management program

- Other Category Projects This Project Can Feed Into:
  - Reduce Readmissions (Cat. 3)
  - Improve Quality (Cat. 3)
  - Reduce Harm from Medical Errors (Cat. 3)
  - Prevent Ventilator Associated Pneumonia (VAP) Infection (Cat. 3)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Expand Chronic Care Management Models (Cat. 2)
  - Redesign for Cost Containment (Cat. 2)
  - Implement/Expand Care Transitions Programs (Cat. 2)
  - Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Develop adaptive screening tools for patients with targeted conditions/indicator/criteria

       a. Metric:

i. Numerator: Number of patients detected as having increased risk by tool

ii. Denominator: Total number of targeted patients admitted

iii. Data Source: EHR, trauma registry, ICU database, EHR screening tool database

iv. Rationale/Evidence: Since many of the subject patients have poor access to primary care, the admission may be an indication of overall worsening health, high-risk behavior and/or poorly managed diseases. By employing an adaptive screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible.

ii. Measure: Develop and implement risk stratification to identify patient populations who would benefit from specialized medical homes, disease management programs, remote monitoring, and other special programs

iii. Measure: Develop criteria to better identify those patients that would benefit from disease management and other special programs

- **Improvement Measures:**

i. Measure: Conduct risk stratification for number or percent of patients with the targeted chronic conditions

a. Metric:

i. Numerator: All major trauma victims successfully screened for targeted conditions.

ii. Denominator: All major trauma victim admissions

iii. Data Source: EHR, trauma registry, EHR screening tool results

iv. Rationale/Evidence: Screening and rapid intervention for at-risk conditions for inpatients have not been funded by traditional insurance or safety-net coverage, despite demonstration of improved outcomes and reduction in costs. Since most of the subject patients have poor access to primary care, the trauma admission may be an indication of overall worsening health, high risk behavior and/or poorly managed diseases. By employing an adaptive computer-based screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible.

ii. Measure: Apply the risk stratification methodology, produce risk scores for # or % of patients, and assign them to the appropriate medical home and disease management program

iii. Measure: Using the risk stratification process, order appropriate interventions and make appropriate timely referrals for number or percent of targeted patients with the targeted conditions, such as implementing remote monitoring (telephonic, web or device-based) and appropriate nurse management follow-up of patients with heart failure post inpatient discharge

a. Metric

i. Numerator: All major trauma victims successfully screened for targeted conditions and appropriate referred without recividism at UCSD or the San Diego Trauma System hospitals.

ii. Denominator: All major trauma victims successfully screened for targeted conditions and appropriate referred

iii. Data Source: EHR, trauma registries, EHR screening tool results

iv. Rationale/Evidence: Safety-net hospital studies have shown that subsets of underprivileged trauma patients have disproportionate rates of readmission, increased hospital costs and excess morbidity and mortality. These adverse outcomes could be reduced by improved screening and management. By employing an adaptive screening tool using a series of checklists and interventions that is continually tailored for the patients' condition, mechanism of injury and phase of care, immediate prevention of hospital-associated adverse outcomes is possible. Appropriate consultations and referrals will be indicated and ordered via the EHR, where available. In addition, long-term plans for secondary prevention of injury and illness can be coordinated for the patient and family, inpatient specialist provider and consultants and primary care providers, and these plans output to patients primary care EHR, where available.

10. Expand Capacity to Provide Specialty Care Access in the Primary Care Setting

- Project Goal: Provide high-demand specialty services within the primary care/medical home setting so that patients can receive some specialty care services concurrent with routine appointments in order to increase patient access to specialty care by avoiding the need for separate specialist visits where possible.

- Potential Project Elements:
  - Provide training to primary care providers to expand their capacity to provide select, basic specialty care within the primary care setting
  - Have high impact specialists regularly rotate through medical homes for team conferences, team training, and patient consultation/co-management

- Develop clinical management protocols for primary care providers to co-manage patients with specialists
- Develop a process to enable enhanced communication between primary care providers and specialists on a regular basis
- Increase clinic hours for select primary care providers to provide expanded care to selected patient population
- Develop a protocol for primary care providers to co-manage patients with clinical pharmacists for select conditions

- Related Projects:
  - Increase Specialty Care Access/Redesign Referral Process (Cat. 2)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Provide training to primary care providers to expand their capacity to provide select, basic specialty care within the primary care setting
       a. Metric: Training of primary care providers in at least one specialty care area
          i. Number of trained primary care providers in the specialty care areas selected
          ii. Data Source: HR, training program materials, or curriculum for training in select medical specialties
          iii. Rationale/Evidence: Enables an expanded role or expanded/additional clinical expertise for primary care providers.
    ii. Measure: Have specialists from most impacted medical specialties regularly rotate through medical homes for team conferences, team training, and patient consultation/co-management
       a. Metric: Specialists consulting on cases with primary care providers in primary care clinic/medical home

i. Numerator: Number of patient cases jointly reviewed by primary care provider and medical specialist in selected medical specialties

ii. Denominator: Number of adult patients seen at the clinic

iii. Data Source: Paper or electronic log of number of cases presented at monthly conference tracked over time. The number of referrals made over time as tracked in practice management system, EHR, or other documentation as designated by DPH system. Practice management system, EHR, or other documentation as designated by DPH system to provide the number of adult patients seen at clinic. Patient charts or patient note in electronic medical record.

iv. Rationale/Evidence: Primary care providers able to consult with medical specialists on a regular basis refer fewer patients for in-person visits into associated medical specialty clinic. This process could include scheduling a one hour meeting/conference once per month where the primary care provider presents cases to the specialist. The following month, the specialist could do a brief (10-15 minute) presentation/review of the topic brought up in a specific case from the prior month before moving on the case presentations from the current month. The primary care provider would have to have their cases and specific question prepared ahead of time. This could allow 3-4 cases per month to be "jointly reviewed." And lessons learned could be shared with all—as opposed to 1:1 consultation.

iii. Measure: Develop clinical management protocols for the most impacted medical specialties jointly created by primary care providers and specialists for the co-management of patients between primary care and targeted medical specialties

a. Metric: Clinical Management Protocols for selected medical specialties

i. Numerator: Clinic Management Protocols for selected medical specialties

ii. Denominator: Total number of medical specialties

iii. Data Source: Written Clinical Management Protocol

iv. Rationale/Evidence: Patients being co-managed by primary care providers and medical specialists according to a jointly created clinical management protocol are more likely to receive care in the most appropriate setting. Also, a health care system which has engaged their primary care and medical specialty providers to create mutually agreed upon parameters for their respective roles is likely to deliver care in the most appropriate setting.

iv. Measure: Conduct specialty care gap assessment

a. Metric: Gap assessment

i. Submission of completed assessment

ii. Data Source: Assessment

iii. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access

- **Improvement Measures:**

i. Measure: Number of patients referred for in-person visits into select medical specialty clinic(s)

a. Metric: Referrals from primary care into select medical specialties

i. Numerator: Number of patients with a given diagnosis who are referred for in-person visits/consultations with select medical specialty clinics

ii. Denominator: Total number of patients with the given diagnosis

iii. Data Source: eReferral management software and appointment scheduling software

iv. Rationale/Evidence: Medical specialty resources will be utilized more appropriately resulting in the prioritization of medical specialty care for patients with conditions that require in-person specialty consults and procedures.

11. Expand Specialty Care Capacity

- Project Goal: To increase the capacity to provide specialty care services to better accommodate the high demand for specialty care services so that patients have increased access to specialty services.

- Potential Project Elements:
  - Identify high impact/most impacted specialty services[10] and gaps in care and coordination
  - Expand high impact specialty care capacity in most impacted medical specialties

- Related Projects:
  - Improve Quality (Cat. 3)
  - Increase Specialty Care Access/Redesign Referral Process (Cat. 2)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)

[10] Such as: Cardio, GI, Ortho, Endocrinology, Psychiatry, and Dermatology, and Gastroenterology

- Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Assess specialty clinic capacity, productivity, and/or care models
        a. Metric: DPH system administrative records
    ii. Measure: Collect baseline data for wait times, backlog, and/or return appointments in specialties
        a. Metric: Establish baseline for performance indicators
            i. Numerator: TBD by the DPH system
            ii. Denominator: TBD by the DPH system
            iii. Data Source: TBD by the DPH system
            iv. Rationale/Evidence: TBD by the DPH system
    iii. Measure: Expand the ambulatory care medical specialties referral management department
        a. Metric: System/personnel in place to manage referrals into medical specialties
            i. Numerator: System components/personnel
            ii. Denominator: Monthly/annual volume of referrals into medical specialties
            iii. Data Source: Number of FTEs/Written description for process of managing referrals into medical specialties
            iv. Rationale/Evidence: A robust referral management department can ensure that referrals are processed, reviewed and the patient's clinical issue addressed in a timely manner.
    iv. Measure: Train primary care providers, specialists and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties
        a. Metric: Training of staff and providers on referral guidelines, process and technology
            i. Numerator: Number of staff and providers trained and documentation of training materials
            ii. Denominator: Total number of staff and providers working in primary care and medical specialty clinics
            iii. Data Source: Curriculum for training

iv. Rationale/Evidence: Training all staff and providers working in primary care and medical specialty clinics on referral guidelines, process, and technology creates the capacity to consistently and uniformly manage all referrals into medical specialties.

v. Measure: Launch a specialty care clinic (e.g., pain management clinic)

a. Metric: Establish/expand specialty care

i. Documentation of new/expanded specialty care clinic

vi. Measure: Conduct a specialty care gap analysis based on community need

vii. Measure: Implement a specialty care access plan

viii. Measure: Complete planning and installation of new specialty systems (e.g., imaging systems)

ix. Measure: Establish specialty care guidelines for the high impact/most impacted medical specialties.

a. Document guidelines and distribution of guidelines.

x. Measure: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment

a. Metric: Reports on file

- **Improvement Measures:**

i. Measure: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties

a. Metric: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties

i. Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties

ii. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of specialist providers in targeted specialties at baseline

iii. Data Source: HR documents or other documentation demonstrating employed/contracted specialists

iv. Rationale/Evidence: Increased number of specialists to meet demand and referral demand for in-person visits and procedures will allow patients to receive more timely services.

ii. Measure: Increase the number of available specialty appointments by XX for the most impacted specialty clinics

a. Metric: Documentation of increase over baseline

iii. Measure: Increase the number of referrals of targeted patients to the specialty care clinic

a. Metric: Achieve targeted of referrals of targeted patients

i. Data Source: Registry and/or paper documentation as designated by DPH system

ii. Rationale/Evidence: Targeted patients are at high-risk of admissions and/or readmissions, and getting the patients to the specialty care clinics can help manage their conditions and therefore avoid unnecessary ED utilization, hospitalizations or readmissions.

iv. Measure: Reduce the number of specialty clinics with waiting times for next routine appointment

a. Metric: Next routine appointment of more than X calendar days and/or to no more than X of X specialty clinics

b. Data Source: DPH appointment scheduling system

12. Enhance Performance Improvement and Reporting Capacity

- Project Goal: To expand quality improvement capacity through people, processes and technology so that the resources are in place to conduct, report, drive and measure quality improvement.

- Potential Project Elements:
  - Enhance improvement capacity within people
  - Enhance improvement capacity through technology

- Related Projects:
  - All Categories 2-4 Projects/Interventions
  - Other

- Key Measures:
  - **Process Measures:**

i. Measure: Establish a performance improvement office to manage data, improvement trajectory and improvement activities across the hospital system

a. Metric: Establishment of office

i. Documentation of establishment of office

ii. Rationale/Evidence: Having an office responsible for performance improvement will increase organizational capacity to and demonstration organizational commitment to performance improvement activities ongoing.

ii. Measure: Establish a program for trained experts on process improvements to mentor and train other staff for safety and quality care improvement

a. Metric: Train the trainer program established

i. Documentation of training program

ii. Data Source: HR, training program materials

iii. Rationale/Evidence: Ongoing training throughout the organization in quality care improvement will increase capacity for quality improvement activities on an ongoing basis.

iii. Measure: Develop reporting methodologies that will enable continuous quality improvement

a. Metric: TBD by DPH system

i. Numerator: TBD by DPH system

ii. Denominator: TBD by DPH system

iii. Data Source: Report systems TBD by DPH system

iv. Rationale/Evidence: It is important to put in place meaningful measurements of quality improvement to measure progress and drive continuous improvement.

iv. Measure: Participate in statewide, public hospital or national clinical database(s) for standardized data sharing

a. Metric: Collaborative membership

i. Documentation of collaborative membership

ii. Data Source: Collaborative membership materials

iii. Rationale/Evidence: Participating in a collaborative has been shown to drive targeted and concerted quality improvement activities with the support of peers and the program.

v. Measure: Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues

a. Metric: Number of learning events

i. Data Source: Learning events' agendas

ii. Rationale/Evidence: It is also important to share the learnings of quality improvement efforts – what worked and what did not work.

vi. Measure: Enhance the organizational infrastructure and resources to store, analyze and share the patient experience data, as well as utilize them for quality improvement

a. Metric: Patient experience data

i. Documentation of methodology for patient experience data collecting and reporting

ii. Data Source: TBD by DPH system

iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can analyzed in a way to draw meaningful and actionable conclusions.

vii. Measure: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)

a. Metric: Number of staff trained

i. Data Source: HR, training programs

ii. Rationale/Evidence: It is essential to have in place the resources and brainpower to drive performance improvement work.

- **Improvement Measures:**

i. Measure: Implement quality improvement data systems, collection, and reporting capabilities

a. Metric: Usable quality improvement data systems

i. Generation of report

ii. Data Source: Quality improvement data systems

iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can analyzed in a way to draw meaningful and actionable conclusions.

ii. Measure: Create a quality dashboard or scoreboard to be shared with organizational leadership on a regular basis that includes patient satisfaction measures

a. Metric: Quality dashboard

i. Submission of quality dashboard

ii. Data Source: Quality improvement data systems

iii. Rationale/Evidence: It is important to accurately collect patient experience data and have the data in a format that can analyzed in a way to draw meaningful and actionable conclusions.

Proposed Category 2 Improvement Projects

Per the Waiver Terms and Conditions, the purpose of Category 2 Innovation and Redesign is "investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management." Therefore, Category 2 would include the piloting, testing and spreading of innovative care models.[11]

DPH systems are demonstrated leaders in delivery system innovation. For the past decade, they have identified and begun implementing effective methods for improving quality, efficiency and expanding access, with a goal of containing cost growth. These efforts go well beyond the four walls of the hospital – they extend to primary and specialty outpatient clinics and urgent care centers, and in many cases encompass the entire hospital system in an effort to improve integration across all settings.

DPH systems serve unique populations that experience significant challenges associated with poverty, such as psychosocial barriers to health and multiple concurrent medical conditions. These institutions have had to get very creative to address the needs of their patient populations with extremely limited resources. They need to further refine these innovations, test new ways of meeting the needs of their target populations and disseminate learnings in order to spread promising practices.

The following improvement projects as specified would be acceptable for DPH systems to include in their Category 2 plans, using similar formatting as shown below in Appendix B: Example DSRIP Categories 1-2 Plan:

1. Expand Medical Homes 393
2. Expand Chronic Care Management Models 401
3. Redesign Primary Care 408
4. Redesign to Improve Patient Experience 413
5. Redesign for Cost Containment 420
6. Integrate Physical and Behavioral Health Care 422
7. Increase Specialty Care Access/Redesign Referral Process 431
8. Establish/Expand a Patient Care Navigation Program 437
9. Apply Process Improvement Methodology to Improve Quality/Efficiency 440
10. Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation 445
11. Use Palliative Care Programs 448
12. Conduct Medication Management 451
13. Implement/Expand Care Transitions Programs 456
14. Implement Real-Time Hospital-Acquired Infections (HAIs) System 460

1. Expand Medical Homes[12]

- Project Goal: Establish a "home base" for patients, where patients have a health care team that is tailored to the patient's health care needs, coordinates the patient's care, and proactively provides preventive, primary, routine and chronic care, so that patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report a greater patient experience of care.

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[11] Please reference Appendix A: *Evidence-Based Models Implemented by California Public Hospital Systems to Enhance Quality, Promote Coordinated Care, Build Medical Homes and Ensure Access*, below.

[12] Please see Appendix A below for a summary description.

- Potential Project Elements:
    - Establish/expand medical homes
    - Restructure staffing into multidisciplinary care teams that manage a panel of patients where providers and staff operate at the top of their license[13]
    - Empanel patients who would most benefit from medical homes
    - Actively manage medical home patient panels
    - The team will be responsible for contacting patients to receive their initial health assessment

- Related Projects:
    - Reduce Readmissions (Cat. 3)
    - Improve Screening Rates (Cat. 3)
    - Improve Diabetes Care Management and Outcomes (Cat. 3)
    - Improve Chronic Care Management and Outcomes (Cat. 3)
    - Expand Chronic Care Management Models (Cat. 2)
    - Redesign Primary Care (Cat. 2)
    - Redesign to Improve Patient Experience (Cat. 2)
    - Improve Patient/Caregiver Experience (Cat. 3)
    - Integrate Physical and Behavioral Health Care (Cat. 2)
    - Other

- Key Measures:
    - **Process Measures:**
        i. Measure: Implement the medical home model in primary care clinics
            1. Metric: Increase number of primary care clinics using medical home model
                a. Numerator: Number of primary care clinics using medical home model
                b. Denominator: Total number of primary care clinics

[13] Providers who operate at the top of their license are being maximally utilized so that (1) the overall capacity of the primary care team is optimized and (2) the patient receives optimal care from the most appropriate team member.

c. Rationale/Evidence: NAPH found that nearly 40% of programs could offer either anecdotal or quantitative evidence of reduced ED usage—attributed to the redirection of primary care-seeking patients from the ED to a medical home.[14] In addition to reductions in ED utilization, the medical home model has helped improve the delivery and quality of primary care and reduce costs at member hospitals.

ii. Measure: Put in place policies and systems to enhance patient access to the medical home

1. Metric: Hospital policies on medical home

a. Documentation of hospital policies on medical home

b. Data Source: Organizations' "Policies and Procedures" documents

c. Rationale/Evidence: Operationalizing the work as part of the "Policies and Procedures" for an organization will make the work the "norm" or expectation for the organization and its employees.

iii. Measure: Reorganize staff into primary care teams responsible for the coordination of patient care

1. Metric: Primary care team

a. Numerator: Number of staff organized into care teams

b. Denominator: Total number of staff

c. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.[15] It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve."[16]

iv. Measure: Expand and redefine the roles and responsibilities of primary care team members

1. Metric: Expanded primary care team member roles

a. Documentation of roles/responsibilities

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[14] NAPH Research Brief February 2010 *Safety Net Medical Homes Establish "Medical Homes"*
[15]Yarnell, K.S., K.I. Pollak, T. Ostbye, K.M. Krause, J.L. Michener. "Primary Care: is there enough time for prevention?" American Journal of Public Health 2003: 93:635-41; and Ostbye, T.,K.S Yarnal, K.M. Krause, K.I. Pollak, M. Gradison, J.L. Michener. "Is there time for management of patients with chronic diseases in primary c are?" Annals of Family Medicine 2005; 3:209-14.
[16] California Health Care Foundation, *Building Teams in Primary Care: Lessons Learned*, Thomas Bodenheimer, July 2007.

b. Data Source: Revised job descriptions and documentation of established orientation and internal trainings for expanded roles and responsibilities beyond the basic educations programs completed prior to hire.

c. Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.[17] It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve."[18] Additionally, "basic MA education programs do not adequately prepare individuals for the roles that MAs are increasingly asked to perform in community clinics. While most MAs are adequately trained in basic clinical skills such as taking and recording vital signs, most MA programs offer little preparation in areas such as patient care coordination or the use of the health information technology in patient management."[19]

v. Measure: Determine the appropriate panel size[20] for primary care provider teams, potentially based on staff capacity, demographics, and diseases

1. Metric: Panel size

a. Number of patients assigned to a provider care team, by provider FTE. For part-time providers or residents who are assigned a dedicated panel, list the true panel size with percentage FTE.

b. Data Source: Patient panel by provider, registry or EHR

c. Rationale/Evidence: Panel size analysis could support panel management decisions as clinics approach population management.[21] "At the heart of the Patient Centered Medical Home model is the relationship between a patient and a provider and his/her practice team. All the activities of an effective patient centered medical home should

[17]Yarnell, K.S., K.I. Pollak, T. Ostbye, K.M. Krause, J.L. Michener. "Primary Care: is there enough time for prevention?" American Journal of Public Health 2003: 93:635-41; and Ostbye, T.,K.S Yarnal, K.M. Krause, K.I. Pollak, M. Gradison, J.L. Michener. "Is there time for management of patients with chronic diseases in primary c are?" Annals of Family Medicine 2005; 3:209-14.
[18] California Health Care Foundation, *Building Teams in Primary Care: Lessons Learned*, Thomas Bodenheimer, July 2007
[19] S. Chapman, M. Chan, T. Bates, "Medical Assistants in Community Clinics: Perspectives on Innovation in Role Development" Research Brief, Center for the Health Professions at UCSF, June 2010.
[20] Measure panel size by the number of patients assigned to a provider care team, by provider FTE. For part-time providers or residents who are assigned a dedicated panel, list the true panel size with percentage FTE. Panel size analysis could support panel management decisions as clinics approach population management.
[21]*Safety Net Medical Home Initiative*. Coleman CF, Phillips KE, eds. Empanelment Implementation Guide: Establishing Patient-Provdier Relationships. 1st ed. Seattle, WA: The MacCollInstitiute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, March 2010.

strengthen and reinforce the primacy of that relationship, and its accountability for the patient's care. The positive impacts of seeing the same provider on patient experience, clinical care, and outcomes have been unequivocally demonstrated by research and practice."[22]

vi. Measure: Establish criteria for medical home assignment

1. Metric: Medical home assignment criteria

a. Submission of medical home assignment criteria, such as patients with specified chronic conditions;[23] patients who have had multiple visits to a clinic; high-risk patients; patients needing care management; high utilizers of health care services;[24] and patients with particular socio-economic, linguistic, and physical needs[25]

b. Data Source: Hospital policies and procedures or other similar documents

c. Rationale/Evidence: With limited resources, it may behoove some organizations to focus their work on medical homes within a subset of patients.[26] Also, some of these higher risk patients are the highest utilizers of health care resources and dollars. Focusing on these cohorts should result in reduced health care costs. At Carolinas Medical Center in Charlotte, NC, interventions targeting high-risk patients who utilized the hospital's medical home resulted in an 80% decrease in hospitalizations and ED visits for the intervention group.[27]

vii. Measure: Track the assignment of patients to the designated care team

1. Metric: Tracking medical home patients

a. Submission of tracking report

b. Data Source: Can be tracked through the practice management system, EHR, or other documentation as designated by DPH system

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[22] Safety Net Medical Home Initiative. Coleman CF, Phillips KE, eds. Empanelment Implementation Guide: Establishing Patient-Provider Relationships. 1st ed. Seattle, WA: The MacColl Institute for Healthcare Innovation at the Group Health Research Institute and Qualis Health, March 2010; Saulz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Ann Fam Med. 2005;3(2):159-66; and Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair, CE, McKendry R. Continuity of Care: a Multidisciplinary Review. BMJ, 2003;327(7425):1219-21.

[23] Such as: Diabetes, hypertension, chronic heart failure, obesity, asthma, post-secondary stroke, community-acquired pneumonia (CAP), HIV/AIDS, chronic pain, and depression.

[24] Such as patients who have presented in the ED, been admitted to the hospital, or visited specialty clinics multiple times.

[25] Such as seniors and persons with disabilities, homeless people, and immigrants.

[26] Presentation by Dr. Marcie Levine at SNI's Seamless Care Initiative Primary Care Workgroup on Empanelment, "Santa Clara Valley Health and Hospital System Empanelment Journey," Dec 8, 2010.

[27] Wade, KE, Furney, SL,Hall, MN (2009) Impact of Community –Based Patient-Centered Medical Homes on Appropriate Health Care Utilization at Carolinas Medical Center. NC Med J, 70(4), 341-345.

c. Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment (e.g., Health Care Reform, more Medi-Cal beneficiaries, patient preference, extended provider leave).

viii. Measure: Develop training materials for medical homes

ix. Measure: Train medical home personnel

1. Metric: Number of medical home personnel trained

2. Data Source: HR documents

x. Measure: Expand and document interaction types between patient and healthcare team beyond one-to-one visits to include group visits, telephone visits, and other interaction types

1. Metric: Documentation of interaction types and expansion of use

xi. Measure: Implement a system to improve prevention services (must select at least one metric):

1. Metric: Implement paper-based or electronic tool to measure prevention services

2. Metric: Implement a system/processes for targeted prevention services

3. Metric: Develop prevention services education management and outreach program

- **Improvement Measures:**

i. Measure: Based on criteria, assign eligible patients[28] to medical homes

1. Metric: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the DPH system

a. Numerator: Number of eligible patients assigned to a medical home

b. Denominator: Total number of eligible patients

c. Data Source: Practice management system, EHR, or other documentation as designated by DPH system

d. Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size: How Many Patients Can One Doctor Manage? *FamPractManag.* 2007 Apr;14(4):44-51

[28] Many patients seen at public hospital systems seek only episodic care and would not avail themselves of a medical home. Eligibility for medical home is determined for each plan, according to unique confluence of patient populations and delivery system structure, using criteria such as 1-2 of primary care visits within 12-24 months, frequent utilization of emergency services, and/or identified medical needs such as chronic conditions.

ii. Measure: New patients assigned to medical homes receive their first appointment in a timely manner

1. Metric: Number or percent of new patients assigned to medical homes that are contacted and for their first patient visit within 60-120 days

a. Numerator: Number of new patients contacted within specified days

b. Denominator: Total number of new patients

c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by DPH system

d. Rationale/Evidence: It is important to get new patients into the medical in a timely manner.

iii. Measure: Patient access to medical home

1. Metric: Third Next-Available Appointment

a. The length of time in calendar days between the day an existing patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be 7 calendar days (lower is better), but depending on the DPH system's starting point, that may not be possible within five years.

b. Data Source: Practice management or scheduling systems

c. Rationale/Evidence: This measure is an industry standard of patients' access to care. For example, the IHI definition white paper on whole system measures site this metric.

iv. Measure: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes

1. Metric: Usual source of care

a. Numerator: Number medical home patients that are able to identify their medical home as their usual source of care

b. Denominator: Total number of medical home patients

c. Data Source: Patient survey

d. Rationale/Evidence: The medical home should be seen by the patient as the patient's "home base" or usual source of care, and this measures the success of the medical home in providing

ongoing, organized care for the patient and educating the patient about medical home services.

v. Measure: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home

1. Metric: Percent of primary care visits at medical home

a. Numerator: Number of enrolled patients' primary care visits with medical home primary care provider/team

b. Denominator: Total number of enrolled patients' primary care visits within the DPH system

c. Data Source: Practice management system, EHR, or other documentation as designated by DPH system

d. Rationale/Evidence: Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforce a continuity of care. Medical home model should enhance continuity.

vi. Measure: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care

1. Metric: Patient appointment reminders

a. Numerator: For select specific preventive service (e.g., pneumococcal vaccine for diabetics), the number of patients in the registry needing the preventive service and who have been contacted to come in for service

b. Denominator: Total number of patients in the registry needing the preventive service

c. Data Source: Registry, or other documentation as designated by DPH system

d. Rationale/Evidence: Panel manager (or staff on care team) identifies patients who have process or outcome care gaps and contacts them to come in for services. This approach has been used with good effect in state and federal health disparities collaboratives. The care team assesses the patient's overall health and co-develops a health care plan with the patient, including health goals, ongoing management, and future visits

vii. Measure: Obtain medical home recognition by a nationally recognized agency (e.g., NCQA)

1. Metric: Medical home recognition/accreditation

a. Documentation of recognition/accreditation

b. Data Source: Nationally recognized agency (e.g., NCQA)

2. Rationale/Evidence: Currently, there is no single medical home recognition body that has taken into account an updated definition for the medical home that includes safety net clinics/practices, but likely in the near future, there may be one. At that point, it will become important to validate the medical home service being providing by seeking and receiving recognition/accreditation.

2. Expand Chronic Care Management Models[29]

- Project Goal: Patients with chronic conditions receive proactive, ongoing care that keep patients healthy and empower patients to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

- Potential Project Elements:
  - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases
  - The composition of care teams is tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
  - Patients can access their care teams in person, by phone or email
  - Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
  - Empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
  - Apply a care management model to patients identified as having high-risk health care needs
  - Redesign rehabilitation delivery model for persons with disability

- Related Projects:
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Screening Rates (Cat. 3)

[29] Please see Appendix A below for a summary description of the chronic Care Model. Some chronic diseases included in DPH plans include diabetes, hypertension, heart failure, asthma, post-secondary stroke, community-acquired pneumonia (CAP), HIV/AIDS, and chronic pain.

- Reduce Readmissions (Cat. 3)
- Expand Medical Homes (Cat. 2)
- Redesign to Improve Patient Experience (Cat. 2)
- Improve Patient/Caregiver Experience (Cat. 3)
- Redesign for Cost Containment (Cat. 2)
- Integrate Physical and Behavioral Health Care (Cat. 2)
- Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Expand the Care Model to primary care clinics

    1. Metric: Increase number of primary care clinics using Care model

       a. Numerator: Number of primary care clinics using Care model

       b. Denominator: Total number of primary care clinics

       c. Data Source: Documentation of practice management

       d. Rationale/Evidence: The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.[30] Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component improved care, and all five studies with interventions in all four domains had positive impacts on patients.[31] Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or more chronic Care Model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).[32]

    ii. Measure: Train staff in the Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care

[30] Source: IHI website. Please see http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/ for more information.
[31] Renders et al, Diabetes Care, 2001; 24:1821 and Bodenheimer, Wagner, Grumbach, *JAMA* 2002; 288:1910.
[32] Tsai AC, Morton SC, Mangione CM, Keeler EB. *Am J Manag Care*. 2005 Aug;11(8):478-88.

1. Metric: Increase number or percent of staff trained

    a. Numerator: Number of relevant staff trained in the Care Model ("relevant" as defined per the DPH system)

    b. Denominator: Total number of relevant staff

    c. Data Source: HR, training program materials

    d. Rationale/Evidence: The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions.[33] Randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component improved care, and all five studies with interventions in all four domains had positive impacts on patients.[34] Also, an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or more chronic Care Model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).[35] Also, it has been shown that "planned care for all" can be more effective than "disease-silo" care. For example, the Cherokee Nation adopted a systems approach to diabetes care in 2002, which included many of the concepts in the Improving Patient Care (IPC) change package, such as patient and population management by registered nurse diabetes care managers; evidence-based guidelines; planned visits; care by a multidisciplinary team; diabetes self-management support and education; use of registries for population management; and data-driven improvement, resulting in improved diabetes care and intermediate outcomes.[36]

iii. Measure: Develop a comprehensive care management program

1. Metric: Care management program

    a. Documentation of program

    b. Data Source: Program materials

iv. Measure: Formalize multi-disciplinary teams

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[33] Source: IHI website. Please see http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/ for more information.
[34] Renders et al, Diabetes Care, 2001; 24:1821 and Bodenheimer, Wagner, Grumbach, *JAMA* 2002; 288:1910.
[35] Tsai AC, Morton SC, Mangione CM, Keeler EB. *Am J Manag Care*. 2005 Aug. 11(8):478-88.
[36] Please see the IHI website for more information: http://www.ihi.org/IHI/Topics/OfficePractices/PlannedCare/ImprovementStories/InnovationsinPlannedCareataCherokeeNationClinic.htm

1. Metric: Number of multi-disciplinary teams, (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists and other providers) *or* number of clinic sites with formalized teams

    a. Number of teams or sites with formalized teams over baseline

    b. Data Source: TBD by DPH system

    c. Rationale/Evidence: In meta-analysis to assess the impact on glycemic control of 11 distinct strategies for quality improvement in adults with type 2 diabetes, team changes and case management showed the most robust improvements.[37] Team changes included adding a team member or "shared care," use of multidisciplinary teams in the primary ongoing management of patients, or expansion/revision of professional roles.

v. Measure: Implement a risk-reduction program for patients with diabetes mellitus to target patients identified as at-risk (e.g., an inpatient or perioperative glycemic control program; if implementing more than one program, may include as two separate milestones)

1. Metric: Implementation of diabetes risk-reduction program

    a. Documentation of program

    b. Data Source: Program materials

vi. Measure: Implement redesign of Rehabilitation delivery model that may include the following elements: patient-centered daily interdisciplinary rounds in acute rehabilitation, self directed task specific motor practice opportunities in acute rehabilitation setting, therapeutic practice for greater than 3 hours per day/5-6 days a week to drive recovery, patient-centered interdisciplinary documentation, peer-delivered wellness programs, and/or home and community focused rehabilitation.

1. Metric: Redesigned Rehabilitation delivery model

    a. Documentation of program elements

    b. Data Source: Program Materials

vii. Measure: Develop Stroke Medical Home

1. Metric: Establish group clinics for individuals with stroke/Transient Ischemic Attack (TIA)

    a. Numerator: Number of individuals with history of stroke/TIA in past 1 year enrolled in group clinic

    b. Denominator: Number of individuals with history of stroke/TIA in past year

[37] Shojania KG, Rani SR, McDonald KM, Grimshaw JM, et al. Effects of Quality Improvement Strategies for Type 2 Diabetes on Glycemic Control, A Meta-Regression Analysis, JAMA, 296(4), 2006.

viii. Measure: Pilot pharmacy-driven anticoagulation project

1. Metric: Number of percent of patients who have been monitored for at least one month without a face-to-face visit

ix. Measure: Implement a test-ordering process for patients with cardiovascular risk factors, including indicators such as blood sugar level, cholesterol, liver and renal monitoring

1. Metric: Increase the rate that these tests are ordered outside an office visit

x. Measure: Train appropriate staff on evidence-based clinical protocols

1. Metric: Documentation of training of staff on evidence-based protocols

xi. Measure: Evaluate and improve process for clinical protocol development

1. Metric: Documentation of evaluation and improvement of process for clinical protocol development

xii. Measure: Implement evidence-based clinical protocols

1. Metric: Documentation of evidence-based clinical protocol

xiii. Measure: Develop program to identify and manage chronic care patients needing further clinical intervention

1. Metric: Documentation of program to identify patients needing screening test, preventative tests, or other clinical services

xiv. Measure: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types

1. Metric: Documentation of interaction types and expansion of use

xv. Measure: Develop and implement program to assist patient to better self-manage their chronic conditions

1. Metric: Documentation of patient self-management program

xvi. Measure: Develop and implement plan for standing orders (i.e., lab orders for chronic conditions)

1. Metric: Documentation of plan for standing orders

xvii. Measure: Develop and implement program for diabetes care managers to support primary care clinics

1. Metric: Documentation and implementation of plan for diabetic care manager support for primary care clinics

xviii. Measure: Implement a diabetes medication titration program that is supported by pharmacy

1. Metric: Documentation of program implemented

- **Improvement Measures:**

i. Measure: Apply the Care Model to targeted chronic diseases, which are prevalent locally

a. Metric: Number of targeted chronic diseases

i. Name the chronic disease included

ii. Data Source: Registry

iii. Rationale/Evidence: an example of a meta-analysis of interventions to improve chronic illness looked at 112 studies, most of which were randomized clinical trials (27 asthma, 21 chronic heart failure, 33 depression, 31 diabetes); interventions that contained one or more chronic Care Model elements improved clinical outcomes (RR .75-.82) and processes of care (RR 1.30-1.61).[38]

ii. Measure: Improve the percentage of patients with self-management goals[39]

a. Metric: Patients with self-management goals

i. Numerator: The number of patients with the specified chronic condition in the registry with at least one recorded self-management goal

ii. Denominator: Total number of patients with the specified chronic condition in the registry

iii. Data Source: Registry

iv. Rationale/Evidence: "Patients with chronic conditions make day-to-day decisions about—self-manage—their illnesses. This reality introduces a new chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education. Self-management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that (1) programs teaching self-management skills are more effective than

[38] Tsai AC, Morton SC, Mangione CM, Keeler EB. *Am J Manag Care*. 2005 Aug. 11(8):478-88.
[39] Self-management goals help patients with coping mechanisms and quality of life related to chronic disease. These goals are developed by the patient, with the help of his or her care team. The patient's ownership of these goals puts the patient at the center of his or her care, and increases the likelihood of achieving goals because they will be specific to the patient's lifestyle and what he/she believes is possible.

information only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs. Self-management education for chronic illness may soon become an integral part of high-quality primary care."[40]

iii. Measure: Implement Stroke Medical Home (must include at least one of the following metrics):

a. Metric: Antiplatelet medication for secondary stroke prevention

i. Numerator: Number of individuals with history/completed stroke and/or Transient Ischemic Attack (TIA) who are on antiplatelet medication and/or have a documented contraindication

ii. Denominator: Number of individuals with history/completed stroke and/or TIA

b. Metric: Blood pressure control among individuals with history of/a completed stroke and/or TIA

i. Numerator: Number of individuals with history of/a completed stroke and/or TIA in past year who have BP< 120/80

ii. Denominator: Number of individuals with history of/a completed stroke and/or TIA in past year

c. Metric: Exercise

i. Numerator: Number of individuals with history of stroke/TIA in past year who exercise at least 150 min per week

d. Denominator: Number of individuals with history of stroke/TIA in past year

iv. Measure: Redesign Rehabilitation Delivery Model (must include at least one of the following metric):

a. Metric: Reduce acute inpatient rehabilitation (case-mix adjusted) length of stay (LOS)

i. Numerator: Case mix adjusted length of stay

ii. Denominator: Baseline Case mix adjusted length of stay

b. Metric: Maintain or Improve (case-mix adjusted) 3-month Functional Independence Measure (FIM) Follow-up scores

i. Numerator: 3-month FIM follow up scores

[40]Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K., "Patient Self-management of Chronic Disease in Primary Care," *JAMA* (May 15, 2008).

c. Denominator: Baseline FIM follow up scores

v. Measure: Number of patient touches recorded in the registry

a. Metric: Total number of in-person and virtual (including email and web-based) visits, either absolute or divided by denominator

i. Numerator: Number of patient touches recorded in the registry

ii. Denominator: Number of targeted patients in the registry ("targeted" as defined by DPH system)

3. Redesign Primary Care

- Project Goal: Increase efficiency and redesign clinic visits to be oriented around the patient so that primary care access and the patient experience can be improved.

- Potential Project Elements:
  - Implement the patient-centered scheduling model[41] in primary care clinics
  - Implement patient visit redesign[42]
  - Achieve improvements in efficiency, access, continuity of care, and patient experience

- Related Projects:
  - Improve Screening Rates (Cat. 3)
  - Improve Diabetes Care Management and Outcomes (Cat. 3)
  - Improve Chronic Care Management and Outcomes (Cat. 3)
  - Expand Medical Homes (Cat. 2)
  - Expand Chronic Care Management Models (Cat. 2)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Other

- Key Measures:
  - **Process Measures:**

[41] See http://patientvisitredesign.com/techniques/advanced_model.html for the full principles of Coleman Associates' Patient Visit Redesign; and http://patientvisitredesign.com/coleman_associates/pcs_program.html for detailed information about the Patient-Centered Scheduling model..[41] Please see Appendix A below for a summary description.
[42] Ibid.

i. Measure: Establish baseline data for patient appointment 'no-show' rates, days to third-next available appointment, and/or primary care visit cycle times [43]

ii. Measure: Implement the patient-centered scheduling model in primary care clinics

a. Metric: Completion of all three phases of the redesign project: (1) Record, document, and examine random patient calls so that staff are able to experience the process of trying to make an appointment from the patient's perspective, (2) Implement open access scheduling in primary care so patients can make same-day or next-day appointments when indicated, and (3) Call patients in advance to confirm their appointments, pre-register patients, update insurance and demographic information, finding out what prescriptions need to be refilled – and if it makes sense, reschedule the appointment if there is a better time for the patient

i. Numerator: Number of primary care clinics that have fully implemented the model

ii. Denominator: Total number of primary care clinics

iii. Data Source: Program materials or other DPH System sources

iv. Rationale/Evidence: Patient Centered Scheduling (PCS) is the proven methodology for improving the ability of patients to see their doctor when they want to—even the same day. PCS is designed to improve patient access, increase continuity of care, decrease the number of patient no-shows and decrease days to third-next-available appointment. Prior to implementation, "secret shopper" calls take place (random patient calls are recorded and documented) and examined so that staff are able to experience the process of trying to make an appointment from the patient's perspective. Patient visits are also mapped from beginning to end to determine how time in the clinic is spent, and to identify any bottlenecks in the visit process. Once these are conducted, the focus turns to reducing no-show rates and time to third next available appointments. One key tactic to reduce no-show rates and wasted time is to do as much pre-work as possible, such as calling patients in advance to confirm their appointments, pre-registering patients, updating insurance and demographic information, finding out what prescriptions need to be refilled—and if it makes sense, rescheduling the appointment if there's a better time for the patient. Doing patient registration and appointment confirmation ahead of time not only minimizes wasted time, but also gives staff the time to prepare and plan for any unforeseen changes, such as cancellations or changes to appointments. Public hospital systems piloting the patient centered scheduling model have seen significant reductions in no-show rates and days to third-next-available appointments-- which will be critical progress in order to truly offer patients a patient-centered medical home.

[43] Please see following pages for the metric specifications.

iii. Measure: Implement open access scheduling in primary care clinics

a. Metric: Open access scheduling

i. Numerator: Number of primary care clinics that have fully implemented open access scheduling

ii. Denominator: Total number of primary care clinics

iii. Data Source: Scheduling materials or other DPH System sources

iv. Rationale/Evidence: Open access scheduling enables patients to see their doctor when they want to—even the same day, which can improve patient access, increase continuity of care, decrease the number of patient no-shows and decrease days to third-next-available appointment.

iv. Measure: Implement patient visit redesign in primary care clinics

a. Metric: Completion of all four phases of the redesign project: (1) Establish method to collect and report cycle time at least monthly, (2) Compare cycle time to other potential measures of efficiency; (3) Map patient visits from beginning to end to determine how time in the clinic is spent, and to identify any bottlenecks in the visit process, and (4) Conduct a series of tests on the visit model, debrief thoroughly, and refine the model

i. Numerator: Number of primary care clinics that have fully implemented the model

ii. Denominator: Total number of primary care clinics

iii. Data Source: Documentation from DPH System

iv. Rationale/Evidence: to increase efficiency and productivity so that more patients can be seen. Since 1998, the Patient Visit Redesign (PVR) model has been the standard in work process design, drastically improving patient visit times in health care organizations throughout the United States. For California's public hospitals, PVR (done in combination with the Institute for Healthcare Improvement's Breakthrough Series Collaborative model for rapid improvement) decreased the amount of waiting time patients experience (cycle time) and increase the number of patients providers see per hour (provider productivity). Through this process, public hospital teams developed and tested strategies to redesign the patient visit in their clinics. Four didactic and interactive learning sessions were conducted, and in between sessions teams tested their models and collected data to track their progress. With support from private foundation grants, 48 public hospital clinic teams improved their patient visit processes through formal a program with the California Health Care Safety Net Institute. From 2005 through 2008, these clinics (which represent 13 public hospital systems) reduced their cycle times by 45% with the average visit being completed in less than an hour, and increased provider productivity.

While the initial cycle times and productivity have slipped slightly since the completion of the program, the majority of clinics still continue to maintain the improvements and spread the model throughout their systems.

v. Measure: Train staff on methods for redesigning clinics to improve efficiency

a. Metric: Number or proportion of staff trained

i. Numerator: Number of relevant primary care clinic staff trained

ii. Denominator: Total number of relevant primary care clinic staff

iii. Data Source: HR, training program materials

vi. Measure: Implement practice management system

a. Metric: Documentation of practice management system, such as vendor contract

i. Rationale/Evidence: A practice management system is a vital technology tool for establishing the capacity to manage the health care of patient groups or populations, including access to primary care

vii. Measure: Establish mechanism for patient self-enrollment in on-line patient portal for access to their health record and bi-directional communication

a. Metric: Documentation of system being established

viii. Measure: Develop a marketing system to encourage patient enrollment

a. Metric: Documentation of marketing strategy

ix. Measure: Develop/implement a system for protocol driven automatic patient reminders (must select at least one metric):

a. Metric: Document system and processes to implement

b. Metric: Documentation of automated process

x. Measure: Develop protocols for breast, colon and prostate screening

a. Metric: Documentation of system, process to implement screening

- **Improvement Measures:**

i. Measure: Reduce patient appointment no-show rates to 10% or less

a. Metric: No-show rate (The percentage of patients with appointments booked prior to the actual day of clinic who did not show up for their scheduled visit. This excludes same-day appointments and appointments cancelled by patient according to organizational definition for cancel).

i. Numerator: Number of patients who missed an appointment in a medical home session

ii. Denominator: Number of patients scheduled for each session

iii. Data Source: Use practice management system to calculate daily for each provider in clinic

iv. Rationale/Evidence: A high no-show rate represents unused or underused capacity, or an inability to satisfy the patient's request for time and/or day of the appointment.

ii. Measure: Reduce third next available appointment times in primary care clinics to fewer than X calendar days

a. Metric: Third Next-Available Appointment

i. The length of time in calendar days between the day a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as an average of the providers in a given clinic. It will be reported for the most recent month. The ultimate improvement target over time would be 7 calendar days (lower is better), but depending on the DPH system's starting point, that may not be possible within five years.

ii. Data Source: Practice management or scheduling systems

iii. Rationale/Evidence: This measure is an industry standard of patients' access to care. For example, the IHI definition white paper on whole system measures sites this metric.

iii. Measure: Reduce average visit cycle time[44] for primary care clinics to 60 minutes or less – without reducing the time a patients spends with his/her provider

a. Metric: Visit cycle time

i. The time from when the patient enters the clinic or clinical area to when they exit in minutes.

ii. Data Source: Practice management or scheduling systems, or another DPH data source

iii. Rationale/Evidence: A lower cycle time indicates a more streamlined process with fewer handoffs and delays.

iv. Measure: Improve productivity of team

a. Metric: Team Productivity

[44] Cycle time is measured from the time a patient enters to the time a patient exits the clinic. The time being reduced within the cycle is the wait times a patient experiences, while time spent with a provider stays the same or in many cases, increases.

i. Number of patient visits completed divided by the time it took to see those patients from start up to wrap up, including charting and relevant chart work.

ii. Data Source: Practice management or scheduling systems, or another DPH data source

iii. Rationale/Evidence: Higher productivity indicates that work surrounding each visit has been engineered to be more efficient and is executed by a team of staff, not just the provider.

v. Measure: Improve patient satisfaction score (this measure may be moved to Category 3, pending the finalization of Category 3)

a. Metric: Patient satisfaction score

i. Improved patient satisfaction score over baseline, as measured by survey of patients accessing primary care

ii. Data Source: Patient satisfaction score

iii. Rationale/Evidence: With increased access to primary care, that is also redesigned around the patient, patient satisfaction may be positively impacted.

vi. Measure: Patient self-enrollment in on-line patient portal for access to their health record and bi-directional communication

a. Metric: Percent of primary care patients enrolled on-line program

4. Redesign to Improve Patient Experience

- Project Goal: Improve how the patient experiences the care and the patient's satisfaction with the care provided.

- Potential Project Elements:
  - Organizational integration and prioritization of patient experience[45]
  - Data and performance measurement
  - Implementing improvements

- Related Projects:
  - All Categories 1-4 Projects/Interventions

- Key Measures:

[45] (1) "Patient experience" is being used as the term that is also inclusive of the experience of patients' families; and (2) "employee experience" is being used as the term that is inclusive of staff and providers.

- **Process Measures:**

  i. Measure: Appoint an executive accountable for experience performance

     1. Metric: An executive accountable for experience is in place

        a. Data Source: Org Chart

        b. Rationale/Evidence: The organizational culture that creates positive patient experience must be driven from the very top of the organization.[46] Depending upon the organization, one executive could be accountable for both patient and employee experience, or two separate executives could be appointed.

  ii. Measure: Write and disseminate a patient/family experience strategic plan

     1. Metric: Strategic plan written and disseminated widely throughout the organization

        a. Submission of strategic plan

        b. Data Source: Internal organizational communications, experience strategic plan

        c. Rationale/Evidence: A strategic plan is seen by experts in the field as an essential foundation for any organizational work toward improving patient experience. Employee experience could be integrated into the patient experience strategic plan, or a separate plan could be created.

  iii. Measure: Include experience vision and objectives into organizational strategy

     1. Metric: Top organizational strategies contain explicit references to patient experience

        a. Submission of strategic plan

        b. Data Source: Organizational strategic plan

        c. Rationale/Evidence: Having patient experience referenced in the top document that governs the operations of the organization will, along with other measures here, solidify the organizational commitment to high performance in this area.

  iv. Measure: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience

     1. Metric: A steering committee in place and meets at least bi-monthly

        a. Documentation of committee proceedings

[46] For example, see materials by Picker Institute, the Institute for Patient and Family Centered Care, as well as national leaders such as Dale Schaller, Bridget Duffy and Anthony DeGioia.

b. Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members

c. Rationale/Evidence: A high-level organizational committee is essential in driving patient experience improvement organization-wide. Employee experience can be driven by the same committee, or a separate committee could be established.

v. Measure: Integrate patient experience into employee training

1. Metric: Include patient experience content into new employee orientation and other organizational learning opportunities

a. Documentation of training materials

b. Data Source: Course/training curricula

c. Rationale/Evidence: Integrating patient experience into all organizational learning is seen as a best practice in the field, as it prompts staff/employees to consider patient experience in all parts of their day-to-day job duties. It is recommended that employee experience also be included in organizational training.

vi. Measure: Integrate patient and/or employee experience into management performance measures

1. Metric: Include specific patient and/or employee experience objectives into management work plans and measures of performance.

a. Data Source: Division/unit/department workplans

b. Rationale/Evidence: Accountability for experience performance must be spread throughout the organization. Just as the executive in charge of the experience agenda is accountable to the CEO, similar accountability structure should be in place at all levels of management and operations.

vii. Measure: Integrate patient and/or employee experience into employee performance measures

1. Metric: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.

a. Data Source: Job descriptions, staff performance metrics

b. Rationale: Each employee should have clear performance expectations as related to patient experience.

viii. Measure: Assess the organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement

1. Metric: Assessment, including answering questions such as: What areas of the organization have regular measures (e.g., inpatient vs. clinics vs. EDs); What

methods are used to obtain experience data (e.g., mailed surveys vs. phone); What are the scores/findings for the organization as a whole?; What are the scores/findings by service line, location, and patient demographics?; What are the response rates by service line, location, and patient demographics?; and/or How are data stored, analyzed, fed back to the "sharp end" and used in quality improvement?

a. Submission of assessment

b. Data Source: Assessment

c. Rationale/Evidence: It is important to clearly establish the organizational baseline as the foundation for improvement work.

ix. Measure: Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data

1. Metric: This will vary from DPH system plan to DPH system plan, based on the gaps identified in the assessment (previous bullet) and the assignment of improvement priorities by organization's leaders. Examples include: Develop a new patient experience survey tool or revise and improve the current ones; Translate and/or simplify written surveys to make them more user-friendly to LEP and low-literacy populations; Implement phone surveys and/or focus groups as alternative methodologies to written surveys; Conduct care experience flow mapping;[47] implement a survey of employee experience[48]; Roll out a pilot of real-time electronic methodology for capturing patients' feedback during the process of care;[49] and/or Implement another innovative method for obtaining patient and/or employee experience information

a. Documentation of inquiry materials

b. Data Source: Depends upon methodology selected

c. Rationale/Evidence: Written mail-in surveys are most commonly used in obtaining patient experience information, yet this methodology often yields small numbers of responses given the socioeconomic circumstances of the typical public hospital patient populations. Therefore, it is important to test other methodologies that may be more applicable and convenient for typical public hospital patient populations.

x. Measure: Develop a plan to roll out a regular inquiry into patient experience in a new area of the organization, which currently does not collect patient experience information, for example, primary care clinics

1. Metric: Patient experience expansion plan

[47] For example, implement "Patient Shadowing" - a method of viewing all care from the eyes of the patients and families, available here http://www.innovationctr.org/toolbox.htm
[48] For example, see NRC Picker Employee Experience Surveys, available here http://nrcpicker.com/default2.aspx?DN=1671,3,1,Documents
[49] For example, TruthPoint, available here http://www.truth-point.com/truthpoint

a. Submission of plan

b. Data Source: Plan

c. Rationale/Evidence: Patient experience information is currently not obtained from all parts of the organization, and it should be. For example, a DPH system that does not currently collect patient experience data in its outpatient settings may want to start implementing this by adopting a validated survey and administering it at regular intervals.

xi. Measure: Administer regular inquiry into patient experience in the new organizational area

1. Metric: Inquiry at regular intervals using methodologies such as: Written surveys, Phone interviews; Focus groups; Care experience flow mapping;[50] Real-time electronic methodology for capturing patients' feedback during the process of care;[51] and/or Another innovative method for obtaining patient experience information

a. Documentation of inquiry

b. Data Source: TBD by DPH system, depending on the methodology selected for patient experience inquiry

c. Rationale/Evidence: Patient experience information should be obtained from all parts of the organization.

xii. Measure: Orchestrate improvement work on identified experience targets, (targets could include, for example, better understanding of HCAHPS results or results of other measures; improved caregiver communication; better discharge planning; improved cleanliness, noise levels and/or dining experience; better ambulatory experience; improved employee experience, etc.)

1. Metric: Workgroups are formed under the steering committee to work on experience targets. Detailed implementation plans are created for each workgroup

a. Data Source: Implementation plans

b. Rationale/Evidence: An organizational structure is needed to perform the improvement work around patient and/or employee experience.

xiii. Measure: Develop and implement organizational strategies to improve patient, family and/or employee experience

1. Metric: Implement and sustain at least one organizational strategy per year aimed at improving patient. family and/or employee experience. Examples include involving patients/families as partners in organizational quality

[50] For example, implement "Patient Shadowing" - a method of viewing all care from the eyes of the patients and families, available here http://www.innovationctr.org/toolbox.htm
[51] For example, TruthPoint, available here http://www.truth-point.com/truthpoint

improvement, development, and/or governance;[52] enhancing nurse-nurse and nurse-patient/family communication;[53] rolling out a campaign of "always events" – those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system;[54] establishing a patient care navigation program (see separate entry in further text), and/or regularly presenting "Patient/Family Testimonials" at key organizational management meetings in order to connect leaders with the real-life experiences of the patients and their families; and/or adopting management practices that result in improved employee experience[55]

a. Number of experience improvement initiatives conducted

b. Data Source: Documentation of strategy(ies) implemented

c. Rationale/Evidence: Developing and implementing strategies to reach organization's experience targets is at the core of improvement work in this area.

xiv. Measure: Perform a mid-course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation

1. Metric: Evaluation performed, following the suggested structure of the baseline assessment, above

a. Submission of evaluation

b. Data Source: Evaluation write-up

c. Rationale/Evidence: It is an integral part of performance improvement to periodically review success of the efforts.

xv. Measure: Develop, implement, and/or enhance a patient experience survey tool

1. Metric: Patient experience survey tool

a. Submission of tool

b. Data Source: Survey tool

xvi. Measure: Develop a training program on patient experience

1. Metric: Training program materials

a. Submission of program materials

xvii. Measure: Train number or percent of providers/clinicians/staff

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[52] For example, include patients/families into organizational efficiency projects such as LEAN, or develop an advisory council of patients and families
[53] For example, "Nurse Knowledge Exchange", available here http://www.innovations.ahrq.gov/content.aspx?id=1803
[54] More information available here http://alwaysevents.pickerinstitute.org/
[55] For example, Evidence Based Leadership by Studer Group, available here http://www.studergroup.com/dotCMS/knowledgeAssetDetail?inode=411208

1. Metric: Number or percent of staff trained
    a. Numerator: Number of staff trained
    b. Denominator: Total number of relevant staff
    c. Data Source: HR documents or training program records

- **Improvement Measures:**

i. Measure: Improve patient satisfaction/experience scores (this measure may be moved to Category 3, pending the finalization of Category 3)
    a. Metric: Improve patient satisfaction scores
        i. Percent improvement of patient satisfaction scores over baseline
        ii. Data Source: Patient satisfaction/experience survey and/or CMS Medicare Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores
        iii. Rationale/Evidence: Improvement in experience scores will be the ultimate measure of success of improvement efforts.

ii. Measure: Improve employee experience scores
    a. Metric: Improve scores on a consistently administered measure of employee experience

iii. Measure: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families
    a. Metric: Demonstrated at least one organization-wide display (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work.
        i. Data Source: Display and internal communication
        ii. Rationale/Evidence: Keeping the workforce informed on the progress of improvement efforts is key to developing an organization-wide ownership of the efforts.

iv. Measure: Make patient and/or employee experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of its patients and their families
    a. Metric: Demonstrate at least one external communication per year aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient and/or employee experience.
        i. Data Source: External communication

ii. Rationale/Evidence: As a community asset, the organization is ultimately accountable to the community for its results, which includes the experience of patients and/or employees.

5. Redesign for Cost Containment

- Project Goal: Develop the capability to test methodologies for measuring cost containment that may be applied to other projects or efforts so that the ability to measure the efficacy of these initiatives is in place.

- Potential Project Elements:
  - Implement cost-accounting systems to measure intervention impacts
  - Establish a method to measure cost containment
  - Establish a baseline for cost
  - Measure cost containment

- Related Projects:
  - Potentially all Categories 3-4 Projects/Interventions
  - Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Review current cost allocation and accounting system capabilities and select a system/methodology that will allow for cost measurement

    ii. Measure: Implement cost-accounting systems to measure intervention impacts

    a. Metric: Cost-accounting system

    i. Documentation of adoption, installation, upgrade and/or interface of technology, and/or implementation of system using existing technology

    ii. Data Source: Cost-accounting system

    iii. Rationale/Evidence: Interventions require the investment of numerous resources at many levels of the delivery system. A cost-accounting system provides the system with the necessary tool to gauge the financial return on investment of their intervention(s).

    iii. Measure: Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions

a. Metric: Cost-accounting methodology/metric

i. Documentation of the methodology and metric (e.g., average cost per case for each hospital bed day for chosen specific clinical conditions; average annual cost of hospitalization for chosen specific primary diagnoses clinical conditions; average cost per case for each bed day for patients hospitalized for chosen specific primary diagnoses clinical conditions)

ii. Data Source: Cost-accounting system or another administrative, financial or clinical data set

iii. Rationale/Evidence: An accurate cost-accounting methodology/metric is a necessary tool for the hospital delivery system to gauge the impact of quality and efficiency improvement interventions on the cost per unit of service for the delivery component the system is trying to improve.

iv. Measure: Establish a baseline for cost

a. Metric: Establish a baseline for cost

i. Submission of baseline data

ii. Data Source: Cost-accounting system or another administrative, financial or clinical data set

iii. Rationale/Evidence: An accurate baseline for cost per unit of service must be established in order for the hospital delivery system to effectively measure its progress towards lowering costs.

v. Train Finance staff on costing methodologies and define, develop, and document methodologies with departments for allocation of costs to specific services

- **Improvement Measures:**

i. Measure: Measure cost containment

a. Metric: TBD by DPH system

i. Numerator: TBD by DPH system

ii. Denominator: TBD by DPH system

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: Despite extensive research through the California Health Care Safety Net Institute, there is no existing methodology for measuring cost containment in the care delivery system where causal, direct impacts can be established, likely due to the multitude of factors and variables. This will be an innovative place to test and perhaps identify one.

6. Integrate Physical and Behavioral Health Care[56]

- Project Goal: Integrate the inter-related components of physical and behavioral health care so that care can be better coordinated and the patient can be treated as a whole person, potentially leading to better outcomes and experience of care.

- Potential Project Elements:
    - Implement physical-behavioral health integration pilots
    - Train primary care providers in behavioral health care
    - Better identify patients needing behavioral health care
    - Improve coordination and referral patterns between primary care and behavioral health
    - Link patients with serious mental illnesses to a medical home or another care management program

- Related Projects:
    - Reduce Readmissions (Cat. 3)
    - Improve Quality (Cat. 3)
    - Reduce Disparities (Cat. 3)
    - Improve Screening Rates (Cat. 3)
    - Improve Diabetes Care Management and Outcomes (Cat. 3)
    - Improve Chronic Care Management and Outcomes (Cat. 3)
    - Expand Medical Homes (Cat. 2)
    - Expand Chronic Care Management Models (Cat. 2)
    - Redesign Primary Care (Cat. 2)
    - Redesign to Improve Patient Experience (Cat. 2)
    - Improve Patient/Caregiver Experience (Cat. 3)
    - Other

- Key Measures:
    - **Process Measures:**
        i. Measure: Educate and/or train primary care clinicians in behavioral health care

[56] Please see Appendix A for a summary description.

1. Metric: Training in behavioral health care (may include training to screen paneled patients for depression at appropriate interval and to initiate indicated treatment)

    a. Submission of curriculum or other educational materials

    b. Data Source: Training program materials

    c. Rationale/Evidence: Mental health and substance abuse issues are extremely common in safety net populations, and either account for or influence a very high percentage of primary care visits (Bureau of Primary Health Care, 2004). The vast majority of patients with behavioral health problems are managed by primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (generally limited to the severely and persistently mentally ill) or because the patient refuses behavioral health specialty care (often because of the stigma attached to such care) (Cunningham, 2009). Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves. Behavioral health patients have significant chronic physical health conditions (Institute of Medicine, 2005) which often go untreated, and these patients suffer increased morbidity, poorer quality of life, and significantly earlier mortality than patients without behavioral health diagnoses (Olfson, Sing, and Schlesinger, 1999).

ii. Measure: Assess demand and capacity for locating behavioral health services in primary care clinics

1. Metric: Demand assessment

    a. Submission of assessment findings

    b. Data Source: Assessment

    c. Rationale/Evidence: The same psychosocial factors which complicate the health care of safety net populations affect both behavioral health and physical health patients (poverty, poor health literacy, limited English proficiency, homelessness, poor sense of self efficacy, chaotic lives, at-risk minority status, etc.)

iii. Measure: Implement physical-behavioral health integration pilots, such as implementing the IMPACT Model[57] and/or Four Quadrant Model[58]

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[57] Excerpted from the IMPACT website at the University of Washington at http://impact-uw.org/about/key.html. Also, please reference the document titled, *Evidence-Based Models Implemented by DPH Systems to Enhance Quality, Promote Coordinated Care, Build Medical Homes and Ensure Access*, which was provided to CMS by the California Health Care Safety Net Institute on November 29, 2010.

[58] The Four Quadrant model is a model for the proposed integration of clinical mental health and behavioral health services. The emphasis is on the prevalence of concurrent disorders (e.g., depression and alcoholism). The Four Quadrant model is based on the 1998 consensus document on mental health and substance abuse/addiction integration service. The severity for each disorder is divided into Four Quadrants: (1) Low mental health – low substance abuse, served in primary care; (2) High mental health – low substance abuse, served in the mental health

1. Metric: Implement the model (may include a model listed below or an alternative model as designated by the DPH system):

    a. IMPACT Model: Compliance with implementing the five essential components: (1) Collaborative care is the cornerstone of the IMPACT model and functions in two main ways; (2) Depression Care Manager; (3) Designated Psychiatrist; (4) Outcome measurement; and (5) Stepped care

    b. Four Quadrant Model: The Four Quadrant model is based on the 1998 consensus document on mental health and substance abuse/addiction integration service. The severity for each disorder is divided into Four Quadrants: 1) Low mental health-low substance abuse, served in primary care; 2) High mental health-low substance abuse, served in the mental health system by staff who have substance abuse competency; 3) Low mental health-high substance abuse, served in the substance abuse system by staff who have mental health competency; and 4) High mental health-high substance abuse, served by fully integrated mental health and substance abuse program.

    c. Data Source: Documentation of workplans, processes, roles/responsibilities, program descriptions, and/or other materials from the pilot

    d. Rationale/Evidence: Recent studies show that integration of behavioral health (mental health and substance abuse) and physical health services should be the standard for advanced health care systems. This finding is part of a larger trend to better integrate the various parts of a health care system in the interest of more cost-effective and comprehensive patient care. The more integrated these various components are at the programmatic and clinical levels, the more likely that patients with complex conditions and socioeconomic challenges will have their medical and psychosocial needs met in a comprehensive fashion, rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost. There is sufficient evidence that there are significant numbers of patients who could benefit from better recognition and treatment of mental health issues within primary care. Health care systems which have successfully implemented programs to integrate behavioral health and primary care services have tended to demonstrate improved care and significant cost savings (Health Management Associates, 2007), in addition to increased provider satisfaction and improved patient satisfaction. A number of high profile organizations, including the Institute of Medicine, the Robert Wood Johnson Foundation, and the Health Resources and Services Administration (HRSA), have either recommended integration of physical and behavioral health services or

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system by staff who have substance abuse competency; (3) Low mental health – high substance abuse, served in the substance abuse system by staff who have mental health competency; and (4) High mental health – high substance abuse, served by a fully integrated mental health and substance abuse program. The Four Quadrant model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning in each local system.

funded projects dedicated to doing so (Health Management Associates, 2007).

iv. Measure: Co-locate behavioral health and primary care (must select at least one metric):

1. Metric: Number of primary care clinics with co-located behavioral health services, *or vice versa*

2. Metric: Transfer behavioral health professionals into primary care clinics

3. Metric: Transition number or percent of stable and compliant seriously mentally ill psychiatric patients from specialty mental health care to a clinic based care model

a. Data Source: Documentation of rotation schedules and/or patient panels, workplans, processes, roles/responsibilities, program descriptions, and/or other materials from the co-location

b. Rationale/Evidence: Recent studies show that integration of behavioral health (mental health and substance abuse) and physical health services should be the standard for advanced health care systems. This finding is part of a larger trend to better integrate the various parts of a health care system in the interest of more cost-effective and comprehensive patient care. The more integrated these various components are at the programmatic and clinical levels, the more likely that patients with complex conditions and socioeconomic challenges will have their medical and psychosocial needs met in a comprehensive fashion, rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost. There is sufficient evidence that there are significant numbers of patients who could benefit from better recognition and treatment of mental health issues within primary care.

v. Measure: Development of a tracking mechanism of referrals from primary care providers to on-site mental health professionals to be used at the pilot of physical-behavioral health sites

1. Metric: A process or mechanism for tracking referrals from primary care providers to on-site mental health professionals, ready for implementation. Process or mechanism must identify the current number of referrals for use as baseline data.

a. Data Source: Documentation of process for creating and adjusting tracking mechanism, including supporting materials such as development of criteria for referral and descriptions of processes, workplans, roles and responsibilities, and timeline and frequency of tracking.

b. Rationale/Evidence: The vast majority of patients with behavioral health problems are managed by primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (generally limited to

the severely and persistently mentally ill) or because the patient refuses behavioral health specialty care (often because of the stigma attached to such care) (Cunningham, 2009). Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves. The more integrated the various components are at the programmatic and clinical levels, the more likely that patients with complex conditions and socioeconomic challenges will have their medical and psychosocial needs met in a comprehensive fashion, rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost.

vi. Measure: Develop patient visit tracking model to establish staffing productivity, patient no show rates, and/or financial cost and reimbursement dimensions of the new service component.

vii. Measure: Track the number of referrals from primary care providers to on-site mental health professionals to be used at the pilot of physical-behavioral health sites

1. Metric: Number of referrals from primary care providers to on-site mental health professionals

a. Once a baseline has been established, number or percent of referrals from primary care providers to on-site mental health professionals over baseline

b. Data Source: Tracking mechanism, into which data will be input and/or evidence of accurate measurement of the number of referrals

c. Rationale/Evidence: The vast majority of patients with behavioral health problems are managed by primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (generally limited to the severely and persistently mentally ill) or because the patient refuses behavioral health specialty care (often because of the stigma attached to such care) (Cunningham, 2009). Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves. The more integrated the various components are at the programmatic and clinical levels, the more likely that patients with complex conditions and socioeconomic challenges will have their medical and psychosocial needs met in a comprehensive fashion, rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost.

viii. Measure: Establish/implement/distribute consensus-care referral guidelines

1. Metric: Submission of developed referral guidelines/policies

a. Rationale/Evidence: In an effort to standardize referrals and the parameters for referrals between physical and behavioral health care providers, the patient can receive a better continuity of care with increased access to holistic health care, and reduce inappropriate referrals.

ix. Measure: Use joint consultations and treatment planning, and coordinate resources to improve patient education, support, and compliance with the medication regimen

1. Metric: Joint consultations

a. Number of joint consultations over baseline

b. Rationale/Evidence: Patients with both behavioral and physical conditions generate significantly higher medical costs than patients with only one set of conditions, and treatment of the behavioral health conditions lowers those costs, particularly if diagnosed early (Olfson, Sing, and Schlesinger, 1999).

x. Measure: Implement a psychiatric evaluation program

a. Metric: Implementation of a psychiatric evaluation program

b. Data Source: Documentation of workplans, processes, roles/responsibilities, program descriptions, and/or other materials related to creation of this program.

xi. Measure: Implement a case management program

1. Metric: Implementation of a case management program.

a. Data Source: Documentation of workplans, processes, roles/responsibilities, program descriptions, and/or other materials related to creation of this program.

b. Rationale/Evidence: Case management has the potential to be an important resource for incorporating preventive and primary care treatment goals. Mental health case managers can play a key role in assisting patients in developing self-management goals, managing chronic conditions, and promoting wellness by supporting tobacco cessation, nutrition, and exercise.[59] Case management is also one of the criteria for the medical home that is beneficial to both physical and mental health (2008), as defined by the National Committee for Quality Assurance (NCQA).

xii. Measure: Convene a clinical content team for development of a structured algorithm to determine selection of pharmacologic therapy for depression.

1. Metric: Select members of the County clinic content team.

xiii. Measure: Implement a structured care algorithm for selection of pharmacologic therapy for depression

1. Metric: Implementation of care algorithm for selection of pharmacologic therapy for depression.

[59] Collins, et al. *Evolving Models of Behavioral Health Integration in Primary Care*. Milbank Memorial Fund, New York. ISBN 978-1-887748-73-5.

a. Data Source: Documentation of workplans, processes, roles/responsibilities, program descriptions, and/or other materials related to creation of this program.

b. Rationale/Evidence: Depression is common in primary care patients, with an incidence from 10 to 15 percent among patients who present to a physician's office for any reason. Many patients benefit from pharmacologic treatment and, because there is little variation in antidepressant effectiveness, medication choices should be made based on patient characteristics, safety, and anticipated side effects.[60]

xiv. Measure: Implement telepsychiatric consultation

1. Metric: Number of clinics with telepsychiatric consultations

- **Improvement Measures:**

i. Measure: Integrate depression screening of targeted patients within the primary care setting

a. Metric: PHQ-9 Depression Score[61] and/or a another depression screening tool for targeted patients (as defined by DPH system) diagnosed with depression seen in an integrated physical/mental health setting

i. Numerator: Number of targeted patients seen in the physical and behavioral health integration pilot primary care clinics that are screened for depression

ii. Denominator: Total number of targeted patients seen in the physical and behavioral health integration pilot primary care clinics

iii. Data Source: Registry, charts, other practice management system, EHR, or other documentation as designated by DPH system

iv. Rationale/Evidence: Optimal management of chronic diseases such as diabetesis often hampered by unrecognized or inadequately treated depression. In addition, improved recognition of depression through systematic screening within the diabetic population will promote better outcomes. The PHQ-9 is recommended as an effective measurement tool; however, there are other effective tools. A critical tool to measure the impact of integrating physical and behavioral health care being adopted in public hospital systems is the PHQ-9 Depression Screening Tool. Research indicates that 10-15% of all primary care patients have depression, which is one of the top five most common conditions found in primary care settings.

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[60] Adams, et al. University of Tennessee College of Medicine, Chattanooga, Tennessee. *Am Fam Physician.* 2008 Mar 15;77(6):785-792.

[61] The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire (PHQ), which is a depression screening tool used widely by primary care clinicians to diagnose mental health disorders. This tool is found to be an efficient way to screen individuals and large groups of patients to improve detection of undiagnosed depression. Also see Appendix A for further information.

According to an evaluation of 20 studies over the past 10 years, the prevalence rate of diabetics with major depression is three to four times greater than in the general population, according to the American Diabetic Association.

ii. Measure: Achieve number or percent of annual history and physicals (H&P) for severely and persistent mentally ill population without regular primary care

a. Metric:

i. Numerator: Number of targeted patients seen in pilot clinic with completed history and physical

ii. Denominator: Total number of targeted patients seen in the pilot clinic

iii. Measure: Increase the number or percent of patients with a behavioral health care need (e.g., primary diagnosis of depression) as identified by the primary care provider, who have access to behavioral health care (e.g., visits with social workers, case managers or psychiatrists), as needed

a. Metric: Primary care-initiated scheduled visits with behavioral health professionals

i. Number of patients with a behavioral health care need (e.g., primary diagnosis of depression) as identified by the primary care provider who have access to visits with behavioral health professionals over baseline

ii. Data Source: Documentation counting the number of patients with a Diagnostic and Statistical Manual (DSM) mental health diagnosis or substance abuse issue, including supporting evidence of proper diagnosis and consultation to provide access to behavioral services

iii. Rationale/Evidence: Failure to detect and treat behavioral health needs leads to unnecessary suffering and disability, and increases the use of health care services. For example, the U.S. Preventative Service Task Force finds that screening for depression in the primary care setting improves detection rates, which in turn helps physicians provide the proper treatment to their patients.

iv. Measure: Provide timely initial behavioral health visit wait times

a. Metric: Initial behavioral health visit wait time among enrolled patients who meet the medical necessity criteria, the median wait time for an initial behavioral health visit will be less than X days (as defined by DPH system in working with behavioral health counterparts)

i. Data Source: Practice management or scheduling systems, or other documentation decided by DPH system and behavioral health counterparts

ii. Rationale/Evidence: Long visit wait times could potentially force patients suffering from mental illness to go without help. This could result in unnecessary emergency room visits or even jail.

v. Measure: Assign patients discharged from the inpatient psychiatric unit to a medical home

a. Metric: Patients discharged from the inpatient psychiatric unit who have an assigned medical home.

i. Numerator: Number of patients discharged from the inpatient psychiatric unit who have an assigned medical home

ii. Denominator: Total number of total patients discharged from the inpatient psychiatric unit

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: Access to primary care is important because newer medications used to treat mental illnesses put patients at increased risks for diabetes and other metabolic problems. By increasing access to behavioral, social and medical services, there is potential to reduce the risk of repeated hospitalizations.

vi. Measure: Increase the number of telepsychiatric consultations

a. Metric: Number of telepsychiatric consultations

vii. Measure: Provide primary care patients behavioral health service (must select at least one metric):

a. Metric: Number or percent of primary care patients receiving behavioral health service(s)

b. Metric: Number or percent of patients referred from primary care system to behavioral health integrated clinic will have received brief treatment through integrated behavioral health service

viii. Measure: Health and behavioral health status data will be collected and tracked on behavioral health patients treated within primary care setting.

a. Metric: Percent of behavioral health patients treated within primary care setting.

ix. Measure: Primary care patients who receive behavioral health services will report improved satisfaction with overall healthcare received; increased involvement in care; and/or improved emotional well being

x. Measure: Reduction in overall time in the ED for psychiatric patients

a. Metric: Reduction in overall time in the ED for psychiatric patients

i. Numerator: Total time spent in ED.

ii. Denominator: ED visits

iii. Data Source: ED electronic record.

xi. Measure: Decreased utilization of the ED services by enrolled program participants

a. Metric: Decreased utilization of the ED services by enrolled program participants.

i. Numerator: ED visits.

ii. Denominator: Program participants

iii. Source: Decision support system.

xii. Measure: Decreased recidivism as measured by decreased re-hospitalization for program participants

a. Metric: Decreased recidivism as measured by decreased re-hospitalization for program participants

i. Numerator: Inpatient admissions.

ii. Denominator: Program participants

iii. Source: Decision support system.

7. Increase Specialty Care Access/Redesign Referral Process

- Project Goal: Increase access to specialty care through increased efficiencies, capacity and systems so that patients in need of specialist care can receive that care in a timely manner.

- Potential Project Elements:
  - Implement transparent, standardized referrals across the system
  - Improve access to specialty care

- Related Projects:
  - Reduce Readmissions (Cat. 3)
  - Improve Quality (Cat. 3)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Other

- Key Measures:

- **Process Measures:**

i. Measure: Develop and implement standardized referral and work-up guidelines

a. Metric: Referral and work-up guidelines

i. Documentation of referral and work-up guidelines

ii. Data Source: eReferral or other referral and work-up policies and procedures documents

iii. Rationale/Evidence: More standardized and extensive pre-visit workups and referral guidelines will help to ensure that (1) patients must meet a common criteria to require a specialty care visit (versus receiving treatment in the primary care setting), (2) patients are triaged by urgency/need to increase specialty care access to those who need it most, and (3) the work required prior to the visit is performed before the visit is scheduled, eliminating the occurrence of multiple, initial specialist visits

ii. Measure: Complete a planning process/submit a plan to implement electronic referral technology (choose at least one metric):

a. Metric: Development of a staffing plan for e-referral

i. Data Source: E-Referral plan, describes the number and types of and staff and their respective roles needed to implement the system.

b. Metric: Development of an implementation plan for e-referral

i. Data Source: E-Referral plan, which describes the technical mechanisms needed to operate e-referral system.

iii. Measure: Develop the technical capabilities to facilitate electronic referral

a. Metric: Demonstrate technical mechanisms to be used to operate e-referral system are in place

i. Data Source: TBD by DPH system

ii. Rationale/Evidence: In order to implement e-referral technology, other technical capabilities may need to be put in place first.

iv. Measure: Implement referrals technology and processes that enable improved and more streamlined provider communications

i. Documentation of referrals technology

ii. Data Source: eReferral or other referral system

iii. Rationale/Evidence: According to a recent University of California at San Francisco (UCSF) report[62], access to specialists is a common barrier for primary care clinicianstrying to deliver high-quality, coordinated care, especiallywhen their patients are poor or uninsured. To offer the standardof care required by the patient-centered medical home model,clinicians must be able to tap into a "medical neighborhood"of specialists and hospitals to obtain timely consultations,diagnostic services, and needed treatments. The way many healthcare networks still communicate is through telephone, paper and fax, which creates process inefficiencies, inaccurate data and slow information updates.

v. Measure: Increase referral coordination resources for primary care and medical specialty clinics by developing and implementing bi-directional communication functionality in the system

a. Metric: Number of primary care and medical specialty clinics that manage referrals utilizing the bi-directional communication function of the referral management system.

i. Numerator: Number of referrals into medical specialty clinics over a defined period of time that are managed utilizing the bi-directional communication function of the referral management system.

ii. Denominator: Total number of referrals into medical specialty clinics over a defined period of time.

iii. Data Source: Patient or electronic medical record that shows the bi-directional communication between primary and medical specialty clinics.

iv. Rationale/Evidence: Enhanced communication about a patient's condition between primary care and medical specialty providers creates the opportunity for better coordinated care and also for the patient to be treated in the most appropriate clinical setting.

vi. Measure: Implement the re-design of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity.

a. Metric: Number of medical specialty clinics that have completed clinic redesign.

i. Numerator: Average cycle time of appointments in medical specialty clinics that have undergone re-design.

ii. Denominator: Overall average cycle time of appointments in all medical specialty clinics.

iii. Data Source: Specialty clinic appointment tracking system.

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[62]See *A Safety-Net System Gains Efficiencies Through 'eReferrals' To Specialists* report. Alice Hm Chen, Margot B. Kushel, Kevin Grumbach, and Hal F. Yee, Jr. http://content.healthaffairs.org/cgi/content/extract/29/5/969

iv. Rationale/Evidence: Re-designing medical specialty clinics in order to shorten appointment cycle time and maximize provider productivity allows the most efficient utilization of specialty provider resources.

vii. Measure: Conduct specialty care gap assessment

a. Metric: Gap assessment

i. Submission of completed assessment

ii. Data Source: Assessment

iii. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access

viii. Measure: Train or education personnel and/or referring providers on referral guidelines

a. Metric: Number of personnel/referring providers trained/educated

ix. Measure: Analyze occurrence of unnecessary specialty clinic follow-up appointments

a. Metric: Number of unnecessary specialty clinic follow-up appointments

b. Data Source: Chart review with protocol for determining unnecessary follow up visits

- **Improvement Measures:**

i. Measure: Implement specialty care access programs (e.g., e-referral technologies)

1. Metric: Number of primary care and medical specialty clinics with specialty care access programs

a. Numerator: Number of primary care and medical specialty clinics with specialty care access programs

b. Denominator: Total number of primary and medical specialty clinics

c. Data Source: Written workflows of referral management processes, documentation of specialty care access program, documentation of utilization of specialty care access program in patient's paper or electronic medical record.

d. Rationale/Evidence: An intentional and well-designed specialty care access program can increase the opportunity for patients to receive timely care in the most appropriate setting.

ii. Measure: Increase the number of referrals for the most impacted specialties that are reviewed and assigned into appropriate categories (i.e., urgent appointment, routine appointment, or e-consult)

1. Metric: Proportion of referrals appropriately categorized

    a. Numerator: Number of referrals appropriately categorized

    b. Denominator: Total number of referrals

    c. Data Source: Referral management system, patient's paper or electronic medical record.

    d. Rationale/Evidence: Reviewing and assigning referrals into categories by urgency as mutually agreed upon by primary and medical specialty providers enhances the likelihood that medical specialists are consistently seeing patients that most need their care in the shortest amount of time possible.

iii. Measure: Reduce the rate of inappropriate or rejected referrals / or Increase the rate of appropriate or accepted referrals

1. Metric: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter.

    a. Numerator: Number of referrals from primary care providers to specialists that were rejected/accepted by specialists

    b. Denominator: Total number of referrals made by primary care providers to specialists

    c. Data Source: eReferral or other referrals system

    d. Rationale/Evidence: Currently, specialty providers have very little ability to provide feedback to primary care providers prior to an appointment being scheduled. Therefore immediately after implementation of e-referral, we expect a significant number of referrals will be "rejected." As primary care providers become more familiar with the guidelines and receive more pre-visit guidance from the specialist, this rejection rate will start to decrease.

iv. Measure: Reduce the average number of specialty follow-up visits

1. Metric: Utilization of medical specialty appointments for routine follow- up care.

    a. Numerator: Number of appointments in medical specialties for routine follow-up care for a targeted group of patients.

    b. Denominator: Total number of appointments for a targeted group of patients.

    c. Data Source: Appointment scheduling software. Paper or electronic medical record indicating purpose of visit in medical specialties clinic.

    d. Rationale/Evidence: Patients should receive care in the most appropriate setting. Monitoring the utilization patterns of patients to

reduce the number of routine follow up appointments provided in an inappropriate setting and re-directing patients helps to achieve more appropriate utilization of medical specialty appointments.

v. Measure: Measure wait times for specialty care appointments

1. Metric: The percent of referrals seen/evaluated by a specialist (either electronically or in-person) within a defined period of time since referral initiation

a. Numerator: The number of patients evaluated by a medical specialist within a defined time period.

b. Denominator: The total number of patients evaluated by a medical specialist within a defined time period.

c. Data Source: Appointment scheduling software.

d. Rationale/Evidence: Tracking wait times for patients into medical specialties allows for targeted interventions in medical specialty clinics. One of the key features of an electronic referral system is to allow specialists to both prioritize referrals and work with primary care referring providers to avoid unnecessary referrals by providing timely feedback. Rather than waiting months for an in-person visit, patients can be effectively managed in through timely advice and feedback from specialists to primary care providers.

vi. Measure: Measure the number of specialty care referrals that result without a specialty clinic visit

1. Metric: TBD by DPH System

vii. Measure: Patients receive a follow-up contact by their primary care provider within 90 days following a request by the specialist

1. Metric: Days to follow-up contact

a. Numerator: The number of patients that receive a follow-up contact by their primary care provider within 90 days following a request by the specialist.

b. Denominator: The total number of patients for whom a specialist has requested a 90-day follow-up appointment with their primary care provider.

c. Data Source: Paper or electronic medical record and appointment scheduling software.

d. Rationale/Evidence: Patients who are seen in primary care within 90 days as follow up to an appointment with a medical specialist are more likely to receive care in the appropriate setting.

viii. Measure: Measure proportion of specialty referrals initiated and processed through the system

1. Metric: E-referrals volume

    a. Numerator: Number of specialty referrals initiated and processed through e-referral technology/system

    b. Denominator: Total number of specialty referrals

    c. Data Source: Documentation of referral in e-referral technology system and referrals received through alternate methods (Faxes/phone calls)

    d. Rationale/Evidence: Moving a traditional paper based referral management system to an electronic referral management system is a tremendous system transition. Measuring the proportion of e-Referrals to traditional paper based referrals allows the system to monitor progress towards the goal of managing all referrals into medical specialties electronically.

ix. Measure: Achieve compliance/meet or exceed standards for specialty care

1. Metric: The number of patients that are seen in medical specialties within the number of days established to meet the standards for specialty care.

    a. Numerator: The number of patients that are given an appointment in medical specialties within the number of days established as the standard.

    b. Denominator: The total number of patients given an appointment in medical specialties.

    c. Data Source: Appointment scheduling software.

    d. Rationale/Evidence: Timely access to medical specialties for patients that cannot be adequately care for exclusively in the primary care setting is a critical component of a well functioning delivery system.

x. Measure: Reduce cycle times for report dictation

1. Metric: Report dictation cycle time

    a. TBD by DPH System

8. Establish/Expand a Patient Care Navigation Program

- Project Goal: Help and support patients especially in need of coordinated care navigate through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings.

- Potential Project Elements:
    - Establish/expand health care navigation services
    - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example Limited English Proficient patients, recent

immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others)

- Connect patients to medical homes, increase access to primary and specialty care, and increase access to chronic care management

- Related Projects:
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Increase Primary Care Capacity (Cat. 1)
  - Expand Medical Homes (Cat 2)
  - Redesign Primary Care (Cat. 2)
  - Expand Chronic Care Management Models (Cat.2)
  - Enhance Culturally Competent Care (Cat.1)
  - Implement/Expand Care Transitions Programs (Cat.2)
  - Increase Specialty Care Access (Cat.2)
  - Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Establish/expand a health care navigation program to provide support to patient populations who are at most risk of receiving disconnected and fragmented care[63]
      a. Metric: Number of patients enrolled in the patient navigation program; frequency and intensity of contact with care navigators.
        i. Documentation of patient navigation program
        ii. Data Source: Patient navigation program materials and database, EMR
        iii. Rationale/Evidence: Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions.[64]

[63] Could be facility-oriented, illness/condition-oriented, and/or focused on patient populations who are at most risk of disconnected care (e.g., "Limited English Proficiency Patient Family Advocate" available here http://www.innovations.ahrq.gov/content.aspx?id=2726, urgent care, ED)

ii. Measure: Provide care management/navigation services to targeted patients (e.g., high utilizers of the ED and/or inpatient services)

a. Metric: Increase in the number or percent of targeted patients enrolled in the program

i. Numerator: Number of targeted patients enrolled in the program

ii. Denominator: Total number of targeted patients identified

iii. Data Source: Enrollment reports

iii. Measure: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources

a. Metric: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program participating

i. Data Source: May vary, such as class participant lists

ii. Rationale/Evidence: Increased patient engagement in such activities can empower patients with the knowledge, information, and confidence to better self-manage their conditions, helping the patients to stay healthy

iv. Measure: Provide navigation services to patients using the ED for episodic care

a. Potential Metrics: (may choose one or more)

i. Number/percent of patients without a primary care provider who received education about a primary care provider in the ED

ii. Number/percent of patients without a primary care provider who were referred to a primary care provider in the ED

iii. Number/percent of patients without a primary care provider who are given a scheduled primary care provider appointment

iv. Number/percent of patients with a primary care provider who are given a scheduled primary care provider appointment

- **Improvement Measures:**

i. Measure: Number of patients without a medical home who use the ED, urgent care, and/or hospital services scheduled from these sites for primary care appointments

a. Metric: DPH administrative data on patient encounters and scheduling records from patient navigator program

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[64] As an example, see "Limited English Proficiency Patient Family Advocate," available at AHRQ's Innovations Exchange, http://www.innovations.ahrq.gov/content.aspx?id=2726

ii. Measure: Measure ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program

a. Metric: ED visits and/or avoidable hospitalizations

i. Numerator: Number of patients enrolled in the navigator program who have had an ED visit or an inpatient admission (timeframe TBD by DPH system)

ii. Denominator: Total number of patients enrolled in the navigator program

iii. Data Source: EMR, navigation program database, ED records, inpatient records

iv. Rationale/Evidence: Avoidable hospitalizations and excessive use of ED are seen as key measures of patients' disconnect from the health care systems.[65] As this is an innovative program, it is a good opportunity to measure whether the program can have a direct impact on reducing ED visits/avoidable hospitalizations.

iii. Measure: Improve patient experience (this measure may be moved to Category 3, pending the finalization of Category 3)

a. Metric: Patient experience/satisfaction survey score

i. Percent improvement in patient satisfaction scores among patients participating in the navigation program

ii. Data Source: Patient satisfaction survey

iii. Rationale/Evidence: Navigation services are proven in numerous studies to result in improved patients' experience with care.[66]

9. Apply Process Improvement Methodology to Improve Quality/Efficiency (Rapid Cycle, Management Engineering, Lean Technology)

- Project Goal: Implement continuous performance improvement in order to improve efficiencies, improve quality, improve experience, reduce inefficiencies, and eliminate waste and redundancies.

- Potential Project Elements:
  - Implement a process improvement methodology
  - Measure continuous improvement

- Related Projects:

[65] For example, see the care transitions work of Eric Coleman, MD, at http://www.caretransitions.org
[66] For example, see the study by Jeanne M. Ferrante, et al., http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2430139/

- Reduce Readmissions (Cat. 3)
- Improve Quality (Cat. 3)
- Reduce Harm from Medical Errors (Cat. 3)
- Improve Patient Flow in the ED (Cat. 2)
- Redesign for Cost Containment (Cat. 2)
- Other

- Key Measures:
  - **Process Measures:**

    i. Measure: Implement a program to improve efficiencies

    a. Metric: Performance improvement events

    i. Number of performance improvement events

    ii. Data Source: TBD by DPH System

    iii. Rationale/Evidence: Improving efficiencies will not only help to reduce waste and redundancies, but also will help providers/staff focus on value-added work and improve quality and experience of care for patients. Increasing efficiencies can help create more patient access and provider/staff capacity.

    ii. Measure: Implement a Lean/Kaizen rapid improvement project

    a. Metric: Kaizen cycle

    i. Documentation that all of the steps included in the cycle of Kaizen were performed: (1) Standardized an operation, (2) Measured the standardized operation (cycle time and amount of in-process inventory), (3) Gauged measurements against requirements, (4) Innovated to meet requirements and increase productivity, (5) Standardized the new, improved operations, (6) Continued the cycle

    ii. Data Source: Documentation of Kaizen rapid improvement project such as Idea sheets, attendance sheets, daily reports of progress made, final report out. Or documentation of materials produced by the Kaizen event such as new standard workflows.

    iii. Rationale/Evidence: Developed by Toyota in the 1950s to strengthen automobile manufacturing infrastructure and maximize resources, Lean is an example of a management engineering approach now being adopted successfully by health care organizations to address a range of quality and operational issues. The Lean method, specifically, provides a range of techniques to create a more efficient and effective workplace by having smooth work flows and

eliminating waste in time, effort, or resources. According to the California HealthCare Foundation report Operations Improvement Methods: Choosing a Path for Hospitals and Clinics by David Belson, PhD, "Lean helps providers work toward a state of continuous improvement, whereby the product flows at the pull of the customer in pursuit of perfection."[67] Also, Denver Health System has had much success implementing Lean process improvement methodologies.[68]

iii. Measure: Train providers/staff in process improvement

a. Metric: Number/proportion of relevant providers/staff trained or number of trainings held

i. Numerator: Number of relevant providers/staff trained

ii. Denominator: Total number of relevant providers/staff

iii. Number of trainings held

iv. Number of providers/staff trained

v. Data Source: Curriculum or other training schedules/materials

vi. Rationale/Evidence: The training and inclusion of providers and frontline staff will encourage a culture of continuous performance improvement and help to make sure that improvements made are impactful and lasting.

iv. Measure: Complete a value stream map, which is a detailed, real-time sequence of steps in a given process to identify value-added and non-value-added steps for the patient and staff

a. Metric: Value stream mapping

i. Submission of completed value stream map

ii. Data Source: Value stream map

iii. Rationale/Evidence: Value stream mapping is a helpful method that can be used in Lean environments to identify opportunities for improvement in lead time. Value stream mapping can be used in any process that needs an improvement.

v. Measure: Target specific workflows, processes and/or clinical areas (e.g., the OR) to improve

a. Metric: TBD by DPH system

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[67] See: http://www.chcf.org/publications/2007/12/improving-efficiency-management-engineering-comes-to-the-safety-net#ixzz11umwfMFJ

[68] Meyer, Harris, "Life in the 'Lean' Lane: Performance Improvement at Denver Health," *Health Affairs* (November 2010), vol. 29 no. 11, 2054-2060.

i. Numerator: TBD by DPH system

ii. Denominator: TBD by DPH system

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: TBD by DPH system

vi. Measure: Identify/target metric to measure impact of process improvement methodology and establish baseline

a. Metric: TBD by DPH system

i. Numerator: TBD by DPH system

ii. Denominator: TBD by DPH system

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: TBD by DPH system

vii. Measure: Compare and analyze data, and identify at least one area for improvement

a. Metric: Analysis and identification of target area

i. Submission of analysis findings/summary and identification of target area

ii. Data Source: Analysis

iii. Rationale/Evidence: It is important to continue to identify areas needing improvement.

viii. Measure: Develop early-warning systems within the EHR to act upon identified problems

a. Metric: Documentation of respective early-warning systems through dashboard reports

ix. Measure: Develop a quality dashboard

- **Improvement Measures:**

i. Measure: Progress toward target/goal

a. Metric: Number or percent of all clinical cases meet target/goal

i. Numerator: Number of relevant clinical cases at target

ii. Denominator: Total number of relevant clinical cases

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: It is estimated that 30% of health care spending - $600-700 billion – is unnecessary and wasteful. Reducing waste

and ensuring that all patients receive appropriate care, especially preventive services, can result in dramatic improvements in health care efficiency and effectiveness.[69] Finding a way to measure this impact could be very beneficial.

ii. Measure: Measure efficiency and/or cost

a. Metric: TBD by DPH system

i. Numerator: TBD by DPH system

ii. Denominator: TBD by DPH system

iii. Data Source: TBD by DPH system

iv. Rationale/Evidence: While process improvement methodologies have demonstrated value in reducing/eliminating waste and non-value added activities, these are difficult to measure, quantify and use to make a business case demonstrating a return-on-investment. Because this is an innovative methodology, the DPH system will report on whether the process improvement methodology was able to show improvement on a selected measure for learning purposes within and beyond the safety net.

iii. Measure: Report findings and learnings

a. Metric: Final report/report summary

i. Submission of report

ii. Data Source: All data sources used for the process improvement events

iii. Rationale/Evidence: While process improvement methodologies have demonstrated value in reducing/eliminating waste and non-value added activities, these are difficult to measure, quantify and use to make a business case demonstrating a return-on-investment. Because this is an innovative methodology, the DPH system will report on whether the process improvement methodology was able to show improvement on a selected measure for learning purposes within and beyond the safety net.

iv. Measure: Number of process improvement champions

a. Metric: Champions

i. Number of trained and designated process improvement champions

ii. Data Source: HR, or training curriculum or other program materials

[69] National Priorities Partnership, http://www.nationalprioritiespartnership.org/PriorityDetails.aspx?id=598.

iii. Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement.

v. Measure: Number of trainings conducted by designated trainee/process improvement champions

a. Metric: Trained by the trainee/champion trainings

i. Number of trainings conducted by designated process improvement trainees/champions

ii. Number of providers/staff trained by designated process improvement trainees/champions

iii. Data Source: Training program curriculum, educational materials, attendance lists, or other materials

iv. Rationale/Evidence: Part of process improvement is implementing a culture change oriented toward continuous performance improvement.

10. Improve Patient Flow in the Emergency Department/Rapid Medical Evaluation

- Project Goal: Reduce wait times in the ED so that patients in need of care are triaged in a timely manner, patients receive care in a timely manner, and fewer patients leave the ED without being seen.

- Potential Project Elements:
  - Analyze ED throughput
  - Increase ED throughput

- Related Projects:
  - Improve Quality (Cat. 3)
  - Other

- Key Measures:
  - **Process Measures:**

i. Measure: Develop processes and systems to accurately capture ED throughput cycle times[70]

a. Metric: ED Door to Doc Times

[70] ED cycle time is triage to ED bed, ED bed to decision-to-admit, decision to orders, orders to ready bed, and ready bed to arrival on floor.

i. Actual time from first presentation to the ED department

ii. Data Source: The actual times of presentation off the initial triage form and patient seen time off the physicians' emergency treatment record.

iii. Rationale/Evidence: California Emergency Physicians Medical Group (CEP) confronted rising patient volumes and limited space by reengineering the patient treatment process, developing the Rapid Medical Evaluation (RME) program. Created in 2002, RME is a proven methodology for reducing wait times by improving patient flow, improving care, and increasing patient satisfaction in the ED, the main tenant being bringing patients to providers as quickly as possible upon arrival to the ED. Under RME, all patients can be seen in a timely manner, usually within 30 minutes of arrival. The treatment process is fluid, adjusting to ensure treatment is provided as quickly as possible. The process begins immediately, including an initial assessment, ordering of labs and X-rays, and in some cases, rapid discharge without utilizing an ED bed. Patients presenting to the ED are escorted immediately to an intake area staffed with a physician, a technician, and a unit clerk. A quick focused interview by the provider results in rapid assignment of patients into two groups depending on acuity and severity of their condition, based on a quick look rather than a full triage. The sicker group goes to the main emergency department for treatment. The less sick group may either be discharged (to home or to a medical home) or sent for lab or radiology studies. The benefits reported are quicker door-to-provider times, fewer patients leaving without being seen and increased revenue because of improved efficiencies.

ii. Measure: Establish interdisciplinary workgroup to validate and improve data capture, and set targets for ED cycle time improvement

a. Metric: ED cycle time

i. Manual or electronic extraction of data from the triage form, emergency treatment record and ED IT systems for discharge time. This may be presented for periodic review.

ii. Data Source: PI Data Tracking Tools

iii. Rationale/Evidence: Presentation of data and review ensures data integrity and presentation to our committees allows the facility as a whole to be more aware of patient wait times, reasons for increase/decrease times are discussed.

iii. Measure: Undertake an initiative to dissect and measure the components of the overall cycle time

a. Metric: Analysis of patient flow

i. Submission of patient flow diagram

ii. Data Source: Patient flow diagram

iii. Rationale/Evidence: Analyzing ED throughput first begins with overview of the process that the facility currently uses. After looking at the flow, it is important to then look at the type of triage criteria the ED uses.[71]

iv. Measure: Develop a robust timestamp process

a. Metric: Door-to-discharge

i. Submission of Door to triage (patient presentation to nurse triage), Door to Provider (patient presentation to ER to Doctor medical screening), and Door to Discharge (patient presentation to ER to discharge home)[72] timestamps

b. Metric: Door-to-admission, which includes three components: 1. Door to admissions decision time, 2. Door to time admissions orders are written, 3. Door to time to admission bed on the nursing unit

i. Door value is always taken from the initial Triage time upon presentation from that time one can calculate the time periods.

ii. Data Source: Actual times of presentation off the initial triage form and patient seen time off the physician's emergency treatment record for admission decision and our tracking board for time of placement in admission floor bed.

- **Improvement Measures:**

i. Measure: Reduce ER wait time / Reduce overall ED cycle time for admitted patients

a. Metric: Door-to-admission

i. Door value is always taken from the initial Triage time upon presentation from that time one can calculate the time periods.

ii. Data Source: Actual times of presentation off the initial triage form and patient seen time off the physicians' emergency treatment record for admission decision and our tracking board for time of placement in admission floor bed.

iii. Rationale/Evidence: Overall cycle time is easy to measure but hard to interpret results. This is due to several factors of the patients stay.

[71] Such as ESI Triage criteria, which is a simple but very effective five-tier triage system of categorizing patients acuity.

[72] This number will vary depending on the addition of orders to complete the medical decision, such as simple blood work, x-rays, ultrasound and CT scan. Many patients would get these tests as outpatient but due to current access to primary care issues we try to complete them when they present. The hard part of evaluating "door to discharge" times is establishing the work-up involved in order for the physician to make a safe and accurate medical decision. Tracking all patients that present to the emergency department in this category will make this data much less useful due to the various treatments required for each patient.

If one patient comes in for a simple medication refill then our cycle time will be very low but if the next patient comes in for a medication refill for his anticoagulate medication then a lab is ordered to obtain the current efficiency of the medication and adjust the dosage accordingly. These patients would come in for the same reason but overall cycle times will vary greatly.

ii. Measure: Decrease in the number of patients who leave the ER without being seen

a. Metric: Left Without Being Seen (LWBS)

i. Numerator: Number of patients who present to the ER but are not seen by the Provider

ii. Denominator: Total number of patients who presented to the ER for that Midnight to Midnight cycle

iii. Data Source: Discharge diagnosis of LWBS in comparison to total number of registered patients per the EMTALA log

iv. Rationale/Evidence: Upon tracking the flow of patients and improving the door to doctor times, the LWBS numbers should drop.

iii. Measure: Improve patient satisfaction (this measure may be moved to Category 3, pending the finalization of Category 3)

a. Metric: Patient Satisfaction Survey

i. Numerator: Respondents Score

ii. Denominator: Respondents

iii. Data Source: Press Ganey or other Patient Satisfaction Scoring System.

iv. Rationale/Evidence: DPH systems find that as a direct result of their emergency departments being overcrowded and over capacity, patient experience may not be as good as it could be. As process improvements are made so that patients have increased access to ED care, it may be helpful to measure the impact that has on patient experience.

11. Use Palliative Care Programs

- Project Goal: Patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

- Potential Project Elements:

- Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program[73]
- Implement a Palliative Care Program to address our patients with end of life decisions and care needs
- Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility
- Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
- Measure how many patients who died in the hospital received a palliative care consult

- Related Projects:
  - Reduce Readmissions (Cat. 3)
  - Improve Quality (Cat. 3)
  - Reduce Disparities (Cat. 3)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program
       a. Metric: Business case
          i. Submission of business case
          ii. Data Source: Business case write-up; documentation of planning activities
          iii. Rationale/Evidence: Studies have established that palliative care reduces the cost of care.[74] It is widely accepted in the field that

[73] Palliative care addresses issues of quality of life, symptom management, and psychosocial support. Submit a plan to expand an existing palliative care program.
[74] For example, see a study by Sean Morrison, et al., http://www.med-ic.org/pdf/PC1.pdf

planning activities are necessary to establish successful palliative care programs.[75]

ii. Measure: Implement/expand a palliative care program

i. Documentation: Palliative care program exists; palliative care team hired and operational

ii. Data Source: Palliative care program

iii. Rationale/Evidence: There is widespread evidence that palliative care can improve the quality of care while reducing cost.[76]

iii. Measure: Number of palliative care consults

a. Metric: Palliative care consults meet targets established by the program

i. Numerator: Number of palliative care consults

ii. Denominator: Target number of palliative care consults

iii. Data Source: EMR, palliative care database

- **Improvement Measures:**

i. Measure: Palliative care patients transitioned from acute hospital care into home care, hospice or a skilled nursing facility (SNF)

a. Metric: Transitions accomplished

i. Numerator: Number of palliative care discharges to home care, hospice, or SNF

ii. Denominator: Total number of total palliative care discharges

iii. Data Source: EMR, data warehouse, palliative care database

iv. Rationale/Evidence: The goal of palliative care is to minimize transfers to ICUs, stays in the hospital, and discharge home with no services; while maximizing patient transitions to home care, hospice and SNF when asked for by the patient because those services often make the most sense given the patient's conditions.

ii. Measure: Among patients who died in the hospital, increase the proportion of those who received a palliative care consult

a. Metric: Percent of total in-hospital deaths who had a palliative care consult

i. Numerator: Number of patients who died in the hospital and received at least one palliative care consult

[75] For example, see the website for CDPC (Center to Advance Palliative Care,) http://www.capc.org/building-a-hospital-based-palliative-care-program/designing
[76] See http://www.capc.org

ii. Denominator: Number of patients who died in the hospital

iii. Data Source: EMR, data warehouse palliative care database

iv. Rationale/Evidence: Ideally, most patients who died in the hospital would have received a palliative care consultation so that the patient and the family have the choice of how the patient spends his/her end of life.

iii. Measure: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

a. Metric: Survey developed and implemented; scores increased over time

i. Result of survey scores

ii. Data Source: Patient/family experience survey

iii. Rationale/Evidence: Palliative care has been proven to result in increased patient and family satisfaction.[77]

12. Conduct Medication Management

- Project Goal: Manage medications so that patients receive the right medications at the right time across the DPH system in order to reduce medication errors and adverse effects from medication use.

- Potential Project Elements:
  - Put in place the teams, technology and processes
  - Develop criteria and identify targeted patient populations
  - Implement a medication management program
  - Manage medications prior to, at and after discharge/ED visits

- Related Projects:
  - Reduce Readmissions (Cat. 3)
  - Improve Quality (Cat. 3)
  - Reduce Harm from Medical Errors (Cat. 3)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)

[77] See a Kaiser study linking palliative care and patient satisfaction, at http://www.kaisersantarosa.org/palliativecarestudy

- Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Implement/expand a medication management program and/or system
       1. Metric: Program elements
          a. Documentation of program, including people, processes and technologies
          b. Data Source: Written medication management plan including workflow for providers.
          c. Rationale/Evidence: A delivery system with a written medication management plan that is consistently followed by all providers can reduce medication errors and increase patient compliance with their medication regimens.

    ii. Measure: Develop criteria and identify targeted patient populations
       1. Metric: Written medication management plan(s)
          a. Numerator: Number of patients in targeted patient population that consistently receive medication management counseling.
          b. Denominator: Number of patients in targeted patient population
          c. Data Source: Paper or electronic medical record citing medication management counseling provided; medication reconciliation documented in paper or electronic medical record
          d. Rationale/Evidence: Patients in targeted population who consistently receive medication management counseling and medication reconciliation are more likely to consistently adhere to their medication regime and maintain better control of their medical condition.

    iii. Measure: Implement a program to improve continuity of medication management from acute care to the ambulatory setting
       1. Metric: Written plan to provide medication reconciliation as part of the transition from acute care to ambulatory care
          a. Numerator: Number of patients who receive medication reconciliation as part of the transition from acute to ambulatory care
          b. Denominator: Number of patients discharged from acute to ambulatory care in a defined time period
          c. Data Source: Paper or electronic medical records

d. Rationale/Evidence: Patients who receive medication reconciliation as part of the transition from acute to ambulatory care are more likely to have and adhere to an appropriate medication regime.

iv. Measure: Redesign triage of medication-related ED visits

1. Metric: TBD by DPH system

a. Numerator: TBD by DPH system

b. Denominator: TBD by DPH system

c. Data Source: TBD by DPH system

d. Rationale/Evidence: TBD by DPH system

v. Measure: Implement a medication refill process

1. Metric: A written medication refill process including workflow for all providers involved in the medication refills (may be designated for a given medication (e.g., Plavix) or conditions/diagnosis (e.g., transient ischemic attack).

a. Numerator: The number of patients empaneled to the clinic (who are on medication X or have condition A) who adhere to the medication refill process

b. Denominator: The total number of patients empaneled to the clinic (who are on medication X or have condition A).

c. Data Source: Clinic records of patient calls and/or patient's paper or electronic medical record. Alternatively, it may be easier to track patients who do not adhere to the new refill process by having the chart flagged when the patient calls/does not follow protocol. The hospital can use pharmacy data to get the total number of patients from the clinic who refilled a given medication that month.

d. Rationale/Evidence: A delivery system with a standard medication refill process that is consistently adhered to will be more likely to provide the right medications at the right time for their patients.

vi. Measure: Develop the health information technology claims-based algorithms to identify patients in need of preventive services

vii. Measure: Develop evidence-based decision rules that will be the clinical content underpinning each point of care decision support message

viii. Measure: Conduct incremental pilot tests of the point of care decision support system in real time during patient encounters, including structured feedback from primary care providers and patients

ix. Measure: Roll out the point of care decision support system

x. Measure: Evaluation of medication adherence using pharmacy claims-based medication possession rates in practices with at least 1 year exposure to the decision support +/- the pharmacist intervention and in the usual care control settings

xi. Measure: Submit a plan to implement bedside barcode scanning

1. Metric: Submission of plan

xii. Measure: Implement bedside barcode scanning

1. Metric: Number of nursing units with bedside barcode scanning

xiii. Measure: Implement smart infusion pumps

1. Metric: Percent of infusions (e.g., Patient Controlled Analgesia (PCA) Infusions, epidural and syringe pumps) using smart infusion pumps

xiv. Measure: Implement safeguards in EHR to ensure compliance with Black Box Warnings.

1. Metric: Safeguards in place for Black Box warnings

- **Improvement Measures:**

i. Measure: Manage medications for targeted patients

a. Metric: Number of patients that consistently receive medication management

i. Numerator: Number of patients that consistently receive medication management counseling at the point of care

ii. Denominator: Number of patients in targeted panel size/patient population (targeted as defined by DPH system)

iii. Data Source: Paper or electronic medical record

iv. Rationale/Evidence: Targeted patients who consistently receive medication management are more likely to adhere to their medication regime and receive the right medication at the right time.

ii. Measure: Implement electronic prescription writing at the point of care

a. Metric: Number of new and refill prescriptions written and generated electronically

i. Numerator: Number of new and refill prescriptions written and generated electronically

ii. Denominator: Number of new and refill prescriptions written in a specific time period

iii. Data Source: Paper or electronic medical record

iv. Rationale/Evidence: If consistently and completely used, electronic prescribing has the potential to reduce medication errors and increase patient compliance with their medication regime.

iii. Measure: Implement electronic medication reconciliation at the point of care

a. Metric: Number of patients that receive electronic medication reconciliation at the point of care

i. Numerator: Number of patients in panel size/population size that receive electronic medication reconciliation at the point of care

ii. Denominator: Number of patients in panel size/population size

iii. Data Source: Paper or electronic medical record

iv. Rationale/Evidence: Implementing electronic medication reconciliation can help ensure that providers consistently deliver accurate medication reconciliation at the point of care.

iv. Measure: Provide reconciliation of medications at discharge

a. Metric: Increase number or percent of identified patients that have medications reconciled as a standard part of the discharge process.

i. Numerator: Number of targeted patients with medications reconciled (targeted TBD by DPH system) when discharged from a hospitalization.

ii. Denominator: Total number of targeted patients hospitalized during a specific time period.

iii. Data Source: Discharge paperwork from paper or electronic medical record.

iv. Rationale/Evidence: Consistently providing medication reconciliation at the time of discharge from a hospitalization enhances the likelihood of patients adhering to an appropriate medication regime and allows for the reduction of medication errors that may result from the lack of medication reconciliation when a patient transitions from one care setting to another.

v. Measure: Increase number or percent of patients that are covered by clinical pharmacists

a. Metric: X% of patients will be covered by clinical pharmacists

i. Numerator: Number of targeted patients covered by clinical pharmacists (targeted TBD by DPH system)

ii. Denominator: Total number of targeted patients

iii. Data Source: Paper or Electronic Medical Record indicating patient is assigned to a clinical pharmacist. Appointment records for clinical pharmacy.

vi. Measure: Measure progress toward therapeutic goal for patients treated

a. Metric: TBD by DPH Progress over a defined period of time from baseline measures (e.g., blood pressure or LDL-cholesterol) to target measure as set by patient and clinical provider.

b. Numerator: Number of patients that have made significant progress (as defined by their provider) from their baseline measures to target measure over a defined period of time.

c. Denominator Number of patients in panel/targeted sample size.

d. Rationale/Evidence: Patients and providers that set mutually agreed upon goals over a defined period of time are more likely to monitor the patient's progress in a consistent manner and intervene appropriately when a patient is not making progress towards their goals.

vii. Measure: Measure medication-related visits to the ED

a. Metric: TBD by DPH System

viii. Measure: Measure the number of patient visits for which a medication is prescribed have medication reconciliation and prescription generation performed electronically

i. Numerator: Number of patient visits for which a medication is prescribed have medication reconciliation and prescription generation performed electronically

ii. Denominator: Total number of eligible patient visits (eligible as defined by the DPH system)

ix. Measure: Increase number or percent of identified patients that have follow-up

i. Numerator: Number of identified patients that have follow-up on medication use (identified as defined by DPH system)

ii. Denominator: Total number of identified patients

x. Measure: Increase medication adherence for targeted patients/with a targeted disease

i. Numerator: Amount of drug taken by patient.

ii. Denominator: Amount of drug the patient should have taken.

xi. Measure: Increase the number or percent of intravenous infusions that are administered via smart pump

13. Implement/Expand Care Transitions Programs

- Project Goal: Create smooth transitions of care from inpatient to outpatient settings so that patients being discharged understand the care regimen, have follow-up care scheduled, and are at reduced risk for avoidable readmissions.

- Potential Project Elements:
    - Develop standardized clinical protocols and care delivery model
    - Integrate information systems so that continuity of care for patients is enabled
    - Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days

- Related Projects:
    - Reduce Readmissions (Cat. 3)
    - Redesign to Improve Patient Experience (Cat. 2)
    - Improve Patient/Caregiver Experience (Cat. 3)
    - Redesign for Cost Containment (Cat. 2)
    - Other

- Key Measures:
    - **Process Measures:**

        i. Measure: Develop protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions

            a. Metric: Care transitions protocols

                i. Submission of protocols

                ii. Data Source: Care transitions program materials

        ii. Measure: Implement standard care transition processes

            a. Metric: Care transitions protocols

                i. Submission of protocols

                ii. Data Source: Care transitions program materials

        iii. Measure: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where

appropriate, additional patient education and/or coaching as identified during discharge

a. Metric: Care transitions protocols

i. Submission of protocols

ii. Data Source: Care transitions program materials

iv. Measure: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge

a. Metric: Care transitions assessment

i. Submission of assessment

ii. Data Source: Care transitions assessment

iii. Rationale/Evidence: It is important to try to coordinate care with facilities outside the DPH system so that patients going in and out of the DPH system can receive optimal care, wherever possible.

v. Measure: Create a patient stratification system designed to identify patients requiring care management, and to accommodate a quicker allocation of resources to those patients with high-risk health care needs

a. Metric: Patient stratification system

i. Report

vi. Measure: Train/designate more ED case managers

a. Metric: Number of trained and/or designated ED case managers over baseline

i. Data Source: HR, job descriptions, training curriculum

vii. Measure: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program

viii. Metric: Documentation of the staffing plan, which describes the number and types of staff needed and the specific roles of each participant

a. Data Source: Staffing and implementation plan.

ix. Measure: Improve discharge summary timeliness.

a. Metric: Discharge summary completion within X hours of discharge.

i. Numerator: Discharge summary complete within X hours of discharge.

ii. Denominator: Patients discharged from specified medical services.

iii. Data Source: Automated report from Health Information Services.

x. Measure: Implement a case management related registry functionality

   a. Metric: Documentation of registry implementation

- **Improvement Measures:**

i. Measure: X% of patients in defined population receives standardized care according to the approved clinical protocols and care delivery model in X% of medical encounters

   a. Metric: TBD by DPH system based on measure described above

ii. Measure: Begin monthly data collection and reporting for chosen metrics. If testing an intervention on a pilot unit, collect and report on monthly data for all discharges from pilot unit

   a. Metric: TBD by DPH system

      i. Numerator: TBD by DPH system

      ii. Denominator: TBD by DPH system

      iii. Data Source: TBD by DPH system

      iv. Rationale/Evidence: TBD by DPH system

iii. Measure: Demonstrate the integration of information systems by stratifying patient demographic data by process, clinical and/or quality data

   a. Metric: Report of stratified data

iv. Measure: Identify the top chronic conditions (e.g., heart attack, heart failure and pneumonia) and other patient characteristics (e.g., medical home assignment and demographics such as age) or socioeconomic factors (e.g., homelessness) that are common causes of avoidable readmissions

   a. Metric: Top Chronic Conditions Report

      i. Submission of report/analysis

v. Measure: Identify X% of high users with ambulatory sensitive conditions[78]

      i. Numerator: Number of high users with ambulatory sensitive conditions identified for care transitions program

      ii. Denominator: Number of high users with ambulatory sensitive conditions

vi. Measure: Link program enrollees to primary care services which utilize the medical home model

[78] Admissions for ambulatory sensitive conditions are gaining more attention as an important prevention quality indicator tied to reliable primary care

a. Metric: Number of identified program enrollees assigned to medical homes

i. Numerator: Number of identified program enrollees assigned to medical homes

ii. Denominator: Total number of identified program enrollees

vii. Measure: Increase the number or percent of patients in the case management related registry

a. Metric: Increase in the number of patients in the case management related registry; patients may be targeted from ED and inpatient areas

viii. Measure: Implement standard care transition processes in specified patient populations.

a. Metric: Measure adherence to processes.

i. Numerator: Number of patients in defined population receives care according to standard protocol.

ii. Denominator: Number of population patients discharged.

iii. Data Source: Hospital administrative data and the patient medical record.

14. Implement Real-Time Hospital-Acquired Infections (HAIs) System

- Project Goal: To be at the forefront of piloting a real-time clinical intervention system that alerts clinicians to the presence of high-risk patient conditions that can lead to HAIs.[79]

- Potential Project Elements:
  - Pilot a real-time clinical intervention system that alerts clinicians to the presence of high risk patient conditions that can lead to HAIs
  - Develop real-time comparison and reconciliation of competing quality indicators for HAIs for real-time feedback to clinicians and improved validity of quality indicators which drive hospital leadership response

[79] Locally, this project would provide a robust automated quality improvement infrastructure to improve patient care through several mechanisms. First, it will employ an HAI intervention to prevent device-associated infections and post-surgical infections. Second, it will provide high efficiency accurate feedback about healthcare associated infections to treating physicians, including education about infection prevention processes. This will include both pre-emptive and post-HAI direct-to-clinician education. Third, it will reconcile distinct major quality indicator systems for HAI reporting to allow accurate and trustworthy metrics for response and action by Infection Prevention Programs and hospital leadership. Fourth, it will provide an invaluable infrastructure for quality improvement programs. Nationally, this project has the potential to reconcile and integrate quality measures from a) CDC's NHSN network used for national and state mandatory HAI reporting, and b) CMS quality measures used for hospital ranking as well as value based purchasing and non-payment rules. Importantly, this reconciliation will improve the accuracy and validity of coded data and may pave the pathway for select quality indicator codes to require additional validation for standardization and meaningfulness. Improvement of claims validity will also improve the use of claims in risk adjustment of performance measures for inter-hospital comparison, and will directly apply to the national focus toward meaningful use of electronic health records.

- Convert feedback and validation processes to automated systems based upon knowledge gained from Clinical Documentation Specialists
- Provide targeted bathing with chlorhexidine for patients with high risk conditions that can lead to HAIs (such as devices)
- Develop software packages and toolkits that facilitate dissemination to other hospitals

- Related Projects:
  - Reduce Hospital-Acquired Infections (Cat. 3)
  - Central Line-Associated Bloodstream Infection Prevention (Cat. 4)
  - Surgical Complications Core Processes (Cat. 4)
  - Redesign to Improve Patient Experience (Cat. 2)
  - Improve Patient/Caregiver Experience (Cat. 3)
  - Redesign for Cost Containment (Cat. 2)
  - Other

- Key Measures:
  - **Process Measures:**
    i. Measure: Implement prompts for prevention and risk identification / Develop daily nursing prompts to identify presence of any medical device (select at least one metric):
       1. Metric: Number of prompts or percent of relevant patients detected (e.g., percent of patients with devices detected on point prevalence check on a sample; prompts on HAPU prevention and risk identification)
       2. Metric: Percent of patients with devices detected on point prevalence check on a total sample of 2 ICUs and 2 non-ICUs
          a. Numerator: Number of patients with any device detected by automated prompt
          b. Denominator: Patients on sampled units with a device

    ii. Measure: Implement Clinical Documentation Specialist review for identified charts (must choose at least one of the following):
       1. Metric: Assess fraction of coded charts meeting specified criteria
          a. Numerator: Patients flagged by Clinical Documentation Specialist review confirmed to have the identified HAI
          b. Denominator: Patients flagged by Clinical Documentation Specialist review

2. Metric: Implement process for a Clinical Documentation Specialist to review and identify Medicare charts likely to be coded for HAI (for example, selection of central line associated blood stream infection (CLABSI)) and trigger review by Infection Prevention program for presence of CLABSI by CDC National Healthcare Safety Network (NHSN) criteria. Evidence of process provided by example cases adjudicated by both methods.

iii. Measure: Develop semi-automated detection of targeted HAI by flagging charts with select criteria / Develop semi-automated detection of CLABSI due to skin commensals by flagging charts with select NHSN criteria

iv. Measure: Develop a real-time intervention system to track targeted HAIs

1. Metric: HAI system

a. Generate report from HAI system

b. Data Source: HAI system

c. Rationale/Evidence: Ideal solutions would incorporate automated systems to target interventions for high risk patients, and provide feedback to clinicians both preemptively and after identified HAI events. Such systems would prompt clinicians to act on current opportunities for prevention and provide relevant education to prevent future events. This may be focused in a particular area, such as non-ICU areas.

v. Measure: Develop real-time comparison and reconciliation of competing quality indicators for HAIs for real-time feedback to clinicians and improved validity of quality indicators which drive hospital leadership response

1. Metric: Real-Time Reconciliation

a. Generate report from HAI system

b. Data Source: HAI system

c. Rationale/Evidence: Solutions to improve the validity and effectiveness of HAI quality indicators include a) reconciling CMS and CDC quality indicators for central line associated bloodstream infections (CLABSI), and catheter associated urinary tract infections (CAUTI) and b) instituting real time feedback to clinicians and infection prevention programs for education on primary prevention strategies.

vi. Measure: Establishment of protocols and survey tools for Clinical Documentation Specialists (CDS)

1. Metric: Protocols and survey tools

a. Submission of protocols and survey tools

b. Rationale/Evidence: The value of the CDS includes identifying discrepancies or uncertainties in the written medical record in real time

and requesting that clinicians provide clarification in the chart, either during the admission or shortly following hospital discharge.

vii. Measure: Development of system for cross-comparison between HAI indicators

1. Metric: Compare HAI indicators

a. Generate report from HAI system

b. Data Source: HAI system

viii. Measure: Development of electronic system for real time feedback of HAI events to clinicians

1. Metric: Real-time feedback

a. Generate report from HAI system

b. Data Source: HAI system

ix. Measure: Development of electronic system for real time education on HAI prevention to clinicians

1. Metric: Real-time education

a. Generate report from HAI system

b. Data Source: HAI system

x. Measure: Initial trending and analysis of HAI quality metrics

1. Metric: Select HAI quality metrics as referenced by DPH system

a. Generate report from HAI system

b. Data Source: HAI system

xi. Measure: Development of shareable toolkits and software for real time reconciliation and feedback

1. Metric: Toolkits and software

a. Documentation of toolkits and software

xii. Measure: Develop recognition software to enable electronic identification of medical charts likely to be coded as having HAI. This software would utilize key words and phrases previously recorded by Clinical Documentation Specialists for identifying potential HAI for coding purposes

1. Metric: Recognition software

a. Documentation of recognition software

b. Data Source: Recognition software system

c. Rationale/Evidence: Automation will also provide an infrastructure by which other domains of coded quality measures can be similarly validated

xiii. Measure: Integration of recognition software with automated HAI reconciliation and clinician feedback modules

1. Metric: Recognition software integration

a. Documentation of recognition software integration with automated HAI reconciliation

b. Data Source: HAI system

xiv. Measure: Initiate chlorhexidine bathing in non-ICU adult patients with medical devices (such as central lines, urinary catheters)

1. Metric: Percent of patients provided chlorhexidine

a. Documentation that prompts function

b. Data Source: HAI system

c. Rationale/Evidence: The reduction in skin bacterial counts due to CHG is the likely explanation for a beneficial effect in reducing healthcare-associated pathogens. This effect is expected to be greatest during times where devices or wounds provide portals of entry for bacteria to enter body tissues and cause infection. CHG has been safely used for bathing, showering and dental hygiene for over 50 years. It is an over-the-counter product that is 4% solution intended for direct application to skin as an antimicrobial skin cleanser. Numerous studies have shown marked reductions in skin bacteria following serial CHG bathing or showering,[80][81][82][83][84][85][86] and it is widely used as a pre-operative showering agent based upon CDC guidelines that

[80] Garibaldi RA. Prevention of intraoperative wound contamination with chlorhexidine shower and scrub. *J Hosp Infect* 1988;11(Suppl B):5-9.

[81] Paulson DS. Efficacy evaluation of a 4% chlorhexidinegluconate as a full-body shower wash. *Am J Infect Control* 1993;21(4):205-9.

[82] Hayek LJ, Emerson JM, Gardner AM. A placebo-controlled trial of the effect of two preoperative baths or showers with chlorhexidine detergent on postoperative wound infection rates. *J Hosp Infect* 1987;10:165-72.

[83] Kaiser AB, Kernodle DS, Barg NL, Petracek MR. Influence of preoperative showers on staphylococcal skin colonization: a comparative trial of antiseptic skin cleansers. *Ann ThoracSurg*1988;45:35-8

[84] Rotter ML, Larsen SO, Cooke EM, Dankert J, Daschner F, Greco D, et al. A comparison of the effects of preoperative whole-body bathing with detergent alone and with detergent containing chlorhexidinegluconate on the frequency of wound infections after clean surgery. The European Working Party on Control of Hospital Infections. *J Hosp Infect* 1988;11:310-20.

[85] Leigh DA, Stronge JL, Marriner J, Sedgwick J. Total body bathing with 'Hibiscrub' (chlorhexidine) in surgical patients: a controlled trial. *J Hosp Infect* 1983;4:229-35.

[86] Ayliffe GA, Noy MF, Babb JR, Davies JG, Jackson J. A comparison of pre-operative bathing with chlorhexidine-detergent and non-medicated soap in the prevention of wound infection. *J Hosp Infect* 1983;4:237-44.

recommend its use.[87] Evidence is mounting that CHG can reduce colonization and infection from a variety of healthcare associated pathogens.[88899091] Studies have demonstrated a 52-87% reduction in bloodstream infection in ICU patients.[92888991]

xv. Measure: Automated physician processes to confirm daily necessity of central lines and urinary catheters, with automated prompts for prevention processes when device dwell time exceeds the institutional median dwell time for that device in that particular patient population

1. Metric: Automated physician processes

a. Documentation that processes function

b. Data Source: HAI system

xvi. Measure: Develop baseline measures of central line dwell time for risk stratified patient populations with central lines

1. Metric: Mean and median dwell time in ICU and/or non-ICU patients

xvii. Measure: Implement response to long central line dwell times

xviii. Measure: Design automated reporting tool using EMR fields

xix. Milestone: Implement targeted automated nursing and physician reminders on prevention for long dwell times and identified HAI cases

1. Metric: Measure the percent of devices detected with long dwell time or identified CLABSI whose clinical providers received notification

a. Numerator: Number of patients with long dwell time or a device-associated HAI whose provider received automated prevention reminders

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[87]Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR, for the Hospital Infection Control Practices Advisory Committee (HICPAC). Guideline for prevention of surgical site infection, 1999. Infect Control HospEpidemiol 1999;20(4):247-278.

[88]Bleasdale SC, Trick WE, Gonzalez IM, Lyles RD, Hayden MK, Weinstein RA. Effectiveness of chlorhexidine bathing to reduce catheter-associated bloodstream infections in medical intensive care unit patients. Arch Intern Med 2007;167(19):2073-9.

[89]Climo MW, Sepkowitz KA, Zuccotti G, Fraser VJ, Warren DK, Perl TM, Speck K, Jernigan JA, Robles JR, Wong ES. The effect of daily bathing with chlorhexidine on the acquisition of methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant enterococcus, and healthcare-associated bloodstream infections: results of a quasi-experimental multicenter trial. Crit Care Med. 2009;37(6):2097-8.

[90]Vernon MO, Hayden MK, Trick WE, Hayes RA, Blom DW, Weinstein RA. Chlorhexidinegluconate to cleanse patients in a medical intensive care unit: the effectiveness of source control to reduce the bioburden of vancomycin-resistant enterococci. Arch Intern Med. 2006;166(3):306-12.

[91]Popovich KJ, Hota B, Hayes B, Weinstein RA, Hayden MK. Effectiveness of routine patient cleansing with chlorhexidinegluconate for infection prevention in the medical intensive care unit. Infect Control HospEpidemiol 2009;30(10):959-63.

[92]Ridenour G, Lampen R, Fiderspiel J, Kritchevsky S, Wong E, Climo M. Use of intranasal mupirocin and chlorhexidine bathing and the incidence of methicillin-resistant *Staphylococcus aureus* colonization and infection among intensive care units patients. Infect Control HospEpidmiol 2007;28:1155-1161.

b. Denominator: Number of patients with long dwell time or a device-associated HAI

- **Improvement Measures:**

i. Measure: Implement daily chlorhexidine bathing (CHG) of patients with central vascular catheters (CVCs)

a. Metric: Percent of patients with CVCs detected on point prevalence check on a sample

i. Numerator: Number of patients with CVCs receiving CHG bathing

ii. Denominator: Number of patients with CVCs on sampled units excluding those actively declining to have chlorhexidine bathing

ii. Milestone: Improve effectiveness of daily nursing prompts to identify presence of medical devices

a. Metric: Achieve at least 80% automated capture of devices measured by assessing the percent of devices detected on point prevalence check on a total sample of 2 ICUs and 2 non-ICUs

i. Numerator: Number of devices detected by automated prompt

ii. Denominator: Number of devices in patients on sampled units

iii. Milestone: Implement daily chlorhexidine bathing of patients with central venous catheters (CVCs) as evidenced by presence of standardized order set

a. Metric: Achieve at least X% capture of patients with CVCs receiving chlorhexidine bathing based upon a point prevalence check of 2 ICUs and 2 non-ICUs in the last quarter of the year.

i. Numerator: Number of patients with CVCs receiving chlorhexidine bathing

ii. Denominator: Number of patients with CVCs on sampled units excluding those actively declining to have chlorhexidine bathing

iv. Measure: Measure impact of automated real-time system on HAI rates

a. Metric: HAI rates

i. Per CDC NHSN or another available metric

ii. Data Source: HAI system

iii. Rationale/Evidence: Goal is reduce HAI rates so measurement of progress toward that goal will demonstrate whether the technology is successful. This measure is optional because – due to the nature of this project being at the forefront of the industry – it is unknown whether it will be able to do this within five years.

v. Measure: Increase number of clinicians confirming receipt of real-time feedback of HAI events

   a. Metric: Clinicians confirming real-time feedback

      i. Numerator: Number of clinicians confirming receipt of real-time feedback of HAI events

      ii. Denominator: Total number of clinicians confirming receipt of real-time feedback of HAI events

      iii. Data Source: TBD by DPH system

vi. Measure: Assessment of HAI rates based upon reconciled vs. non-reconciled metrics

vii. Measure: Implement targeted automated nursing and physician reminders on prevention for long dwell times and identified HAI cases

   a. Metric: Percent of devices detected with long dwell time or identified CLABSI whose clinical providers received notification

      i. Numerator: Number of patients with long dwell time or a device-associated HAI whose provider received automated prevention reminders

viii. Denominator: Number of patients with long dwell time or a device-associated HAIMeasure: Develop a reconciliation and feedback system to improve the accuracy and credibility of nationally competing HAI quality measures

   a. Metric: Development of a system that can be shared nationally

      i. Documentation of learnings and recommendations

      ii. Rationale/Evidence: The importance of a valid quality measure includes: Trustworthiness to drive performance improvement programs; Trustworthiness for clinician buy-in to aim for improvement of these measures; Reconciliation of national quality measures; Validated coding of select claims codes used for national quality measures for inter-hospital comparisons, hospital rankings, and value based purchasing; Improved automated analytic capabilities as valid outcomes can have robust risk adjustment through the use of additional claims data; and Valid coding of claims codes used as quality indicators will eventually allow these codes to be an important example of the meaningful use of electronic health records.

XV. Appendix A: Evidence-Based Models

Implemented by
California Public Hospital Systems to
Enhance Quality, Promote Coordinated Care, Build Medical Homes and Ensure Access
November, 2010
California Health Care Safety Net Institute

Introduction

This paper summarizes several of the foundational models of care improvement and transformation that underlie the proposed California public hospital system initiatives in the DSRIP, including:

- Patient Visit Redesign
- Patient Centered Medical Home Model
- Chronic Care Model
- Patient Centered Scheduling Model
- Behavioral-Physical Health Integration
- E-Referral Model for Improving Outpatient Specialty Care Access
- Improving Language Access: HCIN/VMI
- Improving Collection and Use of Accurate, Consistent Race/Ethnicity/Language (REAL) Data to Ensure Health Equity
- Palliative Care
- Process Improvement in Health Care
- Rapid Medical Evaluation (RME)
- Reducing Readmissions
- Patient-Centered Care/Improving the Patient Experience

Patient Visit Redesign

Every day, public clinics open their doors to already waiting lines of patients who arrive well before their scheduled appointments to avoid even longer wait times, and others walk-in with the hopes of being seen that same day. Ambulatory care clinics often serve as the first point of entry for patients into the public hospital system, and the time spent in a clinic visit becomes the first major indicator for patient satisfaction. Long wait times frustrate patients, providers and staff, and reduce access and quality. Yet, public hospital clinics are already overburdened and often abide by operational processes that don't sync with patient flow or enable greater access.

In addition to the volume of patients being seen at public clinics, operational issues also contributed to the visit wait times. Root causes for clinic inefficiencies included the practice of on-site registration, lack of communication between front office staff and providers, narrow role definitions, as well as multiple hand-offs that transport patients to various locations within the clinic site. To address these issues, public hospitals sought to streamline the way they provide care for their patients, while continuing to maintain quality and patient satisfaction.

Since 1998, the Patient Visit Redesign (PVR) model[93]has been the standard in work process design, drastically improving patient visit times in health care organizations throughout the United States. For California's public hospitals, PVR (done in combination with the Institute for Healthcare Improvement's Breakthrough Series Collaborative model for rapid improvement) decreasedthe amount of waiting time patients experience (cycle time) and increase the number of patients providers see per hour (provider productivity). Through this process, public hospital teams developed and tested strategies to redesign the patient visit in their clinics. Four didactic and interactive learning sessions were conducted, andin between sessions teams tested their models and collected data to track their progress.

With support from private foundation grants, 48 public hospital clinic teams improved their patient visit processes through formal a program with the California Health Care Safety Net Institute. From 2005 through 2008, these clinics (which represent 13 public hospital systems) reduced their cycle times by 45% with the average visit being completed in less than an hour, and increased provider productivity. While the initial cycle times and productivity have slipped slightly since the completion of the program, the majority of clinics still continue to maintain the improvements and spread the model throughout their systems.[94]

Patient-Centered Medical Home Model

Currently, the U.S. healthcare system is disjointed and focused on acute, episodic care that is structured around provider availability. Typically, patients have to navigate a vast system of primary and specialty care providers, lab services, emergency rooms and inpatient departments with little infrastructure to support coordination between different services. Lack of coordination can result in patient and staff frustration, longer wait-times, medical errors, and poor clinical outcomes.

Originally referring to a centralized approach to coordinate medical and other related needs for children with special health care needs, the patient-centered medical home (PCMH) model, or simply "medical home", has since vastly expanded its definition and has been seen as the leading model for primary care delivery in which patients receive well-coordinated services, evidence-based care, and enhanced access to a clinical team. According to Commonwealth Fund, a true medical home is one where "clinicians use decision support tools, measure their performance, and conduct quality improvement activities to meet

[93] See http://patientvisitredesign.com/techniques/the_principles_of_redesign.html, http://patientvisitredesign.com/techniques/the_principles_of_redesign_part_2.html, and http://patientvisitredesign.com/techniques/advanced_model.html for the full principles of Coleman Associates' Patient Visit Redesign.

[94] See report by Ruth Brousseau, PhD, for full summary of the program, impact and accomplishments, and sustainability at http://www.chcf.org/~/media/Files/PDF/T/PDF%20TowardsABetterPatientExperience.pdf.

patients' needs," which will ultimately improve clinical quality and patients' healthcare experiences, and also reduce health system costs.

CAPH and SNI agree with the definition of the components of a patient-centered medical home as articulated by NCQA in its PCMH 2011.[95] As such, the medical home should provide the following:

- Conducts a health assessment of the patient's current and anticipated health care needs in order to tailor health care to the needs of the patient;
- Maintains the patient's health records;
- Develops a proactive health care plan for the patient, in consultation with the patient and where appropriate, the patient's family;
- Uses evidence-based medicine;
- Facilitates enhanced access to health care;
- Provides for timely preventive, primary, and chronic care;
- Provides referrals to specialty and other health care services, and, where appropriate and if needed, community services;
- Facilitates patient self-management support and goal-setting;
- Engages in open and effective communication with patients and families, including providing timely access to qualified health care interpretation if needed and as appropriate;
- Provides health care in a culturally competent manner; and
- Uses measures and technology to support quality and process improvements.

To help California's public hospital systems achieve all the components of a medical home, the California Health Care Safety Net Institute launched a two-year *Seamless Care Center Initiative* to advance the clinical practice and operational efficiency in 26 primary care clinics of five California public hospital systems.

The main goals of the *Seamless Care Center Initiative* are to:

- Implement reliable, safe and efficient care, based on clinical evidence and best practices for prevention and disease care;
- Spread clinical quality, effective chronic care disease management, operational efficiency, and access improvements;
- Identify and train performance improvement leaders internally at each participating hospital system to manage ongoing large-scale improvement work in primary care.

The (Chronic) Care Model

The MacColl Institute for Healthcare Innovation estimates that more than 145 million people, or almost half of all Americans, live with a chronic condition and that almost half of all people with chronic illness have multiple conditions. Furthermore, the rate of chronically ill is expected to increase by more than 1% per year. This suggests that the current management of diseases such as diabetes, heart disease, depression, and asthma, among others, is executed poorly and not in tune with the needs of chronically ill patients.

Root causes are the same throughout the nation: providers often do not follow best practices, there is a lack of care coordination and proper follow-up, and patients are ill-equipped to manage their illness. Improving Chronic Illness Care created the Chronic Care Model (CCM)[96], the well-documented and tested leading model for treating chronic diseases, which summarizes the basic elements for improving care in health systems. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. By using evidence-based change concepts within each element in combination with one another, patients are better-informed and

[95] See http://www.ncqa.org/Portals/0/PublicComment/PCMH2011_draft_standards_527.pdf.
[96] See http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 for detailed information about the Care Model.

then take an active part in their care, while patient care teams have the resources and expertise they need to better manage the chronic illnesses of their patients. The results are more productive interactions between patients and their care teams, and better clinical outcomes for patients with chronic diseases.

In 2005 with 9 public hospital systems, and again in 2007-2008 with 39 primary care improvement teams from 11 public hospital systems, the California Health Care Safety Net Institute worked to improve chronic illness care for people with diabetes. The programs involved regional learning collaboratives, leadership development for the spread of chronic care improvements, and cash grants and consultancy services for adoption and spread of electronic disease registries. The work led to impressive results for both improved processes of care and, most importantly, improvements in the health status of patients tracked in the program.
Activities focused program work on three components of the *Chronic Care Model*, those linked most closely to improvement in blood sugar levels in people with diabetes:

1) Delivery System Design

Improving the health of people with chronic illness requires transforming a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible.[97] That requires not only determining what care is needed, but spelling out roles and tasks for ensuring the patient gets care using structured, planned interactions. And it requires making follow-up a part of standard procedure, so patients aren't left on their own once they leave the doctor's office. More complex patients may need more intensive management (care or case management) for a period of time to optimize clinic care and self-management, with providers needing to respond effectively to the diverse cultural and linguistic needs of patients.
To improve their own delivery systems, public hospitals in California are employing the following:

Daily team huddles before clinic session helps team plan the care for each patient for the day
Ability to offer the patient multiple services on day of visit (e.g. PCP, nutritionist, diabetes educator)
Use of reminder postcards when labs or immunizations are due

2) Clinical Information Systems

Effective management of patients with chronic diseases requires organization of patient and population data to facilitate efficient care with the best clinical outcomes. A good clinical information system:

- Provides timely reminders for providers and patients
- Identifies relevant subpopulations for proactive care
- Facilitates individual patient care planning, and
- Shares information with patients and providers to coordinate care *(2003 update)*
- Monitors performance of practice team and care system

Public hospital systems in California have implemented chronic disease registries to keep track of and help manage patients' clinical information, such as cholesterol and blood sugar levels, and are now establishing care teams with designated patient panels to better manage populations of patients with chronic diseases.

[97] Excerpted from the Improving Chronic Care Web site at http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18.

3) Self-Management Support

All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management.
Effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. Self-management support can't begin and end with a class. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

Public hospitals are using the following models of self-management tools to help support their patients in managing their diseases:

- **Group visits** are initiated by health care teams who facilitate an interactive process of care delivery in a periodic group visit program.[98] The team empowers the patient, who is supported by information and encouraged to make informed health care decisions. The group visit can be conceptualized as an extended doctor's office visit where not only physical and medical needs are met, but educational, social and psychological concerns can be dealt with effectively.

- **Health Coaches** are used by public hospital clinics to help patients navigate the health care system. Health coaches assist patients with paperwork and work with them after medical visits to make sure they fully understand the medications and advice recommended by the physician. Health coaches also discuss with patients how to best incorporate treatment—such as checking blood pressure and injecting insulin—into the patients' day-to-day life in a way that is attainable and comfortable within the patient's lifestyle.

- **Promotoras**, or health promoters, work with Spanish-speaking patient populations to provide nutrition education, self-management support, and regularly follow up with patients to ensure that they are managing their medications and exercise plans. Promotoras have become an essential part of the care team at many public hospitals, and help patients manage their diabetes in a more culturally sensitive and appropriate way.

- **Motivational interviewing** is"a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal."[99]

<u>Patient-Centered Scheduling Model</u>

National statistics indicate that seventy-five percent of patients want appointments on the same day they call. However, traditional patient scheduling systems have multiple problems inherent in their existing structures that make same-day appointments virtually impossible. Rather than being engineered to satisfy patients, traditional scheduling systems are designed by staff and managers to manage the flow of the day. Oftentimes many appointments have different "types" (like "Physical" or

[98] From the Improving Chronic Illness Care *Group Visit Starter Kit* at www.improvingchroniccare.org.
[99] See http://www.motivationalinterview.org/clinical/whatismi.html

"PAP Smear"), with each type having a unique time allotment (i.e., 20, 30, or 45 minutes). Moreover, staff schedules are often out of alignment with patient demand, which creates unnecessarily hectic days. Magnify these problems by double-booking patients and the result is the current situation: lengthy waits and limited access to appointments, dissatisfied patients, and highly stressed staff.

As a result of poor access to appointments, many safety net clinics experience high no-show rates because patients are often not given immediate access to care when they experience episodic acute problems, impacted provider productivity because of patient no-shows, and high patient walk-in rates because patients know this is an effective way for them to be seen quickly in this flawed system. With traditional patient scheduling systems that simply create workarounds without solving the root causes of limited access, an overhaul of the scheduling structure is necessary in order to better serve patients and help staff.

Patient Centered Scheduling (PCS) is the proven methodology for improving the ability of patients to see their doctor when they want to—even the same day.[100] PCS is designed to improve patient access, increase continuity of care, decrease the number of patient no-shows and decrease days to third-next-available appointment. Prior to implementation, "secret shopper" calls take place (random patient calls are recorded and documented) and examined so that staff are able to experience the process of trying to make an appointment from the patient's perspective. Patient visits are also mapped from beginning to end to determine how time in the clinic is spent, and to identify any bottlenecks in the visit process. Once these are conducted, the focus turns to reducing no-show rates and time to third next available appointments. One key tactic to reduce no-show rates and wasted time is to do as much pre-work as possible, such as calling patients in advance to confirm their appointments, pre-registering patients, updating insurance and demographic information, finding out what prescriptions need to be refilled—and if it makes sense, rescheduling the appointment if there's a better time for the patient. Doing patient registration and appointment confirmation ahead of time not only minimizes wasted time, but also gives staff the time to prepare and plan for any unforeseen changes, such as cancellations or changes to appointments.

Public hospital systems piloting the patient centered scheduling model have seen significant reductions in no-show rates and days to third-next-available appointments-- which will be critical progress in order to truly offer patients a patient-centered medical home.

Integrated Physical-Behavioral Health Care

Recent studies show that integration of behavioral health (mental health and substance abuse) and physical health services should be the standard for advanced health care systems. This finding is part of a larger trend to better integrate the various parts of a health care system in the interest of more cost-effective and comprehensive patient care. The more integrated these various components are at the programmatic and clinical levels, the more likely that patients with complex conditions and socioeconomic challenges will have their medical and psychosocial needs met in a comprehensive fashion, rather than falling through the cracks between various "silos," with resultant adverse health outcomes and increased cost.

In a recent analysis of the underlying causes and theories for improving physical-behavioral health integration conducted for CAPH, David Ofman, MD, summarized key studies on this issue and the best practices for integration.[101] According to Dr. Ofman, the key issues that make the case for behavioral-physical health integration are:

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[100] See http://patientvisitredesign.com/coleman_associates/pcs_program.html for detailed information about the Patient-Centered Scheduling model.

[101] See Ofman *Report to the California Association of Public Hospitals and Health Systems (CAPH) / Safety Net Institute (SNI) Concerning Behavioral Health – Physical Health Integration Efforts by Member Health Systems*.

1) Mental health and substance abuse issues are extremely common in safety net populations, and either account for or influence a very high percentage of primary care visits (Bureau of Primary Health Care, 2004).

2) Behavioral health patients have significant chronic physical health conditions (Institute of Medicine, 2005) which often go untreated, and these patients suffer increased morbidity, poorer quality of life, and significantly earlier mortality than patients without behavioral health diagnoses (Olfson, Sing, and Schlesinger, 1999).

3) Patients with both behavioral and physical conditions generate significantly higher medical costs than patients with only one set of conditions, and treatment of the behavioral health conditions lowers those costs, particularly if diagnosed early (Olfson, Sing, and Schlesinger, 1999).

4) The vast majority of patients with behavioral health problems are managed by primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (generally limited to the severely and persistently mentally ill) or because the patient refuses behavioral health specialty care (often because of the stigma attached to such care) (Cunningham, 2009). Many primary care providers feel poorly equipped to handle significant behavioral health issues by themselves.

5) The same psychosocial factors which complicate the health care of safety net populations affect both behavioral health and physical health patients (poverty, poor health literacy, limited English proficiency, homelessness, poor sense of self efficacy, chaotic lives, at-risk minority status, etc.)

6) Health care systems which have successfully implemented programs to integrate behavioral health and primary care services have tended to demonstrate improved care and significant cost savings (Health Management Associates, 2007), in addition to increased provider satisfaction and improved patient satisfaction.

7) A number of high profile organizations, including the Institute of Medicine, the Robert Wood Johnson Foundation, and the Health Resources and Services Administration (HRSA), have either recommended integration of physical and behavioral health services or funded projects dedicated to doing so (Health Management Associates, 2007).

While integration is shown to be necessary to achieve the best patient outcomes and control costs, several known barriers still exist. Funding silos, resistant staff, inaccurate perceptions of different departments, as well as access to care and physical capacity are all complex challenges that need to be addressed in order to make true behavioral-physical health integration.

To better integrate physical and behavioral health services, public hospital systems are implementing and adapting different models. Two key models are the IMPACT model, used at San Francisco Department of Public Health clinics, and the Four Quadrant Model, to be implemented soon at San Mateo Medical Center.

The IMPACT Model[102]

The IMPACT model is a five-component, evidence-based model designed specifically to tackle the unmet needs of elderly depressed patients. IMPACT stands for "Improving Mood Promoting Access to Collaborative Care Treatment". As reported in the December 11, 2002 issue of the Journal of the American Medical Association (JAMA), the IMPACT model more than doubles the effectiveness of depression treatment for older adults in primary care settings.

Five of the most essential elements of the IMPACT Model are:

1. Collaborative care is the cornerstone of the IMPACT model and functions in two main ways:

- The patient's primary care physician works with a care manager to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy)

[102] Excerpted from the IMPACT website at the University of Washington at http://impact-uw.org/about/key.html.

- Care manager and primary care provider consult with psychiatrist to change treatment plans if patients do not improve

2. Depression Care Manager:

This may be a nurse, social worker or psychologist and may be supported by a medical assistant or other paraprofessional. The care manager:

- Educates the patient about depression
- Supports antidepressant therapy prescribed by the patient's primary care provider if appropriate
- Coaches patients in behavioral activation and pleasant events scheduling
- Offer a brief (six-eight session) course of counseling, such as Problem-Solving Treatment in Primary Care
- Monitors depression symptoms for treatment response
- Completes a relapse prevention plan with each patient who has improved

3. Designated Psychiatrist:

- Consults to the care manager and primary care physician on the care of patients who do not respond to treatments as expected

4. Outcome measurement:

- IMPACT care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter. The PHQ-9 is recommended as an effective measurement tool; however, there are other effective tools.

5. Stepped care:

- Treatment adjusted based on clinical outcomes and according to an evidence-based algorithm
- Aim for a 50 percent reduction in symptoms within 10-12 weeks
- If patient is not significantly improved at 10-12 weeks after the start of a treatment plan, change the plan. The change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

Four Quadrant Model.[103]
Here the emphasis is on the prevalence of concurrent disorders (e.g., depression and alcoholism). The Four Quadrant model is based on the 1998 consensus document on mental health and substance abuse/addiction integration service. The severity for each disorder is divided into Four Quadrants: 1) Low mental health-low substance abuse, served in primary care; 2) High mental health-low substance abuse, served in the mental health system by staff who have substance abuse competency; 3) Low mental health-high substance abuse, served in the substance abuse system by staff who have mental health competency; and 4) High mental health-high substance abuse, served by fully integrated mental health and substance abuse program.

A critical tool to measure the impact of integrating physical and behavioral health care being adopted in public hospital systems is the **PHQ-9 Depression Screening Tool.** Research indicates that 10-15% of all primary care patients have depression, which is one of the top five most common conditions found in primary care settings.[104] According to an evaluation of 20 studies over the past 10 years, the prevalence rate of diabetics with major depression is three to four times greater than in the general population, according to the American Diabetic Association. What's worse, research shows that depression leads to poorer physical and mental functioning, so a person is less likely to follow a required diet or medication plan, which is essential to effectively treating diabetes. Consequences of untreated depression include:

- Distress, disability, suicide
- May increase and/or exacerbate:
    - risky behaviors, i.e. unprotected sex, drug and alcohol abuse
    - behaviors that contribute to poor health, i.e. smoking, poor nutrition
    - symptoms of chronic medical illness, i.e. cardiovascular disease, diabetes, and/or
    - use of general medical services

Failure to detect and treat depression leads to unnecessary suffering and disability, and increases the use of health care services. The US Preventative Service Task Force finds that screening for depression in the primary care setting improves detection rates, which in turn helps physicians provide the proper treatment to their patients.

According to the Macarthur Initiative on Depression and Primary Care, the PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire (PHQ), which is a depression screening tool used by primary care clinicians to diagnose mental health disorders. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff, who then select and monitor treatment. This tool is found to be an efficient way to screen individuals and large groups of patients to improve detection of undiagnosed depression. Used effectively, the PHQ-9:

- Is shorter than other depression rating scales,
- Can be administered in person, by telephone, or self-administered,
- Facilitates diagnosis of major depression,
- Provides assessment of symptom severity,
- Has proven effective in a geriatric population[105], and
- Is well validated and documented in a variety of populations

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[103] http://www.thenationalcouncil.org/galleries/resources-services%20files/5.%20Four%20Quadrant%20Diagram.pdf
[104] See UCSF *Depression in Primary Care* presentation by Mitchel Felman, MD http://www.ucsfcme.com/2008/MPS08002/FeldmanDepressionInPrimaryCare.pdf
[105] See LöeweB,et al, 2004 Medical Care

E-Referrals (for improving care coordination, improving efficiency and reducing wait times for specialists)
According to a recent University of California at San Francisco (UCSF) report[106], access to specialists is a common barrier for primary care clinicianstrying to deliver high-quality, coordinated care, especiallywhen their patients are poor or uninsured. To offer the standardof care required by the patient-centered medical home model,clinicians must be able to tap into a "medical neighborhood"of specialists and hospitals to obtain timely consultations,diagnostic services, and needed treatments. The way many healthcare networks still communicate is through telephone, paper and fax, which creates process inefficiencies, inaccurate data and slow information updates. This highly complex network of providers coupled with the poor communication infrastructure creates a barrier to continuum of patient care, increases health risks and does not allow for networks of health care providers (hospitals, specialists, doctors, agencies) to share information and manage the overall system. For example, in arecent six-country survey of patients with chronic illnesses,U.S. patients were most likely to report that when they receivedcare from multiple physicians, test results or medical recordswere not available at the time of their appointments.

To reduce wait times for specialty appointments, e-Referral systems have been introduced in many health care systems. There are many benefits for the patient: there is equality of care for all referred patients, a smooth transition of responsibility and continuity of patient care, and patients appreciate the improved efficiency and smoother communication. Overall, e-Referral can create increased confidence in the efficiency of the health system. According to a California HealthCare Foundation report[107], e-referring works like this:

> *The originating provider initiates the referral by completing a Web-based request form at the point of care. Patient data is registered, and depending on the complexity of the system, the data is filtered according to insurance coverage, preferred language, even access to public transportation. The referral is sent securely to the participating provider who can then review the referral beforescheduling an appointment to ensure that the service is appropriate and all the relevant information is available.*

In California, a good example of e-referral success is the launch of UCSF's and San Francisco General Hospital's (a public hospital) e-Referral system, a Web-based electronic referral system integratedinto the hospital's electronic health record. Twenty-eight specialty clinics and diagnosticservices at San Francisco General Hospital currently use the e-Referral system. For clinics that had been plagued by long wait times, implementationof e-Referral resulted in dramatic improvements. For example,in rheumatology, the median wait time for a non-urgent appointmentinitially dropped from 126 days to 29 days. Severalfactors contributed to the change, including the fact that somerequests were managed without the need for appointments andsome were redirected to other clinics. Patients seen by specialistswere also less likely to require follow-up appointments thanunder the old referral system, because they had received a moreextensive pre-visit workup. Surveys of specialists conductedbefore and after the rollout of e-Referral suggested that thenew system helped clarify the reasons for referrals.

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[106]See *A Safety-Net System Gains Efficiencies Through 'eReferrals' To Specialists* report. Alice Hm Chen, Margot B. Kushel, Kevin Grumbach, and Hal F. Yee, Jr.
http://content.healthaffairs.org/cgi/content/extract/29/5/969
[107]See *Bridging the Care Gap: Using Web Technology for Patient Referrals* at
http://www.chcf.org/publications/2008/09/bridging-the-care-gap-using-web-technology-for-patient-referrals#ixzz11in26l4x

Improving Language Access: HCIN/VMI

As the United States becomes increasingly diverse, American hospital systems face an enormous challenge in providing quality health services to limited English speaking patients. Increasing attention to quality improvement and medical error reduction initiatives cannot overlook the critical element of effective communication between physicians and patients in ensuring successful health outcomes. The dilemma of ensuring effective communication between medical providers and the Limited English Proficient (LEP) population and the deaf and hearing impaired is pervasive, facing not only large, urban public hospital systems in states such as California and New York, but also suburban and rural systems.

According to the 2000 Census, 39.5% of Californians over the age of five speak a language other than English at home and 20% of this population speaks English less than very well. And California's public hospitals and health systems serve a patient population made up of more than 76% people of color and more than half of public hospitals' patients are LEP. As a result, public hospitals encounter a significant challenge in the volume and complexity of their provision of language services. Without adequate language communications systems in place, providers and patients suffer not only frustration, but also adverse clinical outcomes.

California public hospital systems' mission to serve California's most diverse populations, and a high level of administrative and physician leadership and innovation, has uniquely positioned these safety net institutions to lead the nation in innovative, cost-effective, high-quality language services. California public hospital systems use a unique combination of qualified medical interpreters, bilingual clinicians, trained bilingual staff, remote technology and an automated video/voice call center system called Health Care Interpreter Network (HCIN)[108], which is a cooperative of California hospitals and health care providers sharing trained healthcare interpreters through videoconferencing devices and all forms of telephones. HCIN is available throughout each network hospital and connects within seconds to an interpreter on the HCIN system, either at their own hospital or one of their colleague hospitals. By pooling hospital-based staff, routing calls from video devices and telephones, and linking to external interpreting resources, HCIN enables clinicians and front-end staff at every point of patient contact to reach an interpreter on demand, 24 x 7, in 170 languages, at a very manageable cost.

Another area of success has been the publication of *Straight Talk: Model Hospital Policies and Procedures on Language Access*[109]by the California Health Care Safety Net Institute (SNI). The need for clear policy and detailed operational procedures, both to ensure quality health care services and to meet legal and regulatory requirements, is the dilemma of virtually every health care provider in America. The creation of these hospital policies and procedures for language access has been an essential mechanism to setting the standard in the operational actions of the U.S. hospital industry with regards to providing culturally competent care and has helped California's public hospitals become national leaders in providing high quality, cost-effective language services.

Improving Collection and Use of Accurate, Consistent Race/Ethnicity/Language (REAL) Data to Ensure Health Equity

In 2002, the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, signified a new era of national attention to racial and ethnic disparities in the American health care system. Corroborating that report, many research studies have established that Americans* do not all have equal access to health care, or experience similar health care quality and outcomes. Low-income, racial and ethnic minority, limited-English proficient, and other underserved populations often

[108] www.hcin.org
[109] See full document here: http://www.safetynetinstitute.org/content/upload/AssetMgmt/Site/StraightTalkFinal.pdf.

have higher rates of disease, fewer treatment options, reduced access to care, and lower satisfaction with care.

Because public hospitals serve diverse and underprivileged populations by mission and mandate, their vision has always been to provide equitable health care. For decades, public hospitals have remained committed to reducing health care disparities; however, like all of American medicine, they struggle with the resources and other challenges to achieving equitable care for all patients.

A key prerequisite for measuring equity of care and addressing disparities is to collect valid and reliable patient demographic data on race, ethnicity, and preferred language (REAL data). These data elements must be effectively linked to data systems used in health care service delivery (to tailor care to patient needs), as well as data systems used in quality improvement (to identify disparities).

Creating organizational systems for capturing REAL data is a long and resource-intensive process. Currently, the processes for analyzing equity of care are mostly piecemeal and limited in scope, taxing organizational resources. The California Health Care Safety Net Institute (SNI) recently completed a comprehensive assessment of system-level barriers and facilitators of improved REAL data collection and use in public hospital systems. SNI found that California safety net health care systems had an overall strong desire to identify and reduce disparities through the collection and use of REAL data, and in many cases have made great strides in infrastructure development and workforce training toward that goal. However, the study also uncovered significant barriers to effective collection and utilization of these patient demographic data for public hospitals. The key barriers identified include:

- Inadequate electronic healthcare data management systems and/or burdensome processes for integrating /revising the REAL data fields within the existing data management systems.
- Shortage of internal expertise for identifying the optimal categories that fit both the legislative/regulatory requirements and the local community demographic profile,
- Lack of understanding among registration staff, health care professionals and patients alike about the crucial role REAL demographic data collection plays in underscoring the quality of care and reducing disparities.
- Inadequate training of registration staff and other key staff functions on how to effectively communicate with patients about the effort to collect REAL data.
- Lack of knowledge about using the collected REAL data toward quality improvement and disparity reduction. This includes assessing whether disparities exist and understanding them, as well as designing effective improvement interventions.

To address these barriers, key next steps for public hospitals systems include developing tools, HIT protocols and training curricula to improve the collection and utilization of REAL data elements, which is the foundation for achieving significantly greater efficiency and cost-effectiveness in measuring equity of care, thus enabling the designs of more successful efforts to eliminate health care disparities.

Palliative Care

The main objective of health care in the U.S. is to keep patients healthy, and more importantly keep patients alive. Yet the same treatments that prolong life and restore health in one case may prolong dying and promote suffering in another. With the aging of the American population, and the steady growth in the number of people living with chronic illness, palliative care approaches have emerged in recent years to ease the prolonged pain and suffering associated with being severely ill and, ultimately, improves the inevitable experience of dying for patients and their families. It is estimated that 70% of people who experience chronic pain do so without adequate treatment. Symptoms such as anxiety, depression, shortness of breath, and fatigue are sometimes overlooked or ignored by health care professionals. In addition, caregivers of people with chronic or life-threatening illnesses often feel alone in their struggle to provide good care. Palliative care strives to deal with the many issues surrounding people who deal with life-threatening illnesses, and help them make critical decisions about end-of-life care.

Palliative Care developed during the 1960's as an attempt to adequately address some of the unmet needs of severely ill patients and their families. The central focus of the palliative care model is comprehensive,

interdisciplinary care that provides medical, emotional, spiritual and practical support, palliative care helps patients feel better and remain more active and independent while providing control and dignity at a time when patients most need it. It is provided simultaneously with all other appropriate medical treatments, and is coordinated among all caregivers and specialists. A key feature of palliative care is its focus on the patient as well as the family. Terminal illness puts special stress on families, and having the right support can be very helpful. Talking about and planning for the future can help prepare a person and the person's family to make the best choices for everyone involved. Studies show that palliative care improves quality of life for seriously ill patients and consistently reduce symptom distress and improve patient and family satisfaction. Palliative care programs can also alleviate inpatient overcrowding, bed shortages and inappropriate use of intensive care unit beds.
Palliative care, when done right, improves the communication of all parties involved in the patient's care. This improved communication helps patients and their care teams determine the best course of care and the most appropriate settings of care, which in practice often results in providing less aggressive hospital treatment, and a smoother, timelier, and more coordinated transition to non-hospital settings of care.

A collaboration of the California Health Care Safety Net Institute (SNI), the University of California at San Francisco's Palliative Care Leadership Center (PCLC), and the California HealthCare Foundation, has established palliative care programs in two-thirds of California public hospitals, from only 21% before the initiative.

Process Improvement in Health Care

American health care has evolved over time, incorporating many innovations and technologies that have proven to be the most effective for providing high-quality care. Unfortunately, many processes and practices have not evolved as quickly, creating inefficient workflows that unnecessarily lengthen hospital visits. Patient waiting times, staff scheduling, space allocation, and inventory have historically been secondary considerations. Coupled with the fact that hospitals are serving more patients, providing more services, and addressing more quality issues, it's clear that heavy considerations need to be made to maximize efficiency and reduce costs, while still achieving the best clinical outcomes.

One way to achieve these goals is through the application of process improvement methods, such as Lean or management engineering, which are systematic processes for diagnosing and correcting problems in the delivery of care. They can improve care by increasing productivity, controlling costs, and reducing wait times for patients by streamlining work and patient flow, reducing waste, improvement staffing efficiency, improve patient-staff communications, and defining clinical requirements for continuous quality care.[110]

Developed by Toyota in the 1950s to strengthen automobile manufacturing infrastructure and maximize resources, **Lean** is an example of a management engineering approach now being adopted successfully by health care organizations to address a range of quality and operational issues. The Lean method, specifically, provides a range of techniques to create a more efficient and effective workplace by having smooth work flows and eliminating waste in time, effort, or resources. According to the California HealthCare Foundation report *Operations Improvement Methods: Choosing a Path for Hospitals and Clinics*[111] by David Belson, PhD, "Lean helps providers work toward a state of continuous improvement, whereby the product flows at the pull of the customer in pursuit of perfection."

The entire focus of a successful Lean project is on the needs of the patient. This is done by applying the Japanese concept of "Kaizen", or quick iterative experiments in change, along with Lean techniques to "create new work practices that improve care processes, eliminate waste, reduce ambiguity in work assignments, and solve problems." These techniques can be summarized into three categories: using "Takt" time, developing a value stream map, and using "5-S". Takt time defines the pace or rhythm necessary for smooth work flow and is calculated by the time required to complete a task by the quantity needed for the task. A value stream map is a diagram that identifies how work flows and shines a light on wasteful activities. And lastly, "5-S" (sort, set in order, shine, standardize, and sustain) operates under the notion that a well-organized workplace will be efficient. Used all together, waste is virtually eliminated from the continuum of care, while still keeping the quality intact.
To date, five public hospitals in California have incorporated Lean techniques into their systems to eliminate waste and to create a more patient-focused environment that supports timely delivery of treatment with optimum quality at the least cost. For example, Lean has been vital in reliably improving delivery discharge processes for congestive heart failure patients and reducing their preventable re-hospitalizations. These improvements have made a direct impact on CMS core measures scores, with plans to spread Lean methodology throughout their hospital systems.

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[110] See: *Operations Improvement Methods: Choosing a Path for Hospitals and Clinics* by David Belson, PhD: http://www.chcf.org/publications/2007/12/improving-efficiency-management-engineering-comes-to-the-safety-net#ixzz11umwfMFJ
[111] www.chcf.org/publications

Rapid Medical Evaluation (RME)

As the demand for emergency services grows, resources in emergency medicine are being stretched. This causes longer emergency department (ED) wait times, overcrowding, ambulance diversion, increased patient suffering and poor morale. Oftentimes patients ultimately leave the ED without being seen, which results in prolonged illness, prolonged pain, and an increased rate of subsequent hospitalization.
California Emergency Physicians Medical Group (CEP) confronted rising patient volumes and limited space by reengineering the patient treatment process, developing the Rapid Medical Evaluation (RME) program. Created in 2002, RME is a proven methodology for reducing wait times by improving patient flow, improving care, and increasing patient satisfaction in the ED, the main tenant being bringing patients to providers as quickly as possible upon arrival to the ED.
Under RME, all patients can be seen in a timely manner, usually within 30 minutes of arrival. The treatment process is fluid, adjusting to ensure treatment is provided as quickly as possible. The process begins immediately, including an initial assessment, ordering of labs and X-rays, and in some cases, rapid discharge without utilizing an ED bed. Patients presenting to the ED are escorted immediately to an intake area staffed with a physician, a technician, and a unit clerk. A quick focused interview by the provider results in rapid assignment of patients into two groups depending on acuity and severity of their condition, based on a quick look rather than a full triage. The sicker group goes to the main emergency department for treatment. The less sick group may either be discharged (to home or to a medical home) or sent for lab or radiology studies. The benefits reported are quicker door-to-provider times, fewer patients leaving without being seen and increased revenue because of improved efficiencies.

Reducing Readmissions

Hospitalizations are costly, accounting for approximately 31 percent of total health care expenditures.[112]
According to the Academy Health report *Reducing Hospital Readmissions* by Jenny Minott, multiple factors contribute to avoidable hospital readmissions, including poor quality care or poor transitions between different providers and care settings. Readmissions may also occur if patients are discharged from hospitals or other health care settings prematurely, are discharged to inappropriate settings, or do not receive adequate information or resources to receive progressive treatment. System factors also contribute to unplanned hospital readmissions, such as lack of coordinated care or poor communication and information exchange between inpatient and ambulatory providers. Additional data also indicates that the majority of readmissions are for medical services, rather than surgical procedures. Repeated hospital admissions also affect patient morale and leave them feeling lost and confused about the health care system and how to best manage their health.
Identifying and implementing best practices to reduce avoidable readmissions would likely improve quality, reduce unnecessary health care utilization and costs, promote patient-centered care, and increase value in the health care system. Moreover, as some individuals are at greater risk of readmission as a result of individual and/or cultural characteristics, care coordination targeted to particular groups of patients could reduce hospital readmission and may help eliminate disparities in health care.
A proven method for reducing avoidable readmissions is to improve transitional care, which ensures proper coordination and continuity of care as patients move between various locations or levels of care within one organization. A leading model for this work is **The Care Transitions Intervention™**, which has been adopted by over 170 leading health care organizations nationwide. Through this approach, Eric Coleman, MD, a nationally-recognized readmissions expert, says that there are four pillars that provide a core set of medical directions that the patient should have: medication self management, follow-up appointment with the primary care physician or specialist, a knowledge of "red flag" or warning signs of symptoms and how to respond to them, and a personal health record that is a portable core set of medical directions including a medication list and associated allergies, an advance directive, treatment preference, and room for patient questions and concerns.

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[112] See Academy Health *Reducing Hospital Readmissions* report:http://www.academyhealth.org/files/publications/Reducing_Hospital_Readmissions.pdf.

In addition to these four pillars, studies show that care transitions intervention coaching can result in a significant reduction in 30-day hospital readmits, as well as a potential reduction in 90-day and 180-day readmits[113] Care transitions coaches could help patients by modeling behavior to resolve discrepancies, respond to red flags and obtain a timely follow-up appointment, and also help the patient practice for their next encounter with his/her provider and identify two or three questions to discuss. Enhancing the role of patients and caregivers, measuring the quality and safety of care transitions, and using health information technology to promote safe care transitions also play a role in preventing avoidable readmissions.
Over the past few years, California public hospitals have implemented and made important adaptations of various models to reduce avoidable admissions, from Dr. Coleman's Care Transitions Intervention to other models such as **Project RED**[114] or Transforming Care at the Bedside[115]. Four public hospitals have also successfully applied Lean to improve reliable delivery of discharge processes for congestive heart failure patients, showing steady progress in decreasing readmissions for CHF patients.

Patient-Centered Care/Improving the Patient Experience

The main goal of health care is to bring a sick patient to health. To this end, hospital and clinic staff are medically trained to diagnose physical symptoms and heal a patient's illness, and to alleviate any accompanying discomfort or pain. In this simplified sense, the assumption could be made that health care is ultimately patient-centered. However, health care involves much more than a 10-minute visit between a patient and their doctor. A patient's experience of health care begins with a patient trying to gain access to his or her health system, what information (or lack of) is delivered to them while waiting to be seen, the quality of the medical visit, knowledge of how to access other services related to their care, and clarity around post-visit care and medication, as well as a host of other potential interactions within the system of care. This series of interactions involve many *people* who deliver this care-- physicians, nurses, front-line staff, environmental service staff, and many others---so the *way* in which care is delivered affects the overall perception of the services received. And yet while the goal may be to heal patients, current practices and standards support the view that the "providers are the experts, family are visitors, and patients are body parts to be fixed."[116] In this view, care then is centered more around the providers and current system structure rather than around the patient.

The way care is delivered not only matters to patients but has a direct impact on quality and patient safety. The Institute of Medicine's 2001 report *Crossing the Quality of Chasm* identified patient-centeredness as an essential foundation for quality and patient safety.[117] In the report *Patients' Satisfaction with Care and Quality of Care,*the research shows that hospitals that perform well on HCAHPS also have a higher performance on hospital quality standards.[118] A recent report published by Health Services Research also shows that patient experience indicators, such as response times and cleanliness, affect infection rates and other safety measures.[119]To add further complexity, recent findings indicate a direct link between the employee experience and the patient experience of care.

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[113] See *A Look at Care Transitions* article: http://nashville.medicalnewsinc.com/reducing-unplanned-hospital-readmissions-cms-2426.
[114]http://www.ahrq.gov/news/kt/red/
[115]http://www.ihi.org/IHI/Topics/MedicalSurgicalCare/MedicalSurgicalCareGeneral/ImprovementStories/TransformingCareattheBedsideinitiativePrototypephase.htm
[116] See *Patient Centered Care Improvement Guide*, Picker Institute and Planetree, October 2008.
[117] See *Patient Centered Care Improvement Guide*, Picker Institute and Planetree, October 2008.
[118]Jha, et al. *Patients' Satisfaction with Care and Quality of Care* . New England Journal of Medicine. October 2008.
[119] Isaac, et al. *The Relationship Between Patients' Perception of Care and Measures of Quality and Safety.* Health Services Research. August 2010.

Because the patient experience spans every department within the health care system and the research on this subject is relatively new, there is limited evidence that would wholly support any one method for improving the overall patient experience. However, there is research available for targeted practices and departments that show possible improvement in HCAHPS scores. According to the Studer Group, the emergency department (ED) is a hospital's major point of entry for patients, accounting for 50% of inpatient admissions nationally.[120] What's more, patients admitted through the ED rated care "more negatively than those patients admitted through other avenues." Using the Studer Group's evidence-based leadership tactics modified for the ED setting, hospitals can improve and drive consistency in the patient experience.[121] Through this method, patients are kept informed of the plan of care and wait times, post-visit phone calls are conducted, and leadership is engaged in working effectively with their highest and lowest performing staff. In the outpatient setting, evidence points to the correlation between wait times and patient satisfaction where longer wait times were associated with lower patient satisfaction scores.[122] The report further found that "…time spent with the physician was the strongest predictor of patient satisfaction. The decrement in satisfaction associated with long waiting times is substantially reduced with increased time spent with the physician (5 minutes or more). Importantly, the combination of long waiting time to see the doctor and having a short doctor visit is associated with very low overall patient satisfaction." Several improvement agencies employ various methods for reducing patient waiting times without reducing time spent with the provider (such as Patient Visit Redesign[123]) and for keeping patients informed of wait times.

In California's public hospital systems, improving the patient experience has become a top organizational priority. While individual systems are in the beginning stages of addressing the patient experience, others have been able to implement improvement activities to improve patient satisfaction. San Mateo Medical Center has made significant strides in improving their HCAHPS scores using Press Ganey survey tools and coaching to help drive improvement. Focusing on specific processes such as morning team huddles and noise reduction, San Mateo has seen their HCAHPS scores increase by 35-45%, which they have been able to maintain on a consistent basis.

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[120] Studer, et al. *The HCAHPS Handbook*. Fire Starter Publishing. 2010.
[121] Baker *Excellence in the Emergency Department: How to Get Results.*. Fire Starter Publishing. 2009.
[122] Anderson et al. *Willing to Wait?: The Influence of Patient Wait Time on Satisfaction with Primary Care.* BioMed Central Health Services. 2007.
[123] See http://patientvisitredesign.com/about_redesign/index.html.

XVI. Appendix B: Example DSRIP Categories 1-2 Plan

The purpose of this document is to confirm agreement on the framework for Categories 1-2. In order to achieve this goal, below is one sample Categories 1-2 plan to demonstrate the following:

- The categories into which projects fall (overall framework)
- The orientation of projects in different categories toward common goals
- The indirect, correlated linkages that exist amongst projects across Categories 1-3
- Examples of the types of process measures include: milestones and metrics across the years
- That all milestones will be measurable (all milestones must specify metrics or refer to recognized metrics)
- The inter-relation of the projects, which taken together work to provide improved quality of care for patient populations

Category 1: Per the California Section 1115 Waiver Terms and Conditions, the purpose of Category 1: Infrastructure Development is "investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services." Therefore, this sample Public Hospital System A plan's Category 1 includes infrastructure development, including investment in people, places, processes and technology. This category is foundational to the success of Categories 2-3. This plan describes how the Category 1 infrastructure development will enhance capacity to conduct, measure and report on quality/performance improvement, expand access to meet demand, and enable improved care with strong emphasis on building coordinated systems that promote preventive, primary care.

1. Example Project: Increase Primary Care Capacity
   - ***Goal:*** Public Hospital System A's primary care capacity is only able to serve about 70,000 patients annually, compared to an estimated demand of 90,000. Primary care capacity, resources, infrastructure, and technology are severely limited. Our goal is to be able to better treat the volume of patients who need primary care in the primary care setting, with limited wait times. In order to provide more preventive, primary, and chronic care in the primary care setting, it is critical to expand primary care capacity. This includes increased efficiencies to maximize the capacity Public Hospital System A already has, as well as adding capacity so that we can treat more patients. In order to do this, we propose to:
     - Expand Primary Care Clinic Hours; and
     - Re-Integrate Urgent Care Services into Primary Care Clinics, in order to significantly reduce the need for a dedicated same day provider to see urgent care patients because instead, primary care teams will be able to see their own patients with urgent care needs. Enhanced capacity for each primary care team to see its own patients with urgent and ongoing needs enhances care continuity. The reintegration of urgent care services into primary care will require intricate planning.
   - ***Expected Result:*** At least 90% of patients can get in to see their primary care team within 7 days as a result of expanding primary care capacity, including through expanded clinic hours and the reintegration of urgent care services into primary care.
   - ***Related Projects:*** Expanded primary care capacity also feeds into the expansion of medical homes and more organized care delivery, better prevention and management of chronic conditions, integrated physical-behavioral health care, and better utilization of health care resources. With expanded primary care capacity, more patients can have access to primary and preventive care, which increases opportunities to prevent disease and treat it early, and patients upon discharge can be scheduled for follow-up appointments and care at a primary care clinic, thereby reducing the risk and consequences of worsening health conditions.

1. Example Project: Increase Primary Care Capacity					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
1. **Milestone:** Develop a plan to expand the hours of the primary care clinic to include evenings and weekends, as measured by (1) identification of current patient volume, (2) assessment of new patient waiting list, (3) development of plan to expand the hours, and (4) a plan to re-integrate urgent care services into primary care clinics. • **Metric:** Documentation of completion of all four items, including timeframes and submission of the proposed new clinic hours.	2. **Milestone:** Implement a system to accommodate urgent care needs in at least 1 primary care clinic, as measured by achieving at least 15% of empaneled patients scheduled within 7 calendar days. • **Metric:** Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment.[124] The rate is an average, measured monthly, for all medical home clinics combined. It will be reported for the most recent month.	3. **Milestone:** Expand the hours of the clinic by at least 8 hours per week. • **Metric:** Documentation of new clinic hours. 4. **Milestone:** Implement a system to accommodate urgent care needs in at least 1 additional (2 total) primary care clinics, as measured by achieving at least 30% of empaneled patients scheduled within 7 calendar days. • **Metric:** Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment.	5. **Milestone:** Expand the hours of the clinic by at least 16 hours per week. • **Metric:** Documentation of new clinic hours. 6. **Milestone:** Implement a system to accommodate urgent care needs in at least 1 additional (3 total) primary care clinics as measured by achieving at least 60% of empaneled patients scheduled within 7 calendar days. • **Metric:** Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment.	7. **Milestone:** Implement a system to accommodate urgent care needs in at least 1 additional (4 total) primary care clinics as measured by achieving at least 90% of empaneled patients scheduled within 7 calendar days. • **Metric:** Third-Next-Available Appointment Available Within 7 Calendar Days: Number of Calendar days until third next available appointment.	• Expand Medical Homes (Cat. 2) – see pp. 6-7 • Redesign Primary Care (Cat. 2) – see p. 8 • Improve Screening Rates (Cat. 3) • Improve Chronic Care Management and Outcomes (Cat. 3) • Reduce Readmissions (Cat. 3)

[124] Taken from IHI definition in white paper on whole system measures

2. Example Project: Enhanced Interpretation Services
   - ***Goal:*** At Public Hospital System A, 52% of patients speak a language other than English as their primary language. Effective communication is crucial to effective health care because patients need to understand their medications, interventions, and ongoing care. Public Hospital System A already begun work to make sure that all patients will receive equitable health care in their preferred language. This is a strategic priority because all patients should receive high-quality health care. As a safety net provider, it is a critical part of our mission to do so. Therefore, this project will improve communication between the patient and the provider so that patients can be more involved in their health care and better receive equitable health care. In this project, we are focusing on increasing patients' access to qualified health care interpretation in a timely manner. As a member of the Health Care Interpreter Network (HCIN), which is a cooperative of California hospitals and health care providers sharing trained health care interpreters through an automated video/voice call center system, we can connect within seconds to an interpreter on the HCIN system. When a language is not available from an interpreter at one of the HCIN hospitals, the call connects automatically to a contracted telephonic language provider. HCIN provides interpretation for 170 languages, including American Sign Language (ASL), 24/7. By pooling hospital-based staff, routing calls from video devices and telephones, and linking to external interpreting resources, HCIN enables clinicians and front-end staff at every point of patient contact to reach an interpreter on demand at a very manageable cost. HCIN is an advanced, cost-effective, and innovative solution to language access needs. However, we know that the system is not always used when it could be. These "failure to utilize" situations are often related to inadequate training of personnel or insufficient access to the technology. We need to improve HCIN use among providers and staff and expand its video capacity to all medical home and specialty clinics, and all inpatient areas to improve communications between patients and providers so that patients are fully involved in their care, and so that providers are able to fully understand their patients' health care needs.
   - ***Expected Result:*** Expanded health care interpretation so that patients can receive instantaneous interpretation from a qualified health care interpreter, as evidenced by at least 1,500 qualified health care interpreter encounters per month, which is the estimated approximate current need.
   - ***Related Projects:*** Better communication between patients and providers can reduce medical and medication errors, help better solve health-related issues, empower patients to manage their conditions, and reduce the possibility of complications and readmissions. Effective patient-provider communication is integral to high-quality care and a key measure of patient-centeredness and cultural competency.

2. Example Project: Enhanced Interpretation Services					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
8. **Milestone:** Develop a plan to expand the video use of HCIN to all patient care	**9. Milestone:** Conduct a gap analysis to determine	**10. Milestone:** Provide at least 1,000 qualified health care	**11. Milestone:** Provide at least 1,200 qualified health care interpreter	**12. Milestone:** Provide at least 1,500 qualified health care interpreter encounters per month	• Reduce Readmissions (Cat. 3) • Improve Chronic Care Management

2. Example Project: Enhanced Interpretation Services					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
areas within the hospital and its outpatient clinics • **Metric:** Documentation of plan, including workplan and timelines.	HCIN hardware and training needs • **Metric:** Report the results of the gap analysis.	interpreter encounters per month[125] • **Metric:** Average number of HCIN plus in-person interpreter encounters recorded per month.	encounters per month • **Metric:** Average number of HCIN plus in-person interpreter encounters recorded per month.	• **Metric:** Average number of HCIN plus in-person interpreter encounters recorded per month.	and Outcomes (Cat. 3)

3. Example Project: Collection of Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities
   - ***Goal:*** Public Hospital System A's patients are diverse: 58.5% are Hispanic/Latino, 14.7% are White, 4.9% are Black, 9.3% are Asian, and 12.6% Other. While Public Hospital System A may presume that health care disparities might exist, we are an enterprise that believes in using data to drive quality improvement. Therefore, we believe it is imperative to stratify quality data, such as clinical outcomes and interventions, by race, ethnicity and language ("REAL data") so that we know the facts of where disparities exist. By having this knowledge, we will be able to target improvements in health care equity appropriately and effectively, and measure our progress along the way. Providing equitable care is critical to getting patients engaged in their care – every patient, regardless of who they are, deserves high quality health care. It is likely that race, ethnicity and language disparities exist both in accessing and receiving care; however, we have unreliable data by which to identify them. Therefore, it is our goal to develop the ability to: (1) Collect patient demographic data in a way that can be compared to quality and health outcomes data; (2) Stratify patient demographic data by outcomes to identify disparities; and (3) Engage in quality improvement projects to reduce health care disparities that have been identified.
   - ***Expected Result:*** Data is available to identify disparities for at least 90% of patients.
   - ***Related Projects:*** Reducing disparities in health care will support improved care for a multitude of Categories 3-4 projects through the provision of equitable health care.

[125] The number of qualified health care interpreter encounters per month, based on one of the reporting months within the prior year. "Qualified health care interpreter" is defined as one who has: 1) been trained in healthcare interpreting; 2) adheres to the professional code of ethics and protocols of healthcare interpreters; 3) is knowledgeable about medical terminology; and, 4) can accurately and completely render communication from one language to another. This definition can be found in the California Health Care Safety Net Institute's *Straight Talk: Model Hospital Policies and Procedures on Language Access*<http://www.safetynetinstitute.org/content/upload/AssetMgmt/Site/StraightTalkFinal.pdf>.

3. Example Project: Collection of Accurate Race, Ethnicity, and Language (REAL) Data to Reduce Disparities					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
13. **Milestone:** Develop a plan to stratify patient outcomes and quality measures by patient demographic information such as race, ethnicity, gender, primary language, and literacy level ("REAL data") in order to identify potential health care disparities and develop strategies to facilitate equitable health care outcomes • **Metric:** Documentation of plan, including workplan and timelines.	**14. Milestone:** Establish data stratification and comparison processes for capturing accurate REAL data and linking it to quality data, including designating specified data fields for REAL data recording • **Metric:** Documentation of established processes, including workplan and timelines.	**15. Milestone:** At least 70% of unique patients have the designated REAL data fields recorded as structured data • **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in the Electronic Health Record (EHR) ○ **Numerator:** Number of unique patients with designated REAL data fields recorded ○ **Denominator:** Number of total unique patients	**16. Milestone:** At least 80% of unique patients have the designated REAL data fields recorded as structured data • **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in the Electronic Health Record (EHR) ○ **Numerator:** Number of unique patients with designated REAL data fields recorded ○ **Denominator:** Number of total unique patients	**17. Milestone:** At least 90% of unique patients have the designated REAL data fields recorded as structured data • **Metric:** The percent of patients with Race, Ethnicity and Language (REAL) fields identified in the Electronic Health Record (EHR) ○ **Numerator:** Number of unique patients with designated REAL data fields recorded ○ **Denominator:** Number of total unique patients **18. Milestone:** Perform REAL data analysis and identify at least 2 specific health care disparities • **Metric:** Report the results of the analysis and provide documentation of the workplan, including timelines, to address and reduce the disparities	• Reduce Readmissions (Cat. 3) • Improve Screening Rates (Cat. 3) • Improve Chronic Care Management and Outcomes (Cat. 3) • Expand Medical Homes (Cat. 2) – see pp. 6-7 • Redesign Primary Care (Cat. 2) – see p. 8

Category 2: Per the Waiver Terms and Conditions, the purpose of Category 2 Innovation and Redesign is "investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management." Therefore, this sample Public Hospital System A plan's Category 2 includes the piloting, testing, and spreading of innovative care models. Public Hospital System A's patient population experiences significant challenges associated with poverty, such as psychosocial barriers to health and multiple concurrent medical conditions. Public Hospital System A has had to get very creative to address the needs of the patient population with extremely limited resources. Public Hospital System A needs to further refine these innovations, test new ways of meeting the needs of our target populations, and disseminate learnings in order to spread promising practices.

4. Example Project: Expand Medical Homes

- ***Goal:*** Only 20,000 of our patients are assigned to medical homes: thereby missing opportunities to provide better care through improved prevention screenings and routine primary and chronic care. Only about 60% of our providers are organized as care teams, while the remaining is still functioning in a more traditional approach. Only 1 of our 6 primary care adult clinics is organized as a medical home. We want to make sure the medical home model is embedded within our care delivery model so that all patients can receive the right care in the right place at the right time. This is a strategic priority for Public Hospital System A because by providing more patients with coordinated care services grounded in their primary care medical homes, patients can stay healthier, thereby reducing avoidable ED visits, admissions, and readmissions. Patients will receive this care in a proactive, planned manner so that they can receive evidence-based interventions. In 2007, Public Hospital System A opened a new primary care clinic, which piloted many components of what we believe should be spread and sustained throughout our primary care clinics. This initiative included comprehensive clinic redesign through which we implemented:
    - Medical home team-based care,
    - Expanded staff roles,
    - Performance outcomes measurement,
    - Effective use of health information technology (IT),
    - Coordination of care with support staff, and
    - Health promotion and education.

  For example, staff includes nutritionists, social workers, community health workers and therapists. Services include group visits, case management, telephone outreach and home-health care. Team communication methods are in-person, via conference calls and other methods, including email and written reports. Public Hospital System A has piloted the medical home model, but needs to spread it throughout the hospital system. Right now, some primary care clinics are utilizing some components of these models, but not necessarily all. For example, while most clinics make some attempt to empanel patients, there is variation in the rigor of this process and inconsistency in commitment to scheduling patients with their designated care team.

- ***Expected Result:*** At least 90% of eligible patients are assigned to primary care teams serving as their medical homes (increasing from 20,000 empaneled patients to 30,000 empaneled patients, an increase of 10,000 empaneled patients or a 50% improvement). Care teams actively manage their patient panel so that patients are reminded of services needed and receive coordinated care rooted in a primary care setting. Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforces a continuity of care.
- ***Related Projects:*** By spreading the medical home model to all of our primary care clinics in order to be able to empanel tens of thousands of patients comprehensively and systemically, we can make a real difference in the experience, results and cost of health care.

4. Example Project: Expand Medical Homes					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
19. **Milestone:** Develop and submit a plan, in conjunction with the Health Plan of County A, to empanel patients to primary care teams serving as medical homes to coordinate patients' health care needs. The system will include (1) restructuring staff ; (2) utilizing information services technology to track the assignment of patients; and (3) designation of staff to actively manage patient panels. • **Metric:** Documentation of completion of all three items, including timeframes and submission of the proposed expansion of the system to empanel patients. 20. **Milestone:** At least 60% of eligible patients[126] will be assigned to medical homes • **Metric:** Medical Home Assignment. To reap the full	**21. Milestone:** At least 65% of eligible patients will be assigned to medical homes • **Metric:** Medical Home Assignment ○ **Numerator:** Number of eligible patients assigned to a primary care provider ○ **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months)	**22. Milestone:** At least 70% of eligible patients will be assigned to medical homes • **Metric:** Medical Home Assignment ○ **Numerator:** Number of eligible patients assigned to a primary care provider ○ **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months)	**23. Milestone:** At least 75% of eligible patients will be assigned to medical homes • **Metric:** Medical Home Assignment ○ **Numerator:** Number of eligible patients assigned to a primary care provider ○ **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12	**24. Milestone:** At least 90% of eligible patients will be assigned to medical homes • **Metric:** Medical Home Assignment ○ **Numerator:** Number of eligible patients assigned to a primary care provider ○ **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months) **25. Milestone:**	• Improve Preventive Screening Rates (Cat. 3) • Improve Chronic Care Outcomes (Cat. 3) • Reduce Readmissions (Cat. 3)

[126] An "eligible patient" for the purposes of this section of this proposal is a patient seen by his or her primary care provider team at least twice within the last 12 months.

benefits of the medical home, a patient must have a consistent care team that they can rely on both for routine preventative care and for their urgent medical needs. ○ **Numerator:** Number of eligible patients assigned to a primary care provider ○ **Denominator:** Number of eligible patients (patients seen at the same primary care clinic at least twice in last 12 months)			months)	Report shared learnings of the medical home model, and any findings related to impact on improved health, experience and cost	

5. Example Project: Primary Care Redesign
   - ***Goal:*** We currently have about 1,800 patients waiting for primary care medical home appointments. It may be difficult for the patient to get a primary care appointment in a timely manner due to traditional office hours and the practice of medicine structured around the physician, not around the patient In order to address this challenge, Public Hospital System A will redesign primary care to achieve increased efficiencies to maximize the capacity we already have. This plan seeks to build upon work we have started to standardize clinic-level data across Public Hospital System A so that we can better understand cycle time, wait times for primary care, and patient satisfaction. In order to do this, we propose to: (1) Build internal capacity with the resources we already have through implemented efficiencies that will reduce primary care cycle times, patient no-show rates, and days to third next available appointments; and (2) Implement the Patient Centered Scheduling Model so that patients can get in to see their primary care team when needed and when it is convenient for the patient to enable expanded access to primary care. Historically at Public Hospital System A, patient appointment "no-show" rates have been as high as 30%.
   - ***Expected Result:***Patient "no-show" to appointment rate is less than 10% as a result of improved access when it is convenient for the patient, and due to establishing an ongoing relationship with his/her care team that reinforces continuity of care.
   - ***Related Projects:*** With increased access to primary care, patients are better able to receive preventive, primary and ongoing care, developing a continuity of care with their primary care team.

5. Example Project: Primary Care Redesign					
Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
26. **Milestone:** Develop a plan to build capacity into primary care team schedules, including use of the Patient Centered Scheduling Model and resourcing and training staff in order to reduce patient appointment "no-show" rates • **Metric:** Documentation of the plan, including workplan and timeframes.	**27. Milestone:** Achieve at least a 25% or lower patient no-show rate for primary care medical homes[127] due to enhanced continuity of care and lasting relationships established between the provider and the patient • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	**28. Milestone:** Achieve at least a 12% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	**29. Milestone:** Achieve at least a 10% or lower patient no-show rate for primary care medical homes • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominato r:** Number of patients scheduled for each session	**30. Milestone:** Maintain 10% or lower patient no-show rate for primary care medical homes in order to demonstrate sustainability of the improvement for at least 4 consecutive quarters • **Metric:** No-show rate ○ **Numerator:** Number of patients who missed an appointment in a medical home session ○ **Denominator:** Number of patients scheduled for each session	• Improve Preventive Screening Rates (Cat. 3) • Improve Chronic Care Outcomes (Cat. 3) • Reduce Readmissions (Cat. 3)

6. Example Project: Increase Quality/Efficiency through Application of Lean Process Improvement Methodology
   - ***Goal:*** The ultimate goal is that care throughout the system is: Safe – no harm; Effective – prevent disease and complications and minimize suffering, disability, and death; Efficient – the right care, without waste; Patient-Centered – informed, involved, educated, relieved of pain and suffering; Timely – without unwanted delay; and Equitable – the right care for ALL.In an effort

[127] For this and other milestones using this measure, measurement is determined based on the percentage of the patients scheduled for each session who did not show up for their medical home visit. The rate is an average measured monthly. This measurement would be based on the most recent reporting month.

to continue to provide high quality services to those needing care, Public Hospital System A has piloted a restructuring of its limited resources, including increasing efficiencies, eliminating waste and redundancies and improving quality, and shifting utilization of staff to be more focused on value-added activities. Our goal is to spread this work throughout the system. Lean work includes identifying value-added and non-value-added activities, fostering an organizational culture with a commitment to continuous quality improvement, and involving all relevant staff in helping to redesign processes to improve quality and flow and reduce waste. By providing safer, higher quality care, patients' health outcomes may improve, along with their experience of the care.

- ***Expected Result:***Higher quality, more efficient patient care by implementing 12 Lean Kaizen events over five years to gain efficiencies and reduce waste and redundancies. Since this project is innovative and redesign-oriented, we will be reporting whether quality and efficiency are impacted and we will be sharing our learnings.
- ***Related Projects:*** Reduce 30-day all-cause readmissions for target clinical conditions and/or improve performance on CMS processes of care measures. The intention of more value-added work is also higher quality care, and Lean has been used as an effective method to focus on making impacts on patients' health and experience.

6. Example Project: Increase Quality/Efficiency through Application of Lean Process Improvement Methodology

Attachment Q - Delivery System Reform Incentive Payments (DSRIP) Metrics
Category 1 &2 – Infrastructure Development, Innovation & Redesign Improvement Projects

Year 1	Year 2	Year 3	Year 4	Year 5	Related Projects
31. **Milestone:** Develop target for annual cost avoidance based on goal for reducing avoidable readmissions, and the capacity to measure progress toward the target. • **Metric:** Documentation of the establishment of the metric and a methodology to measure progress made toward the target over the course of the five years.	**32. Milestone:** Implement at least 3 Lean Kaizen rapid performance improvement events in at least 2 areas and train at least 5 providers and at least 10 staff. • **Metric:** Documentation that all of the steps included in the cycle of Kaizen were performed: • Standardized an operation • Measured the standardized operation (cycle time and amount of in-process inventory) • Gauged measurements against requirements • Innovated to meet requirements and increase productivity • Standardized the new, improved operations • Continued the cycle	**33. Milestone:** Implement at least 3 additional Lean Kaizen rapid performance improvement events in at least 1 additional area and train at least 10 providers and 10 additional staff. • **Metric:** # of Lean Kaizen rapid performance improvement events per measurement indicated in Year 2.	**34. Milestone:** Implement at least 3 additional Lean Kaizen rapid performance improvement events in at least 2 additional areas and train at least 5 additional providers and at least 10 additional staff. • **Metric:** # of Lean Kaizen rapid performance improvement events per measurement indicated in Year 2.	**35. Milestone:** Produce final report for costs for hospitalization for chosen specific primary diagnoses clinical conditions. Share the learnings from this redesign process toward improved quality, increased efficiency. • **Metric:** Submission of numerator and denominator established in Year 1, and comparison to the baseline and the target.	• Reduce Readmissions (Cat. 3) • Improve Quality (Cat. 3)

Attachment Q - Delivery System Reform Incentive Payments (DSRIP) Metrics
Category 3 – Population-focused Improvement

I. Introduction

As defined within these California Section 1115 Demonstration STCs, the purpose of Category 3: Population-focused Improvement is to provide "investments in enhancing care delivery for the 5-10 highest burden (morbidity, cost, prevalence, etc.) conditions in public hospital systems for the population in question. Examples of such initiatives drawn from the CAPH hospitals' initial proposals are: A. Improved Diabetes Care Management and Outcomes; B. Improved Chronic Care Management and Outcomes; C. Reduction of Readmissions; and D. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems)."

The measure set below for Category 3 includes measures that are:

A. Aligned with the low-income, Medicaid, and uninsured population in question;
B. Identified as high priority given the health care needs and issues of the patient population served by DPH systems; and
C. Viewed as valid health care indicators to inform and fuel improvements in population health within the health care safety net.

II. Category 3 Structure

A. Each DPH system plan will include each required measure listed below as milestones in the 5-year plan.
B. Each DPH system plan will include Category 3 milestones for DY 7-10, as specified per domain below.
   With the Category 3 emphasis on the reporting of population health measures to gain information and understanding on the health status of key populations and to build the capacity for reporting on a comprehensive set of population health metrics, DPH systems will measure and report on the below measures within each of the below five domains, but will not have milestones associated with the achievement of specific improvements.

III. Category 3 Reporting of Data Measures – Five Domains:

A. **Patient/Care Giver (CG) Experience**
   All of the CG Consumer Assessment of Healthcare Providers and Systems (CAHPS) questions included for the themes listed below are required to be included in DPH system plans for DY 8-10. For DY 8 only, data from the last 2 quarters of the demonstration year shall suffice to meet the DY 8 reporting requirement to allow for DPH systems to put in place CG CAHPS and the related data and logistics. Full demonstration year data for DY 9 and 10 is required.

   1. Data Source: CG CAHPS[128]
   2. Each CG CAHPS theme includes a standard set of questions. The following CG CAHPS' themes will be reported on:
      a. Getting Timely Appointments, Care, and Information
      b. How Well Doctors Communicate With Patients
      c. Helpful, Courteous, and Respectful Office Staff
      d. Patients' Rating of the Doctor
      e. Shared Decision making
   3. The reporting of the measures must be limited to ambulatory care clinics only.

B. **Care Coordination**

[128] See: http://www.cahps.ahrq.gov/cahpskit/files/309-4_CG_Reporting_Measures_4pt.pdf

DPH system plans must include 2 measures in DY 7 (#6 -7) and all measures in DY 8-10:

1. Potential Inpatient Data Sources: Inpatient discharge diagnoses, hospital computer system, medical records, claims, registry and/or ambulatory care EMR (if available)
2. Measurement: The data for measurement will be extracted from one of the following ambulatory care data sources:
   a. Manually, using a sampling approach;[129]
   b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample).
   c. A data warehouse;
   d. A practice management system; or
   e. An electronic medical record (EMR)
      i. Diabetes, short-term complications (derived from AHRQ Prevention Quality Indicator (PQI) #1)[130]
         A. **Metric:**
            1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years[131] with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
            2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
      ii. Uncontrolled Diabetes (derived from AHRQ Prevention Quality Indicator (PQI) #14)[132]
         A**. Metric:**
            1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 – 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
            2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
      iii. Congestive Heart Failure (derived from AHRQ Prevention Quality Indicator (PQI) #8)[133]
         A. Metric:
            1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for CHF within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
            2. **Denominator:** Number of patients age 18 years and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
      iv. Chronic Obstructive Pulmonary Disease (derived from AHRQ Prevention Quality Indicator (PQI) #5)[134]

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[129] See Appendix A: Sampling Approach
[130] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=15408&search=Diabetes+Mellitus%2C+Type+1
[131] Age 18-75 is how HEDIS defines eligible diabetics.
[132] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=15425
[133] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=15419
[134] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=9041

A. Metric:

1. **Numerator:** All inpatient discharges from the DPH system of patients age 18 years and older with ICD-9-CM principal diagnosis code for COPD within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 years and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

C. **Patient Safety**

Category 4 shall deem to meet this domain.

D. **Preventive Health**

DPH system plans must include 2 measures in DY 7 (#10-11) and all measures in DY 8-10:

1. Data Source: Registry, ambulatory care EMR, practice management system, and/or another data source as specified by the DPH system
2. Measurement: The data for measurement will be extracted from one of the following sources:
   a. Manually, using a sampling approach;[135]
   b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample);
   c. A data warehouse;
   d. A practice management system; or
   e. An electronic medical record (EMR)

i. Mammography Screening for Breast Cancer[136]

A. Metric:

1. **Numerator:** All female patients age 50 – 74 years[137] who had a mammogram to screen for breast cancer within 24 months who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

ii. Influenza Immunization[138]

A. Metric:

1. **Numerator:** All patients age 50 and older who received an influenza immunization during the flu season (September through February) who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

iii. Child Weight Screening

A. Metric:

1. **Numerator:** All patients age 2 – 18 years with a calculated BMI documented in the medical record within the demonstration year reporting period.
2. **Denominator:** Number of patients age 2 – 18 years who have visited the DPH system primary care clinic(s) within the current demonstration year.

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[135] See Appendix A: Sampling Approach
[136] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=14620
[137] The age range as per the U.S. Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm.
[138] Derived from: http://www.qualitymeasures.ahrq.gov/content.aspx?id=14991

iv. Pediatrics Body Mass Index (BMI)[139]

A. Metric:

1. **Numerator:** All patients age 2 – 18 years with a BMI above the 85th percentile within the demonstration year reporting period
2. **Denominator:** Number of patients age 2 – 18 years who have visited the DPH system primary care clinic(s) in the current demonstration year with a BMI recorded.

v. Tobacco Cessation[140]

A. Metric:

1. **Numerator:** Number of patients 18 years and older who screened positive for tobacco use and who received or were referred to cessation counseling within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients 18 years and older who screened positive for tobacco use who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

E. **At-Risk Populations**

DPH system plans must include 2 measures in DY 7 (#15-16) and all measures in DY 8-10. For measures #20-21, in DY 8, DPH systems will report a minimum of two quarters of data (not a full year's worth of data) to provide more time to further develop their ability to do the reporting, develop the reporting processes, test the processes, and work out the reporting and data challenges that come with reporting a new measure:

1. Data Source: Registry, ambulatory care EMR, practice management system, and/or another data source as specified by the DPH system
2. Measurement: The data for measurement will be extracted from one of the following sources:
   a. Manually, using a sampling approach;[141]
   b. A registry with a minimum of 325 patient records system-wide to align with the number of records needed for statistical sampling. All applicable patient records will be reported (not a sample);
   c. A data warehouse;
   d. A practice management system; or
   e. An electronic medical record (EMR)

i. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl)[142]

A. Metric:

1. **Numerator:** All patients age 18 – 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

ii. Diabetes Mellitus: Hemoglobin A1c Control (<8%)[143] – NQF 0575

A. Metric:

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[139] Please reference: http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html
[140] Derived from: http://qualitymeasures.ahrq.gov/content.aspx?id=14635
[141] See Appendix A: Sampling Approach
[142] Derived from: http://www.hmohelp.ca.gov/healthplans/gen/gen_rci.aspx
[143] Derived from: http://www.hmohelp.ca.gov/healthplans/gen/gen_rci.aspx

1. **Numerator:** All patients age 18 – 75 years with diabetes whose most recent hemoglobin A1c level is in control (<8%) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

iii. 30-Day Congestive Heart Failure Readmission Rate

A. Metric:

1. **Numerator:** All patients age 18 years and older who experience a readmission with a ICD-9-CM principal diagnosis for CHF or related conditions (within 30 days of discharge for an index l admission with ICD-9-CM principal diagnosis code for CHF) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months[144]
2. **Denominator:** Number of patients age 18 years and older with CHF who have visited the DPH system primary care clinic(s) two or more times in the past 12 months[145] and had an admission

iv. Hypertension (HTN): Blood Pressure Control (<140/90 mmHg)

A. Metric:

1. **Numerator:** Number of patients age 18 – 75 years with a diagnosis of hypertension with the most recent blood pressure level (in clinic or with ambulatory blood pressure monitoring) in control (less than 140/90 mmHg) within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 18 – 75 years with a diagnosis of hypertension who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

v. Pediatrics Asthma Care[146]

A. Metric:

1. **Numerator:** Number of patients age 5 – 18 with persistent asthma who were prescribed at least one controller medication for asthma therapy within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients age 5 – 18 with persistent asthma who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

vi. Optimal Diabetes Care Composite (Minnesota Community Measurement as adopted by the National Quality Forum)[147]

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[144]Exclusion: planned readmissions (for example, chemotherapy schedule, radiation, rehab, planned surgery, renal dialysis, blood transfusions). "Related conditions" will be defined consistently for all DPH systems, (e.g., 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93 and 428.XX).

[145]Exclusions: labor and delivery, transfers to another acute care hospital, patients who die before discharge

[146] Derived from: http://qualitymeasures.ahrq.gov/content.aspx?id=23966&search=asthma and http://www.nhlbi.nih.gov/guidelines/asthma/08_sec4_lt_0-11.pdf. Exclusions include: Patients diagnosed with emphysema or chronic obstructive pulmonary disease (COPD), cystic fibrosis or acute respiratory failure any time on or prior to December 31 of the measurement year.

[147] See: http://www.goapic.org/Presentations/NQFDraft1010.pdf

A. Metric: The percentage of adult diabetes patients who have optimally managed modifiable risk factors with the intent of preventing or reducing future complications associated with poorly managed diabetes

1. **Numerator:** Number of patients ages 18 – 75 with a diagnosis of diabetes, who meet all the numerator targets of this composite measure within the demonstration year reporting period who have visited the DPH system primary care clinic(s) two or more times in the past 12 months
2. **Denominator:** Number of patients ages 18 – 75 with a diagnosis of diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months

IV. Appendix A: Sampling Approach

A sampling approach can be applied to generate a statistically significant random sample:

A. If there are up to 200 patients, then include all 200 patients to define the numerator;
B. If there are 201-500 patients, then include a simple random sample of 201 patients to define the numerator;
C. If there are 501-1,000 patients, then include 275 patients in the random sample to define the numerator; or
D. If there are more than 1,000 patients, then include 325 patients in the random sample to define the numerator.

This methodology employs a standard calculation with 95% accuracy (the sample size groupings are generated based on a P value of approximately 0.05, per http://www.surveysystem.com/sscalc.htm.

Attachment Q - Delivery System Reform Incentive Payments (DSRIP) Metrics
Category 4–Urgent Improvement In Care

The goal of Category 4 is to make urgent improvement in care that:

1. Has a Promised Impact on the Patient Population, including interventions that have been demonstrated to produce measurable and significant results across different types of hospital settings, including in safety net hospitals;
2. Has a Strong Evidence Base, meaning interventions that have been endorsed by a major national quality organization, with reasonably strong evidence established in the peer reviewed literature, including within the safety net; and
3. Is Meaningful to Populations Served in California's Public Hospital Systems because, without significant improvement in this intervention, California public hospitals' patients are at risk of harm, needless suffering, or premature/preventable death.

Interventions:

1. The superset includes 7 interventions, and for each, specifies the measures that designated public hospital (DPH) system DSRIP plans must include for each intervention.
2. DPH systems will select two common interventions, and an additional two interventions of their own choosing from the superset below (please see pages 4-12).
3. DPH systems may choose interventions that, according to their local circumstances, are identified as a high priority.
    a. DPH system plans must articulate the reasons for choosing the two interventions selected.
    b. A DPH system is considered to have achieved top performance for each measure within an intervention if it has a DY 7 baseline that meets or exceeds the high performance level set by the state (as described below in paragraph 2.e of the milestone section). For DY 9 and 10, a DPH system that meets the criteria for top performance for a particular measure must add a stretch measure (for the same intervention) with an associated improvement target, if available, from the Category 4 superset of nationally vetted and endorsed measures . If a DPH has demonstrated top performance for all applicable measures for an intervention from the Category 4 superset (and any additional stretch measures), maintenance of top performance is permitted.
    c. No DPH system may choose both Hospital-Acquired Pressure Ulcer Prevention and Falls with Injury Prevention as its two selected interventions because both are rare events.
    d.
4. For DPH system plans that cover multiple campuses that are included within the scope of the DSRIP Category 4 plan, the plan may specify if the data will be reported on an aggregated basis.

Milestones:

Attachment Q - Delivery System Reform Incentive Payments (DSRIP) Metrics Category 4–Urgent Improvement In Care

1. Milestones will include the measures specified for the interventions below. The measures specified for the interventions may include: (1) Process Measures (e.g., a bundle); and/or (2) Outcome Measures (e.g., clinical outcomes such as mortality rate).
2. Both Process milestones and Outcome milestones must include Improvement Targets where appropriate.
    a. The superset below specifies the Improvement Targets, or a process to establish an Improvement Target, for each measure per intervention.
    b. The Improvement Target for each measure per intervention will be determined based on the progress a DPH system has already made by DY 6-7 pursuant to baseline data starting no earlier than July 2009.
    c. In the case where no baseline data is available by DY 6, a baseline will be determined in DY 7 based on 6-12 months of data. In the case where no benchmark is available by DY 6 due to the lack of baseline data, a benchmark may be determined in DY 7 if a sufficient comparable dataset has been established.
    d. Improvement Targets for process milestones and outcome milestones must be justified in the DSRIP plan and approved by the state and CMS. In setting improvement targets, relevant scientific literature should be cited or the absence or paucity of references, noted; benchmarks (or their unavailability) should be noted; and any other rationale (e.g. performance trajectory approximated based on a similar topic) for targeting should be stated.
    e. To assist DPHs in setting meaningful improvement targets, the state will set a high performance level and a minimum performance level for Central Line Insert Practices (CLIP) Adherence, Stroke Management, and Venous Thromboembolism (VTE) Prevention and Treatment. These levels will be used as guidelines to set targets for DY 9 and 10 as follows (unless the state and CMS determine that the unique circumstances of the DPH or the measure merit a different improvement target standard):
        i. If relevant data are available, high performance levels should be set to the 90th percentile of national or California aggregate performance and minimum performance levels should be set to the 25th percentile of national or California aggregate performance, where available. If relevant data are not available, the state will propose an alternative high performance level and minimum performance level as appropriate (subject to CMS review and approval).
        ii. The improvement targets for DY 9 and 10 must, at a minimum, meet or exceed the minimum performance level.
        iii. If a DPH's DY 7 baseline performance on a measure is below the high performance level, the DPH must set an improvement target that exceeds the baseline and, at a minimum, meets the minimum performance level in DY 9 and closes at least 10 percent of the gap between the DPH's performance and the high performance level by DY 10, as applicable. If needed, the state will propose an alternative rate according to intervention-specific data (subject to CMS review and approval).

iv. If a DPH's DY 7 baseline value on a measure meets or exceeds the high performance goal, the provider will be considered to have achieved "top performance" on the measure (as described above in paragraph 3.b. of the Category 4 intervention section) and must select a different stretch measure (in the same intervention) to improve upon for DY 9 and 10 according to the method described in paragraph iii above, as applicable. If a baseline is not available in DY 7 or 8, then a baseline will be set for this new measure in DY 9 and an improvement target to close the gap with the high performance level will be set for DY 10.

3. For DY 7-10, DPH system plans must also include a milestone for reporting to the State of California. (The state will then consolidate this reporting and send to CMS).

4. Consistent with the intent of the DSRIP program, outcome milestones will not be replaced with process milestones. : Acceptable process milestones include:

    a. Implementation of improved processes and/or process improvement methodologies;

    b. The reporting and sharing of results and/or data;

    c. Participation in a collaborative;

    d. Sharing data, promising practices, and/or findings with peer groups and/or a quality improvement entity to foster shared learning and/or to conduct benchmarking;

    e. Designation of/hiring personnel and/or process improvement teams;

    f. Training of personnel and/or process improvement teams;

    g. Implementation of a measurement system and/or process;

    h. Reporting and/or conducting an assessment of progress and/or the efficacy of the process improvements;

    i. Establishment of a baseline and/or implementation of a process to establish a baseline and/or begin collecting baseline data;

    j. Putting in place data collection, reporting or management infrastructure; and/or

    k. Other process milestones aligned with implementing the intervention (e.g., infrastructure, redesign, implementation of evidence-based processes, and measurement of evidence-based outcomes related milestones).

Timeline:

- DPH system plans will include Category 4 milestones for DY 6-10.
- Per the *Incentive Pool – Program Mechanics and Review Process* (pages XX-XX), in the first 6 months of DY 8, there will be a Mid-Point Assessment that will include reviewing the superset of Category 4 interventions, including whether an intervention should be removed, updated, or added to the superset for DY 9-10.

- Any modifications to Category 4 targets required by revisions to this attachment must be submitted by DSRIP plans to the state by no later than October 14, 2013.

Two Common Interventions for All DPH Systems:

1. **Severe Sepsis Detection and Management**

   a. Elements

      i. Implement the Sepsis Resuscitation Bundle: to be completed within 6 hours for patients with severe sepsis, septic shock, and/or lactate > 4mmol/L (36mg/dl)

      ii. Make the elements of the Sepsis Bundle more reliable

   b. Key Measures:

      CMS has indicated that it is interested in using this intervention as a learning laboratory. Therefore, the emphasis of this intervention will be on learning, testing, and innovation. The learnings will inform ongoing DPH system efforts to reduce sepsis mortality.

      i. Process Measure: Percent compliance with elements of the Sepsis Resuscitation Bundle (4 elements are outlined below), as measured by percent of hospitalization with severe sepsis or septic shock where targeted elements of the Sepsis Resuscitation Bundle were completed.

         1. Metric: The 4 elements of the sepsis resuscitation bundle for which there is the most evidence of reliability and efficacy::

            a. Serum lactate measured

            b. Blood cultures obtained prior to antibiotic administration

            c. Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions

            d. In the event of hypotension and/or lactate >4 mmol/L (36mg/dl):

               i. Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent)

               ii. Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) >65 mm Hg or equivalent.

         2. Data Definition[148]: DPH System

         3. Every DPH must report ICD-9 coded data for sepsis bundle compliance using the codes included below. With approval from

[148] Please refer to Appendix A: Sources of Data Definitions for further information on all Category 4 sources that include the definitions for the data.

the state and CMS, DPHs may also report sepsis bundle compliance using their own internal definition. DPHs are required to provide, through plan modifications, a detailed narrative on how their health system defines its sepsis protocols and procedures.

ICD-9 Codes:

Severe Sepsis	995.92
Septic Shock	785.52

The following patients should be excluded from both the process and outcome measures:

i. Any patient who elects palliative care or is designated DNR or DNI prior to or within 24 hours of admission or diagnosis

ii. Any patient who refuses care

iii. Any patient transferred to a DPH with a diagnosis of severe sepsis or septic shock upon admission or becomes septic within 24 hours of admission

4. Improvement Target: DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

ii. Outcome Measure: Sepsis mortality

1. Metric:

a. Numerator: Number of patients in population who expired during current month hospitalization with severe sepsis or septic shock.

b. Denominator: Number of patients identified in the population that month with severe sepsis or septic shock based on patients who received services with the following ICD-9 codes:

Severe Sepsis	995.92
Septic Shock	785.52

The following patients should be excluded from both the process and outcome measures:

i. Any patient who elects palliative care or is designated DNR or DNI prior to or within 24 hours of admission or diagnosis

ii. Any patient who refuses care

iii. Any patient transferred to a DPH with a diagnosis of severe sepsis or septic shock upon

admission or becomes septic within 24 hours of admission

2. Data Definition: DPH System
3. Every DPH must report ICD-9 coded data for sepsis mortality using the codes above. With approval from the state and CMS, DPHs may also report sepsis mortality data using their own internal definition. DPHs are required to provide, through plan modifications, a detailed narrative on how their health system defines its sepsis protocols and procedures.
4. Improvement Target: Since strong evidence does not exist linking a particular process bundle to predictable levels of improvement in outcomes, DPH systems will measure and report on mortality, but will not have milestones associated with achievement of specific improvements in mortality.

2. Central Line-Associated Bloodstream Infection (CLABSI) Prevention

a. Elements

i. Implement the Central Line Bundle

ii. Make the process for delivering all bundle elements more reliable

b. Key Measures

i. Process Measure: Central Line Insertion Practices (CLIP) Adherence

1. Metric:

a. Numerator: Number of CLIP observations with 100% bundle adherence as reported through the National Healthcare Safety Network (NHSN) for all intensive care units, including adult, pediatric, and neonatal intensive care units.

b. Denominator: Number of CLIP observations as reported through the National Healthcare Safety Network (NHSN) for all intensive care units, including adult, pediatric, neonatal intensive care units.

2. Data Definition: Most current National Healthcare Safety Network (NHSN) protocols as adopted by the California Department of Public Health (CDPH).
3. Improvement Target: DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline, based on the method described on pages 295-296. DPHs that meet the criteria for top performance based on DY 7 data will measure performance across additional units, e.g. non-ICU and ED area.

ii. Outcome Measure: Central Line-Associated Bloodstream Infections (CLABSI)

1. Metric:

a. Numerator: Number of laboratory-confirmed central-line associated bloodstream infections for each of three patient care areas – ICU, NICU, and Acute Care Units – and in aggregate.

b. Denominator: Device days as described by Data Definition.

2. Data Definition: Most current National Healthcare Safety Network (NHSN) protocols as adopted by the California Department of Public Health (CDPH). The three patient care areas are defined by CDPH.

3. Specialty Care Areas will be excluded. DPHs without a NICU are not required to report data for this area.

4. Improvement Target: Based on the baseline data, each DPH system will target improvement over its baseline. Improvement targets shall be set for two patient care areas: ICUs (excluding NICUs) and Acute Care Units. If applicable, DPHs will report NICU data separately but will not have an associated improvement target.

DPH Systems Must Choose a Minimum of Two of the Following Interventions:

1. Surgical Site Infection (SSI) Prevention

a. Element

i. Surgical site infection prevention

b. Key Measure

i. Outcome Measure: Surgical Site Infection

1. Metric: Aggregate Standardized Infection Ratio (SIR)

a. Numerator: Observed number of surgical site infections for Class 1 ("Clean") and 2 ("Clean contaminated") wounds as specified by the Complex A/R SIR Report in NHSN.

b. Denominator: Expected number of class 1 and class 2 infections as specified by the Complex A/R SIR Report in NHSN.

c. Beginning in 2013, the surveillance period is determined by NHSN Procedure Category. For procedures with 30-day surveillance periods, DPHs will report data for the current demonstration year. For procedures with a 90-day surveillance period, the data collection time period

begins 3 months prior to the current DY and continues for 12 months.

d. To comply with the top performance requirements described on pages 295-296, a DPH that has an aggregate SIR<1 and significantly below expected in DY7 must add additional procedures to ensure that the SIR is not significantly below expected. These additional procedures will be tracked and reported in DY9 and DY10.

2. Data Definition: Most current National Healthcare Safety Network (NHSN) protocols as adopted by the California Department of Public Health (CDPH).

3. Improvement Target:

a. DY 9 targets will be based on data from DY 8 and DY 10 targets will be based on data from DY 9. The methodology is described below. Note: Statistical significance, as defined by p-value < 0.05 and 95% confidence interval below 1.0 (calculated by NHSN), will only be used to determine which of the three target categories below DPHs must report on.

i. If SIR>1 in the previous DY, DPH will reduce SIR by 10%.

ii. If SIR<1 in previous DY but not significantly below expected, DPH will reduce SIR by 5%.

iii. If SIR<1 in previous DY and significantly below expected, DPH will continue demonstrating improvement.

2. Hospital-Acquired Pressure Ulcer Prevention

a. <u>Elements</u>

i. Conduct a pressure ulcer admission assessment for all patients

b. <u>Key Measure</u>

i. Outcome Measure: Hospital Acquired Pressure Ulcer Prevalence

1. Metric:

a. Numerator: Patients with Category II, III, IV or unstageable pressure ulcers and deep tissue injuries.

b. Denominator: All patients 16 years or older assessed on the day of the study

2. Data Definition: Collaborative Alliance for Nursing Outcomes (CALNOC)

3. Improvement Target: Hospitals will achieve Top Quartile of less than 1.1%
4. Additional Measures: DPHs that achieve top performance based on DY 7 performance must add AHRQ Patient Safety Indicator (PSI) #3 as a reporting only additional measure for DY 9 and DY 10.

3. Stroke Management

a. Elements

i. Discharged on Antithrombotic Therapy

ii. Anticoagulation Therapy for Atrial Fibrillation/Flutter

iii. Thrombolytic Therapy

iv. Antithrombotic Therapy By End of Hospital Day 2

v. Discharged on Statin Medication

vi. Stroke Education

vii. Assessed for Rehabilitation

b. Key Measures

i. Process Measures:

1. Metric:

a. Discharged on Antithrombotic Therapy

b. Anticoagulation Therapy for Atrial Fibrillation/Flutter

c. Thrombolytic Therapy

d. Antithrombotic Therapy By End of Hospital Day 2

e. Discharged on Statin Medication

f. Stroke Education

g. Assessed for Rehabilitation

2. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures
3. Improvement Target: For the 7 Process Measures enumerated above, DPH systems will report baseline data in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

ii. Outcome Measure: Reporting on stroke mortality rates

1. Metric:

a. Numerator: Number of acute stroke deaths

b. Denominator: Number of acute stroke cases

2. Source of Data Definition: Office of Statewide Health Planning and Development (OSHPD)

3. Improvement Target: Since strong evidence does not exist linking a particular process bundle to predictable levels of improvement in outcomes, DPH systems will measure and report on mortality, but are not required to have milestones associated with the achievement of specific improvements in mortality.

iii. Additional Measures: As described on pages 295-296, DPHs that meet the criteria for top performance based on DY 7 data for one or more stroke process measures above must report baseline data during DY 9 and set improvement targets in DY 10 for all three of the following measures:

1. Stroke Mortality Measure (currently reporting only)

2. National Institute of Health Stroke Scale

3. Door to IV tPA in 60 min

4. Venous Thromboembolism (VTE) Prevention and Treatment

a. Elements

i. VTE Prophylaxis

ii. Intensive Care Unit VTE Prophylaxis

iii. Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

iv. Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol

v. VTE Discharge Instructions

vi. Incidence of Potentially-Preventable Venous Thromboembolism

b. Key Measures

i. Process Measures:

1. VTE Prophylaxis

a. Metric:

i. Numerator: Patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:

1. the day of or the day after hospital admission

2. the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission

ii. Denominator: All patients except as outlined by the Specifications Manual for National Hospital Inpatient Quality Measures

b. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures

c. Improvement Target: Since reliable benchmark and/or baseline data is not available for this measure, DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

2. Intensive Care Unit VTE Prophylaxis

a. Metric:

i. Numerator: Patients who received VTE prophylaxis or have documentation why no VTE was given:

1. The day of or the day after ICU admission or transfer

2. The day of or the day after surgery end date for surgeries that start the day or the day after ICU admission or transfer

ii. Denominator: Patients directly admitted or transferred to ICU

b. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures

c. Improvement Target: Since reliable benchmark and/or baseline data is not available for this measure, DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

3. Venous Thromboembolism Patients with Anticoagulation Overlap Therapy

a. Metric:

i. Numerator: Patients who received overlap therapy

ii. Denominator: Patients with confirmed VTE who received warfarin

b. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures

c. Improvement Target: Since reliable benchmark and/or baseline data is not available for this measure, DPH systems will report a baseline in DY 7. Based on the

baseline data, each DPH system will target improvement over its baseline.

4. Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
    a. Metric:
        i. Numerator: Patients who have their IV UFH therapy dosages and platelet counts monitored according to defined parameters such as nomogram or protocol
        ii. Denominator: Patients with confirmed VTE receiving IV UFH therapy
    b. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures
    c. Improvement Target: Since reliable benchmark and/or baseline data is not available for this measure, DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

5. VTE Discharge Instructions
    a. Metric: VTE patients with documentation that they or their caregivers were given written discharge instructions or other educational material addressing all of the following:
        i. Follow-up monitoring
        ii. Compliance issues
        iii. Dietary restrictions
        iv. Potential for adverse drug reactions/interactions
        v. Activity requirements or restrictions
    b. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures
    c. Improvement Target: Since reliable benchmark and/or baseline data is not available for this measure, DPH systems will report a baseline in DY 7. Based on the baseline data, each DPH system will target improvement over its baseline.

ii. Outcome Measure: Incidence of Potentially-Preventable Venous Thromboembolism

1. Metric:

a. Numerator: Patients who received no VTE prophylaxis prior to the VTE diagnostic test order date

b. Denominator: Patients who developed confirmed VTE during hospitalization

2. Data Definition: Specifications Manual for National Hospital Inpatient Quality Measures

3. Improvement Target: Since deep evidence does not exist linking a particular process bundle to predictable levels of improvement in outcomes, DPH systems will measure and report on incidence of potentially-preventable venous thromboembolism, but are not required to have milestones associated with the achievement of specific improvements.

iii. Additional Measures: As described on pages 295-296, DPHs that meet the criteria for top performance for DY 7 data on VTE process measures must add AHRQ Patient Safety Indicator #12 as a reporting only measure for DY 9 and DY 10.

5. Falls with Injury Prevention

a. Elements

i. Prevalence of patient falls with injury

b. Key Measure

i. Outcome Measure: Prevalence of patient falls with injury

1. Metric:

a. Numerator: Falls with injury

b. Denominator: Per 1000 patient days

2. Source of Data Definition: Collaborative Alliance for Nursing Outcomes (CALNOC)

Improvement Target: Zero falls with injury per 1000 patient days for at least six consecutive months out of a year

Appendix A: Sources of Data Definitions

1. University HealthSystem Consortium

https://www.uhc.edu
The University HealthSystem Consortium (UHC), Oak Brook, Illinois, formed in 1984, is an alliance of 112 academic medical centers and 255 of their affiliated hospitals representing approximately 90% of the nation's non-profit academic medical centers.
Data Sources: UHC Clinical Data Base/Resource Manager, 3Q09 - 2Q10 discharges
UHC HQMR Report (reports Core Measures), 2Q09 - 1Q10 discharges
N = 47 National Association of Public Hospitals for UHC CDB/RM; 44 for Core Measures
Data compares 11 CAPH member average against NAPH reporting hospitals.

2. Collaborative Alliance for Nursing Outcomes (CalNOC)

https://www.calnoc.org
CalNOC has one of the largest regional nursing quality databases in the nation reporting nursing-sensitive quality measurements related to hospital performance and patient safety. Today more than 200 hospitals from across the United States and Europe have made CALNOC an International Advocate for patient safety and performance measurement.
Data Sources:

- Comparison Data (All Hospitals) for Care Hours and Falls --- Total Facility Injury Falls per 1000 Pt Days, October 2009 To September 2010, N = 180 California hospitals
- From OCTOBER 2009 To SEPTEMBER 2010\Comparison Data (All Hospitals) for Prevalence Studies: Total Facility % of Pt. with Hospital Acquired Pressure Ulcers Stage II, III, IV + unstageable, October 2009 To September 2010, N = 197 California hospitals

3. National Healthcare Safety Network (NHSN)

http://www.cdc.gov/nhsn/
The National Healthcare Safety Network (NHSN) is a voluntary, secure, internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems managed by the Division of Healthcare Quality Promotion (DHQP) at CDC.

Data Source: 2009 NHSN Report
(http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.PDF)

4. **California Department of Public Health**

http://www.cdph.ca.gov/programs/hai/Pages/HealthcareAssociatedInfections.aspx
The California Department of Public Health is dedicated to optimizing the health and well-being of the people in California.
Data Source: CDPH Technical Report: Healthcare-associated Bloodstream Infections in California Hospitals

5. California Hospital Assessment and Reporting Taskforce (CHART)

(also known as Cal Hospital Compare)
http://www.calhospitalcompare.org
A partnership among The California HealthCare Foundation, the University of California at San Francisco Philip R. Lee Institute for Health Policy Studies, and the California Hospitals Assessment and Reporting Taskforce (CHART), CHART is a not-for-profit public benefit corporation. CHART contains ratings for clinical care, patient safety, and patient experience for the more than 240 hospitals, representing over 85% of acute care hospital admissions in California, that have chosen to participate in this important voluntary effort.

6. Office of Statewide Health Planning and Development (OSHPD)

http://www.oshpd.ca.gov/

The Office of Statewide Health Planning and Development is one of 13 departments within the California Health and Human Services Agency. OSHPD administers programs which endeavor to implement the vision of "Equitable Healthcare Accessibility for California."

Data Source: AHRQ — Inpatient Quality Indicators (IQIs) Hospital Inpatient Mortality Indicators for California, 2007 Mortality Indicators Report

7. **Specifications Manual for National Hospital Inpatient Quality Measures**

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1141662756099

The Specifications Manual for National Hospital Inpatient Quality Measures (Specifications Manual) is the result of the collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission to publish a uniform set of national hospital quality measures. The specifications for VTE and Stroke measures can be found on this web page.

Appendix B: Additional Specifications

- According to California Department of Public Health's technical report on healthcare-associated bloodstream infections in California hospitals from January 2009 through March 2010:
    - There are substantial caveats in using the California Department of Public Health (CDPH) Healthcare-Acquired Infection (HAI) Report, including:
        - Rate differences due to variations in surveillance practices as well as infection risk;
        - Inter-facility variation may reflect different clinical practices related to deliver of health care including infection control practices, the underlying medical complexity of the patients being served, and the surveillance methods used to identify infections and persons at risk;
        - Data is not risk adjusted in accordance with NHSN methods required in statue due to the way in which the data was reported to CDPH; and
        - Risk stratification method used to attempt to characterize similar underlying infection risk among similar hospital types.
- However, the CDPH appears to be making significant improvements and will likely align measure definitions with NHSN.
- For Hospital-Acquired Pressure Ulcers, DPH systems will report to CALNOC, but CHART's report of the CALNOC data can be used for measuring performance and benchmarks.
- For the 3 measures in which hospitals typically experience very small incidences – Central Line-Associated Bloodstream Infections, Hospital-Acquired Pressure Ulcers, and prevalence of Falls with Injury – the Improvement Targets need to be set as absolute targets in order to be meaningful.

Attachment Q - Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Introduction

Ryan White-eligible persons diagnosed with HIV have been enrolled in coordinated systems of care in California since 1991. People diagnosed with HIV living in California have received coordinated medical outpatient care (primary and specialty) through Ryan White Parts A, B, C and D, with pharmaceuticals provided largely from the California AIDS Drug Assistance Program (ADAP), funded by Ryan White Part B, State general funds and rebates. In addition, persons diagnosed with HIV have received case management, and a variety of other Ryan White services, including, but not limited to, dental, substance abuse treatment or counseling, home health, and mental health services.

As part of the Demonstration, California has implemented the Low Income Health Program (LIHP), as such, is one of the early adopters in the country of the early Medicaid expansion available under the Affordable Care Act. In the summer of 2011, HRSA provided guidance to California regarding the Ryan White statutory "payer of last resort" requirement in relationship to the LIHP. Specifically, HRSA has stated that Ryan White HIV/AIDS Treatment Extension Act of 2009 Sections A, B, C, and D, including ADAP, must be considered payer of last resort, so these programs cannot pay for any LIHP-covered services for a person who is eligible for and enrolled in the local LIHP. Additionally, such low-income persons diagnosed with HIV who otherwise meet LIHP eligibility standards may not be excluded by the LIHP. This means that low-income persons diagnosed with HIV previously covered by a Ryan White system of care, will, upon enrollment in a LIHP, be required to receive covered outpatient medical care, pharmaceuticals, and mental health services from providers within their County LIHP network. All other remaining services not covered by the LIHP could continue to be provided through Ryan White, where available. Beginning January 1, 2014, these low-income persons diagnosed with HIV will be served through a combination of Medi-Cal (Medicaid expansion) or California Health Benefits Exchange, and Ryan White.

HIV care is complex, and if transitions in coverage and care provision are not managed carefully, poor patient outcomes and increased health system costs can result. As a result, it is critical that Designated Public Hospital (DPH) systems, as primary providers of care to LIHP enrollees, focus delivery system reforms so as to build the infrastructure needed to optimally coordinate services for this vulnerable population. Incentivizing such investments will help support the ongoing transformation of ambulatory care services, including an emphasis on prevention and continuity of care, within the DPH systems.

These DSRIP Category 5 HIV Transition projects will assure that persons diagnosed with HIV make the transitions of coverage from Ryan White to California's LIHPs without loss of core medical or other critical services. DPH systems with approved 5 year Delivery System Reform Incentive Pool (DSRIP) plans under the Demonstration will be able to establish "Category 5" HIV Transition projects to develop programs of activity that support efforts to provide continual access to high-quality, coordinated, integrated care to patients diagnosed with HIV, particularly those LIHP enrollees who previously received services under the Ryan White program. These projects must be in addition to any other DSRIP projects and must establish new or enhance existing programs.

As a core element of the DSRIP Category 5 projects, each participating DPH system will develop its own HIV Transition Project plan that is specifically designed to strengthen the ability of its directly-operated health care delivery systems to serve persons diagnosed with HIV, with a

particular focus on outpatient medical services. This Category 5 HIV Transition Project will provide funding for incentives for delivery system reform and is not intended to provide direct payment for services. Regardless of the current participation in the Ryan White program, delivery system reforms, including the example initiatives proposed below, are needed across the diverse set of DPH system providers in California. Through careful development of tailored plans addressing infrastructure, program design and improvements in clinical and operational outcomes, DPHs can align their proposed Category 5 projects with the most pressing needs within their system of care for patients diagnosed with HIV, and align Category 5 projects to the priorities in local Ryan White service plans.

Any DPH system with an approved DSRIP 5 year plan as of July 1, 2011, which is located within a County operating a LIHP, and is a participating provider thereof, may propose a Category 5 HIV Transition project. Participating DPH systems must modify their existing DSRIP 5 year plans to include Category 5 HIV Transition projects. DPHs will report progress on their HIV Category 5 projects according to Attachment P – Supplement 1, Section III, Reporting, Assessment and Modification Process, of the Standard Terms and Conditions that governs reporting for Category 5 of the DSRIP.

DSRIP Category 5 project payments are intended to support and reward DPH systems for improvements in their delivery systems that meet the special needs of enrollees diagnosed with HIV/AIDS. As such, the payments are not direct reimbursement for expenditures incurred by the DPH systems in implementing reforms, and are not reimbursement for health care services that are recognized under the Special Terms and Conditions or under the State Plan. The Category 5 project payments are not considered patient care revenue and should not be offset against the certified public expenditures incurred by DPH systems for health care services, DSH or administrative activities as defined under the STCs and/or under the State plan.

Participating DPH systems will engage with local HIV/AIDS stakeholders regarding their DSRIP Category 5 plan. DPH systems will be expected to describe their stakeholder engagement process in their plan modification narrative. The participating DPH systems will submit to DHCS a description of their local stakeholder process.

DHCS, in collaboration with the State Office of AIDS (OA), California Department of Public Health (CDPH), will review this information, and provide the plan modification summaries and stakeholder process descriptions to a representative subgroup of stakeholder members participating in the state-level OA/DHCS LIHP Stakeholder Advisory Committee (SAC) for review also. The OA/LIHP SAC was convened by DHCS and CDPH OA to advise on program transition issues and communication processes related to the Ryan White program and LIHP. The OA/LIHP SAC meets on a bi-weekly basis and includes representatives from HIV provider groups, HIV advocate organizations, LIHP entities, and HIV-care consumers. The DSRIP Category 5 Transition Projects proposal status is a standing agenda item for this committee. A representative subset of OA/LIHP SAC members will review the plan modification summaries and descriptions of the local stakeholder engagement process, and provide comments to DHCS and State Office of AIDS on whether the local process included appropriate local stakeholder and clinical expertise involvement. The state-level stakeholder review process will occur within the review period established for DHCS review of plan modifications pursuant to Attachment P Supplement 1. The OA/LIHP SAC Subgroup will be active on a flow basis, as the DPH plan modifications are submitted to DHCS. The Subgroup will have a two-day review cycle for each plan modification. The comments provided by the Subgroup may be considered by DHCS in its

review and approval of the DSRIP plan modifications for the Category 5 HIV Transition projects. In addition, the Subgroup will report back to the larger OA/LIHP SAC on the review process.

DSRIP Category 5 Description

Following is a description of the proposed HIV Transition project component structure within the DSRIP plans, including lists of projects from which the DPH systems will select. Category 5 Plans will highlight the infrastructure, programs, and services that must be put in place to ensure that persons diagnosed with HIV can be cared for in an integrated and coordinated system of care. DPH systems must ensure the projects proposed are consistent with nationally recognized/accredited standards of HIV care. In addition, requesting or handling of protected health information (PHI) or personal information (PI) must be consistent with the PHI/PI requirements outlined in the LIHP contract and governing law. By ensuring that all providers serving patients diagnosed with HIV have the necessary set of capabilities, the HIV Transition Project will provide essential support in the continued development of a robust, broad, and high-quality delivery system for patients diagnosed with HIV, despite the effects of coverage shifts. In doing so, the HIV Transition Project is critical to sustaining a high level of service delivery for patients diagnosed with HIV as they transition from Ryan White to the LIHP and ultimately to Medi-Cal in 2014.

Each participating DPH system will submit a Category 5 HIV Transition Project plan oriented to meet the goals of quality care, care continuity, care coordination and seamless coverage transition. Category 5 plans will include appropriate projects with milestones for each applicable Demonstration year (or portion thereof), i.e., Demonstration Year 8 and the first 6 months of Demonstration Year 9. While milestones may apply to more than one period, the Category 5 plans must uniquely specify the particular progressive improvement (and metric) for that period. DPH systems will specify the Category 5 metrics to be used to measure progress in each reporting period in table format.

Milestones should help to better coordinate and integrate health care services and improve the quality of care delivered for persons diagnosed with HIV through, for example, building physical and IT infrastructure, promoting innovation in the way care is delivered, and building the skills and capabilities of staff serving patients diagnosed with HIV. Based on the progress made toward achieving the milestones, DPH systems will receive DSRIP payments associated with that particular milestone. Because each DPH system has distinct local needs and resources, plans will vary and identified milestones will likely differ.

Each plan will include projects and milestones for the following categories:

1. **Category 5a – Improvements in infrastructure and program design:** Each plan will include projects and milestones that are able to improve how care is delivered to HIV patients with an emphasis on ensuring efficient coordination of services among providers.
2. **Category 5b – Improvements in clinical and operational outcomes:** Each plan will also include projects and milestones that measure HIV patients' health and health care.

Additionally, each plan will include activities related to shared learning, such as participating in learning collaboratives/initiatives, training and education, and identifying and communicating best practices so that effective interventions and models can be more rapidly and broadly disseminated.

Attachment Q - Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Below are the projects, within each category, from which the selections are to be made. Associated milestones that may be selected within each category are also provided. These milestones are not meant to be adopted by every DPH system, but rather serve to demonstrate a comprehensive array of potential improvement activities and metrics through which progress can be measured. Therefore, in designing their HIV Transition Project plans, DPH systems may select from the milestones included here or may propose other milestones that accomplish the Category 5 HIV Transition aims and are better suited to meet their particular needs. However, it is important to note that the overall undergirding of the projects (i.e., the models and constructs) will be similar across the DPH systems in that each HIV Transition Project plan must include activities under both categories as well as shared learning. Importantly, DPH systems may not propose projects that are to be performed as a part of Categories 1-4 of their existing DSRIP plan.

Category 5a: Infrastructure & Program Design

The infrastructure and programmatic efforts that are undertaken in this category are foundational. These activities will be designed to enhance the ability of DPH systems to provide care within patient-centered medical homes, an essential building block to ensuring delivery of high-quality medical care for patients diagnosed with HIV. Listed below are seven projects of which each participating DPH must select three (3), allowing each DPHs' proposed plan to be tailored to their system's needs. For the purposes of participation in DSRIP Category 5a HIV Transitions Projects, a DPH must select three (3) and only three (3) of the below listed Category 5a projects. Any additional projects that a DPH elects to implement will not be eligible for any DSRIP Category 5 Incentive Payments. For each selected project, each DPH must complete all associated milestones listed below unless the DPH indicates in their project proposal that a particular milestone is not relevant/applicable, provides suitable rationale, and proposes an alternative milestone as a substitute. DPHs are responsible for determining the timeline along which they will achieve each Category 5a milestone; however each DPH must have milestones that are achieved in the first six (six) months of the Incentive Program and milestones that are achieved in the final twelve (12) months of the Incentive Program.

Category 5a Projects:

1. Empanel patients into medical homes with HIV expertise, which may include, as applicable, Ryan White and non-Ryan White providers.
2. Implement a Disease Management Registry module suitable for managing patients diagnosed with HIV.
3. Build clinical decision support tools to allow for more effective management of patients diagnosed with HIV.
4. Develop retention programs for patients diagnosed with HIV who inconsistently access care.
5. Enhance data sharing between DPHs and County Departments of Public Health to allow for systematic monitoring of quality of care, disease progression, and patient and population level health outcomes.
6. Launch electronic consultation system between HIV primary care medical homes and specialty care providers.
7. Ensure access to Ryan White wrap-around services for new LIHP enrollees.

Further detail and milestones of these projects are provided below.

Empanel patients into medical homes with HIV expertise which may include, as applicable, Ryan White and non-Ryan White providers: While all LIHPs must assign enrollees to medical homes, empanelment into medical homes specifically equipped to care for patients diagnosed with HIV is a critical component of care provision for this population. The purpose of this DSRIP Category 5a Project is for the DPHs to determine the optimal staffing models and work activities that are needed to provide a medical home for persons diagnosed with HIV. Medical homes specifically suited to care for patients diagnosed with HIV may differ from non-HIV medical homes in a number of ways, e.g.:

- HIV-focused medical homes utilize clinicians with HIV expertise.
- Nurses in HIV-focused medical homes often take on additional roles, such as screening for medication adherence challenges.
- Panel Management has a greater level of complexity and depth than is often the case for traditional medical homes. Panel managers must track and follow-up traditional HIV disease indicators (e.g., CD4 counts, Viral Load, Lipids, LFTs, other STIs, vaccine status, etc.) as well as serve an expanded health coach role to include HIV transmission risk reduction strategies; such intensive services often requires a more intensive staffing models than in medical homes that do not focus on patients diagnosed with HIV.
- Retention programs, such as that described in the milestone below, may be a supplemental service offered within HIV-focused medical homes.
- In cooperating with other stakeholders and funders, HIV-focused medical homes coordinate or directly provide a high-level of wrap-around services (e.g., nutrition support, pharmacy support, behavioral health/psychiatric support, substance abuse services, social work services, care navigation, wellness services) essential to patients diagnosed with HIV.

To adequately prepare for implementation of medical homes that are able to care for HIV patients, clinics will need to determine the optimal staffing model for provision of multi-disciplinary team-based care to optimize access, retention, and treatment adherence and improve health outcomes and self-management. DPH systems shall include in the Plan Modification a narrative setting forth the experience and qualifications of the clinical staff utilized to care for the HIV population. Unique panel weighting / patient risk-adjustment methodologies could be developed for building panels of patients diagnosed with HIV; such methodologies will necessarily differ from panel weighting methodology for non-HIV patients in traditional primary care medical homes. For example, patients may be weighted according to consideration of factors such as: 1) prior utilization patterns of HIV care services; 2) prior history of difficulty in adhering to treatment plans; 3) time since HIV diagnosis; 4) existence and management of other co-morbid conditions and 5) persistently poor health status. Specific milestones related to this project are listed below.

- Select/develop optimal staffing model(s) for use in medical homes that care for patients diagnosed with HIV.
- Define the roles and responsibilities of team members.
- Implement a staffing model appropriate for LIHP patients empanelled in a medical home with HIV expertise, including pharmacy and medication adherence services for patients with advanced disease and co-morbidities.
- Develop patient weighting/ risk-adjustment algorithms for assigning patients diagnosed with HIV to medical homes.
- Empanel patients into medical homes.

Implement a Disease Management Registry module suitable for managing patients diagnosed with HIV: Disease Management Registries (DMR) are able to track clinical quality and health outcomes for patients empanelled in medical homes. Many DMRs have optional HIV modules. These specialized clinical modules will allow HIV providers to effectively monitor and deliver key aspects of HIV care that are known to be associated with improved health outcomes among HIV-positive populations. HIV modules can be configured with the ability to track clinical performance measures that allow the HIV provider team to identify and focus intensive clinical services and interventions on those patients who are not meeting treatment goals. Specific milestones related to this project are listed below.

- Identify/develop HIV DMR module.
- Pilot use of HIV DMR module in clinics.
- Implement HIV DMR module in all clinics that serve as a medical home for HIV-positive patients.
- Document ongoing evaluation of clinical performance measures and use of data for performance improvement activities.

Build clinical decision support tools to allow for more effective management of patients diagnosed with HIV: Clinical decision support tools allow clinicians to better manage HIV patient panels through the use of disease-specific rules and queries that allow providers to identify patients in the medical home who are not meeting a prioritized set of HIV care goals consistent with national treatment guidelines and standards of care. Rules will allow providers and the care team to identify patients who, for example, (1) are out of care or inconsistently/sub-optimally accessing care, (2) qualify for antiretroviral therapy (ART) but are not receiving it, (3) are on ART but not achieving viral suppression and full benefit of therapy, and (4) are in need of screening or treatment for other co-morbidities or preventive health services. After relevant patient populations are identified, specific tools will help guide the clinician toward proper diagnostic or therapeutic decisions. Tools may be built into the DMR to facilitate appointment planning, reminders, and outreach services or care coordination. The use of these tools will result in achieving more timely, patient-responsive, and efficient delivery of care to empanelled HIV patients. Specific milestones related to this project are listed below.

- Define full set of clinical decision support tools that will be available.
- Deploy Information Technology (IT) programming and resources to develop clinical decision support tools.
- Pilot, refine, and fully implement clinical decision support tools within medical homes that care for patients diagnosed with HIV.
- Establish and implement protocols and procedures for tracking use of clinical decision support tools and evaluating impact on disease management, service provision, and clinical health outcomes.
- Ensure that protocols are consistent with DHHS guidelines (http://www.aidsinfo.nih.gov/guidelines/) as feasible, considering IT and other technical constraints.
- Ensure that protocols for co-morbidities (e.g. care and treatment of diabetes, hypertension) are consistent with established guidelines.

Develop Retention Programs for patients diagnosed with HIV who inconsistently access care: Patients diagnosed with HIV must regularly access and engage with their medical homes in order to enjoy optimal health outcomes. Failure to engage in consistent HIV care is a significant challenge for many DPH systems and is associated with suboptimal adherence to ART, virologic treatment failure, increased rate of community viral resistance, increased secondary HIV

transmission, and poorer survival rates. To address the need to successfully re-engage patients lost to HIV care and improve subsequent retention in consistent HIV care, DPH systems may implement clinic-based Retention Programs. Patients identified as being out of regular medical care including those who are recently diagnosed will be referred to the Program which will utilize investigative techniques to locate lost-to-care patients and offer them client-centered interventions to improve their linkage and retention in HIV medical care. Specific milestones related to this project are listed below.

- Define criteria for enrolling patients in Retention Program.
- Identify staffing models for implementation of Retention Program.
- Implement Retention Program in medical homes for patients diagnosed with HIV.
- Track effectiveness of Retention Program along pre-defined outcome metrics.

Enhance data sharing between DPH system providers and the County Departments of Public Health: Improved health information exchange will allow for more systematic monitoring of quality of care, disease progression, and patient and population level health outcomes among HIV cohorts. This includes developing an electronic data interface (EDI) between the Designated Public Hospital systems and Department of Public Health data systems in order to facilitate collection of standardized performance measures and key utilization and health outcome data (e.g., HIV viral load, CD4 cell counts) across the population of individuals diagnosed with HIV in each County. As HIV patients transition from Ryan White to the LIHP and ultimately to Medicaid in 2014 under the ACA, robust data sharing and exchange are critical to ensuring that access and high-quality care remains uninterrupted and that all patients, regardless of payer, are cared for according to the same high standards and goals of care. Improved data sharing will also enhance public health efforts to track and improve population health, reduce morbidity and mortality, and reduce forward transmission in order to stem the local HIV epidemic. When possible, programs will use existing HIV databases to obtain clinical information to help develop clinically appropriate primary care plans for HIV patients. Specific milestones related to this project are listed below.

- Identify and map domains for data exchange.
- Develop and implement Electronic Data Interface.
- Establish and implement protocols and procedures for ongoing monitoring and use of data to improve quality of care and population health.

Launch electronic consultation system between HIV primary care medical homes and specialty care providers: Implementation of an electronic consultation (eConsult) system will permit secure web-based dialog between referring HIV primary care providers and selected specialists on a specific patient requiring specialty services. eConsult has been demonstrated in other county health systems to reduce unnecessary face-to-face specialty visits, improve the effectiveness of visits when they are necessary, enhance primary care provider satisfaction with patient care, and meet standards for timely access to specialty care. Electronic consultation improves coordination of care between specialists and primary care providers, which reduces redundant, inappropriate, and over use of specialty services, and enhances the timeliness and effectiveness of specialty care delivery. This system also fundamentally transforms the relationship between specialists and primary care providers such that they see themselves as part of the same, as opposed to different, patient care teams. This transformation in relationship and documentation of communication is expected to reduce medical-legal liability and improve provider morale. Moreover, electronic consultation will greatly enhance the efficiency of the specialists' time and effort. Specific milestones related to this project are listed below.

- Establish Specialty – Primary Care workgroups for priority specialties to develop shared approaches, including referral protocols and guidelines for management of specific conditions, to common and important medical conditions for patients diagnosed with HIV.
- Develop and implement Electronic Data Interface for e-Consultations between primary care medical homes for patients diagnosed with HIV and select sub-specialties.
- Develop mechanism to track referral volume, demand, and appropriateness of referrals over time.

Ensure access to Ryan White wrap-around services for new LIHP enrollees: HIV ancillary services will continue to be available for RW-eligible clients regardless of the payer of their medical care. Referrals for new LIHP enrollees will be coordinated through the initial eligibility screening process, and services may be promoted through existing service sites, through outreach programs, and through electronic media to expand client awareness of available programs. Care coordination services comprised of multidisciplinary teams located within the medical home have been shown to improve access and retention, while addressing other factors that may create barriers to continued, effective engagement in medical care, such as housing, mental health services, substance use treatment, treatment adherence counseling, transportation, and oral health services. Specific milestones related to this project are listed below.

- Establish a mechanism such as an MOU between the DPH and LIHP with the local Ryan White system of care to ensure that transitioned HIV patients are assessed for wrap-around services.
- Ensure care coordination within each medical clinic designated as a medical home for patients diagnosed with HIV. Care coordination staff will work with the primary care team to assess patient need, develop care plans to promote engagement and retention in medical care, and address cofactors that may create barriers to such care.

Category 5b: Clinical and Operational Outcomes

Activities under this category will be designed to drive DPH systems to select and commit to achieving discrete patient outcomes across several clinical domains. In doing so, DPH systems can help assure they are making concrete gains in patient quality and operational effectiveness that will have lasting benefits for patients who choose to make DPH systems their permanent medical home.

All DPH systems will be required to report data on six (6) Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) HIV Core Clinical Performance Measures for individuals enrolled in the local LIHP who access care within the DPH system; DPHs will also select four (4) and only four (4) additional Performance Measures on which they will report data Lists of required measures and the menu of optional measures are listed below. Documentation of each performance measure from the HRSA HAB website as of July 2012 is included in this Attachment Q – Supplement 1 (HRSA HAB website: http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html).

Group 1: Required Core Clinical Performance Measures – DPHs to report on each of the following:

- CD4 T-Cell Count (defined as of July 2008)
- HAART (defined as of July 2008)
- Medical Visits (defined as of July 2008)
- PCP Prophylaxis (defined as of July 2008)

- Viral Load Monitoring (defined as of November 2011)
- Viral Load Suppression (defined as of November 2011)

Additional Performance Measures – DPHs to report on four (4) and only four (4) additional metrics from Groups 2, 3 and Medical Case Management, with at least one (1) metric from each group:

Group 2 Defined as of August 2008 unless otherwise noted	**Group 3** Defined as of April 2009	**Medical Case Management** Defined as of November 2009
• Adherence Assessment and Counseling • Cervical Cancer Screening • Hepatitis B Screening (defined as of November 2011) • Hepatitis B Vaccination • Hepatitis C Screening • HIV Risk Counseling • Lipid Screening • Oral Exam • Syphilis Screening • TB Screening	• Chlamydia Screening • Gonorrhea Screening • Hepatitis/HIV Alcohol Counseling • Influenza Vaccination • MAC Prophylaxis • Mental Health Screening • Pneumococcal Vaccination • Substance Use Screening • Tobacco Cessation Counseling • Toxoplasma Screening	• Care Plan • Medical Visits

For each metric, DPH systems will measure and report as described on the HRSA HAB website (http://hab.hrsa.gov/deliverhivaidscare/habperformmeasures.html; July 2012) their baseline performance as set forth in Table 1 above. Data collection shall be consistent with the sampling methodology set forth in Attachment Q Category 3 Appendix A "Sampling Approach". Each Plan Modification, where applicable, will provide explanations on how data will be collected, frequency of data collection, and how each DPH will review and adjust, if needed, its performance targets. After the baseline data is collected, each DPH system will be responsible for achieving a performance improvement target by the end of the transition program in order to receive the incentive funding associated with each measure. The target improvement is determined after the baseline data is reported by the DPH after taking into account input from DHCS and CMS and shall be consistent with the requirements set forth in Table 1 in Supplement 1 to Attachment P. Where available, DPHs' will tie their performance improvement target to National Goals, Targets, or Benchmarks for Comparison, as defined in each HAB HIV Performance Measure.

Other Elements Required for DSRIP Category 5 HIV Transition Projects

Each DPH must also develop and include activities that promote shared learning in their DSRIP Category 5 HIV Transition Projects plan. These may include the following actions:

- Participate in a collaborative.
- Share learnings from implementing process improvements, e.g., through presentations and reporting.

- Share data, promising practices, and/or findings with peer groups and/or a quality improvement entity to foster shared learning and/or to conduct benchmarking activities.
- Collaborate in the dissemination/implementation of best practices with HIV/AIDS agencies and public health departments, LIHPs in which the DPH system participates, other public agencies and/or other relevant non-profit or private organizations.

Other key elements of DSRIP Category 5 HIV Transition project proposals will be developed and defined to provide the broader context and rationale. These key elements include the overall goal and the significance of that goal to HIV patients and the DPH, the reasons for selecting the milestones, metrics, improvements and targeted goals based on relevancy to the HIV population and circumstances, community need and priority, and DPH starting point. Such key elements will be tailored to the individual DPH system in consultation with DHCS, and with input from stakeholders and frontline workers from the HIV/AIDS community. Examples of key elements which must be included are:

- Specific challenge(s) the projects are seeking to address.
- Solution(s) identified to address the challenge(s), including an explanation of how each proposed project will work to fill the gap/need or solve the issue.
- Detailed description of proposed project and corresponding milestones for each six (6) month interval.
- Evidence-based justification for the specific milestone or target selected (e.g., outcomes milestones set in accordance with published standards of HIV care). Where available, milestones must be aligned with nationally recognized/accredited standards of HIV care and, where relevant, must be aligned with the Federal Implementation Plan of the National HIV/AIDS Strategy. All clinical guidelines and standards must be referenced.
- Baseline measurement for each County related to each proposed project, with specific performance targets and strategies to move from baseline to target.
- Expected results of the projects and how those align with the goals of the Federal Implementation Plan of the National HIV/AIDS Strategy.
- Description of how achievement of the proposed milestone will improve coordination and integration of services for patients diagnosed with HIV, and align with the continuum of Ryan White supported programs in the locality.
- Interrelationship of proposed projects and milestones.

Attachment Q – Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

HRSA HAB PERFORMANCE MEASURES

Group 1: Required Performance Measures:

- CD4 T-Cell Count
- HAART
- Medical Visits
- PCP Prophylaxis
- Viral Load Monitoring
- Viral Load Suppression

Additional Performance Measures – Four (4) additional metrics from Groups 2, 3, and Medical Case Management required, with at least one (1) metric from each group:

Group 2	Group 3	Medical Case Management
• Adherence Assessment and Counseling • Cervical Cancer Screening • Hepatitis B Screening • Hepatitis B Vaccination • Hepatitis C Screening • HIV Risk Counseling • Lipid Screening • Oral Exam • Syphilis Screening • TB Screening	• Chlamydia Screening • Gonorrhea Screening • Hepatitis/HIV Alcohol Counseling • Influenza Vaccination • MAC Prophylaxis • Mental Health Screening • Pneumococcal Vaccination • Substance Use Screening • Tobacco Cessation Counseling • Toxoplasma Screening	• Care Plan • Medical Visits

Attachment Q – Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Group 1:

Required Performance Measures:

- CD4 T-Cell Count (defined as of July 2008)
- HAART (defined as of July 2008)
- Medical Visits (defined as of July 2008)
- PCP Prophylaxis (defined as of July 2008)
- Viral Load Monitoring (defined as of November 2011)
- Viral Load Suppression (defined as of November 2011)

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

Performance Measure: CD4 T-Cell Count	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year	
Numerator:	Number of HIV-infected clients who had 2 or more CD4 T-cell counts performed at least 3 months apart during the measurement year
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client have a CD4 count test conducted during the reporting period? (Y/N) a. If yes, list the quarters of these tests
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[2] National HIVQUAL Data:[3]

	2003	2004	2005	2006
Top 10%	87.2%	87.7%	90.3%	87.5%
Top 25%	74.2%	78.0%	76.6%	78.8%
Median*	61.0%	62.7%	63.9%	62.5%

*from HAB data base

Outcome Measures for Consideration	○ Rate of opportunistic infections in the measurement year ○ Rate of clients with progression to AIDS in the measurement year ○ Mortality rates

Basis for Selection and Placement in Group 1:

The CD4 T-cell count plays a vital role in determining the staging of HIV disease and indicating the need for prophylaxis against opportunistic infections. It continues to be used in decisions regarding initiation or adjustment of antiretroviral treatment.

The most recent CD4 T-cell count is the strongest predictor of subsequent disease progression and survival, according to clinical trials and cohort studies data on patients receiving antiretroviral therapy.[4]

Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Public Health Service Guidelines:

" In general, CD4 T-cell count should be determined every three to six months to (1) determine when to start antiretroviral in patients who do not meet the criteria for initiation; (2) assess immunologic response to

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

antiretroviral therapy; and (3) assess the need for initiating chemoprophylaxis for opportunistic infections." [3]
References/Notes:
Guidelines state that CD4 T-cell counts should be measured at least every 3-4 months depending on the stage of the disease. The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but can and should be measured at more frequent intervals if needed.
[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [2]IHI Measure reads, "Percent of Patients/Clients with a CD4 Count Test in the Past 4 Months" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/Percentof+patientswithaCD4countestinthepast4months.htm) [3]National HIVQUAL data looks at the percent of clients who have a CD4 T-cell count done every four months, not every six months. (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [4]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

Performance Measure: HAART	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with AIDS who are prescribed HAART	
Numerator:	Number of clients with AIDS who were prescribed a HAART regimen[1] within the measurement year
Denominator:	Number of clients who: • have a diagnosis of AIDS (history of a CD4 T-cell count below 200 cells/mm^3 or other AIDS-defining condition[2]), and • had at least one medical visit with a provider with prescribing privileges[3], i.e. MD, PA, NP in the measurement year.
Patient Exclusions:	1. Patients newly enrolled in care during last three months of the measurement year
Data Element:	1. Is the client diagnosed with CDC-defined AIDS? (Y/N) a. If yes, was the client prescribed HAART during the reporting period? (Y/N)
Data Sources:	• Ryan White Program Data Report, Section 2, Items 26 and 31 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base. • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[4] CDC and HIVRN data consistent that 80% of those in care "eligible for ARVs" on tx. This includes CD4<350 and not just AIDS.[5,6] National HIVQUAL Data:[7,8]

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	100%	100%	100%	100%
Median*	100%	88.9%	95.7%	100%

*from HAB data base

Outcome Measures for Consideration:	◦ Rate of opportunistic infections in the measurement year ◦ Rate of HIV-related hospitalizations in the measurement year ◦ Mortality rates
Basis for Selection and Placement in Group 1:	
"Randomized clinical trials provide strong evidence of improved survival and reduced disease progression by treating symptomatic patients and patients with CD4 T-cells <200 cells/mm^3."[9] Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.	

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

US Public Health Service Guidelines:
"Antiretroviral therapy is recommended for all patients with history of an AIDS-defining illness or severe symptoms of HIV infection regardless of CD4 T-cell count."[10]
References/Notes:
[1]Many authorities recommend two baseline CD4 T-cell measurements before decisions are made to initiate antiretroviral therapy because of wide variations in results. The test should be repeated yet a third time if discordant results are seen. The optimal time to initiate antiretroviral therapy among asymptomatic patients with CD4 T-cell counts >200 cells/mm^3 is unknown. This measure focuses strictly on the subset of patients for whom antiretroviral therapy is unequivocally recommended—those with a CD4 T-cell count below 200 cells/mm^3 or history of another AIDS-defining condition. Asymptomatic patients with CD4 T-cell counts of 201–350 cells/mm^3 should be offered treatment. For asymptomatic patients with CD4 T-cell of >350 cells/mm^3 and plasma HIV RNA >100,000 copies/ml most experienced clinicians defer therapy but some clinicians may consider initiating treatment. (See reference 8 below) [2]AIDS Defining conditions are noted in CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR 1992;41(no. RR-17). (http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm) [3]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [4]IHI Measure reads, "Percent of Patients with Appropriate ARV Therapy Management" http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAppropriateARVTherapyManagement.htm) [5] Gebo, JAIDS January 2005, vol. 38, pp. 96-103. [6] Teshale Abstract #167, CROI 2005. [7] The National HIVQUAL data may not be directly comparable due to varying exclusions. Indicator definitions can be accessed at http://www.hivguidelines.org/Content.aspx?PageID=53. [8]http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf [9]"HAART, CD4<200" (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [10]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; p. 9. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

Performance Measure: Medical Visits	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year	
Numerator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP, in an HIV care setting[2] two or more times at least 3 months apart during the measurement year
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year
Data Element:	1. Is the client HIV-infected? (Y/N) a. Did the client have at least 2 medical visits in an HIV care setting during the reporting period? (Y/N) i. If yes, list the quarters of these visits
Data Sources:	• Ryan White Program Data Report, Section 5, Items 42 and 43 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	None available at this time.
Outcome Measures for Consideration	◦ Rate of HIV-related hospitalizations in the measurement year ◦ Rate of HIV-related emergency room visits in the measurement year ◦ Rate of opportunistic infections in the measurement year ◦ Mortality rates
Basis for Selection and Placement in Group 1:	
Clinicians should schedule routine monitoring visits at least every 4 months for all HIV-infected patients who are clinically stable.[3,4] Greater experience among primary care physicians in the care of persons with AIDS improves survival.[5] Measure reflects important aspects of care that significantly impacts mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.	
US Public Health Service Guidelines:	
In general, patients with early-stage disease are seen at 3-month intervals to undergo routine medical evaluation and monitoring of CD4 T-cell count, viral load and CBC. During the initial evaluation more frequent visits are common because there is so much information to transmit. Visits should also be more frequent when therapy is introduced and when the CD4 T-cell count is <200 cells/mm^3 because complications	

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

are more likely.[6] Multiple studies have demonstrated that better outcomes are achieved in patients cared for by a clinician with expertise. This has been shown in terms of mortality, rate of hospitalizations, compliance with guidelines, cost of care, and adherence to medications. The definition of expertise in these studies has varied, but most rely on the number of patients actively managed. Based on this observation, the Panel recommends HIV primary care by a clinician with at least 20 HIV-infected patients and preferably at least 50 HIV-infected patients. Many authoritative groups have combined the recommendation based on active patients, along with fulfilling ongoing CME requirements on HIV-related topics.[7]
References/Notes: Guidelines state that routine monitoring of HIV-infected patients should occur at least every 3-4 months depending on the stage of the disease.[7] The timeframe of 6 months was determined by clinical expert consensus for the purpose of this measure, but CD4 T-cell counts can and should be measured at more frequent intervals if needed.
[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [2]An HIV care setting is one which received Ryan White HIV/AIDS Treatment Modernization Act of 2006 funding to provide HIV care and has a quality management program in place to monitor the quality of care addressing gaps in quality of HIV care. [3]New York State Department of Health. Primary care approach to the HIV-infected patient. New York: New York State Department of Health; 2004. p. 8. http://www.hivguideliens.org/Content.aspx?pageID=257[Accessed November 27, 2007]. [4]AETC National Resource Center. Clinical Manual for Management of the HIV-Infected Adult http://www.aidsetc.org/pdf/AETC-CM_071007.pdf [Accessed November 27, 2007]. [5]Kitahata MM, Van Rompaey SE, Dillingham PW, Koepsell TD, Deyo RA, Dodge W, Wagner EH. Primary care delivery is associated with greater physician experience and improved survival among persons with AIDS. J Gen Intern Med. 2003 Feb;18(2):157-8. [6]Bartlett JG, Cheever LW, Johnson MP, Paauw DS [eds]. A Guide to Primary Care of People with HIV/AIDS. Rockville(MD): US Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2004, p. 167. http://hab.hrsa.gov/tools/primarycareguide/. [Accessed November 27, 2007]. [7]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. Department of Health and Human Services. December 1, 2007; 1-143. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf. Accessed December 12, 2007.

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Performance Measure: PCP Prophylaxis	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm^3 who were prescribed PCP prophylaxis	
Numerator:	Number of HIV-infected clients with CD4 T-cell counts below 200 cells/mm^3 who were prescribed PCP prophylaxis
Denominator:	Number of HIV-infected clients who: • had a medical visit with a provider with prescribing privileges[1], i.e. MD, PA, NP at least once in the measurement year, and • had a CD4 T-cell count below 200 cells/mm^3
Patient Exclusions:	1. Patients with CD4 T-cell counts below 200 cells/mm^3 repeated within 3 months rose above 200 cells/mm^3 2. Patients newly enrolled in care during last three months of the measurement year
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, was the CD4 T-cell count <200 cells/mm^3? (Y/N) i. If yes, was PCP prophylaxis prescribed? (Y/N) 1. If no, was the CD4 count repeated within 3 months? (Y/N) a. If yes, did it remain below 200 cells/mm^3? (Y/N) i. If yes, was PCP prophylaxis prescribed? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	IHI Goal: 95%[2] National HIVQUAL Data[3]:

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	100%	100%	100%	100%
Median*	93.3%	90.9%	92.3%	94.4%

*from HAB data base

Outcome Measures for Consideration:	○ Rate of PCP in the measurement year ○ Mortality rates ○ Cost savings
Basis for Selection and Placement in Group 1:	
Pneumocystis pneumonia (PCP) is the most common opportunistic infection in people with HIV. Without treatment, over 85% of people with HIV would eventually develop PCP. It is a major cause of mortality among persons with HIV infection, yet is almost entirely preventable and treatable. Pneumocystis almost always affects the lungs, causing a form of pneumonia. People with CD4 T-cell counts under 200 cells/mm^3	

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HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 1

are at greatest risk of developing PCP. The drugs now used to prevent and treat PCP include TMP/SMX, dapsone, pentamidine, and atovaquone.[4]

Before the widespread use of primary PCP prophylaxis and effective ART, PCP occurred in 70%--80% of patients with AIDS. The course of treated PCP was associated with a mortality rate of between 20% and 40% in persons with profound immunosuppression. Approximately 90% of cases occurred among patients with CD4 T-cell counts <200 cells/mm^3. [5]

Measure reflects important aspect of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Public Health Service Guidelines:

HIV-infected adults and adolescents, including pregnant women and those on HAART, should receive chemoprophylaxis against PCP if they have a CD4 T-cell count <200 cells/mm^3.[6]

References/Notes:

[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.
[2] IHI Measure reads, "Percent of Patients with a CD4 Cell Count Below 200 cells/mm^3 Receiving Pneumocystis Carinii Pneumonia (PCP) Prophylaxis"
[3](http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf)
[4] http://www.aidsinfonet.org/factsheet_detail.php?fsnumber=515
[5] Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15) (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5315a1.htm)
[6] Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51 (No. RR-8) (http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf or http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf)

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HAB HIV Core Clinical Performance Measures

U.S. Department of Health and Human Services HRSA Health Resources and Services Administration

HAB HIV Core Clinical Performance Measures
Viral load monitoring and viral load suppression
November 2011

Performance Measure: Viral Load Monitoring	
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with a viral load test performed at least every six months during the measurement year	
Numerator:	Number of patients with a viral load test performed at least every 6 months
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 60 days in between each visit
Patient Exclusions:	Patients newly enrolled in care during last 6 months of the measurement year
Data Element:	1. Does the patient, regardless of age, have a diagnosis of HIV/AIDS? (Y/N) a. If yes, did the patient have at least two medical visits during the measurement year, with at least 60 days in between each visit? (Y/N) i. If yes, list the dates the viral load tests were performed. 1. Were viral load tests performed at least every six months during the measurement year? (Y/N)
Data Sources:	• Ryan White Program Services Report (RSR) questions 47 (date of first outpatient/ambulatory care visit); 48 (outpatient/ambulatory care visits dates); and 50 (viral load counts) • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	**National HIVQUAL Data:** [1]

	2003	2004	2005	2006	2007	2009
Top 10%	100%	100%	100%	100%	98.9%	100%
Top 25%	97.1%	97.0%	95.7%	95.7%	95.5%	94.2%
Median*	89.7%	90.9%	89.6%	91.6%	90.3%	89.4%

*from HAB data base

Basis for Selection and Placement in Group 1:

Viral load testing serves as a surrogate marker for response to antiretroviral therapy and can be useful in predicting clinical progression.

Measure reflects important aspects of care that significantly impacts survival and mortality. Data collection is currently feasible and measure has a strong evidence base supporting the use.

US Department of Health and Human Services Guidelines:

Antiretroviral therapy (ART) should be initiated in all patients with a history of an AIDS-defining illness or with a CD4 count <500 cells/mm^3. The primary goal of ART is to reduce HIV-associated morbidity and mortality. This is best accomplished by using antiretroviral therapy to maximally inhibit HIV replication, as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays. [2]

HAB HIV Core Clinical Performance Measures

Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART)…Thus, viral load testing serves as a surrogate marker for treatment response and can be useful in predicting clinical progression.[2]
References/Notes:
[1]HIVQUAL-US Indicator: Percent of patients who received a viral load test during each six-month semester http://hivqualus.org/index.cfm/22/9842 and https://www.ehivqual.org/ [2]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 10, 2011; pp. 9, 27-28. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf
Corresponding National Quality Forum (NQF) Endorsed Measure:
None

HAB HIV Core Clinical Performance Measures

Performance Measure: Viral Load Suppression	
Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with viral load below limits of quantification[1] at last test during the measurement year	
Numerator:	Number of patients with viral load below limits of quantification[1] at last test during the measurement year
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV/AIDS who: • had at least two medical visits during the measurement year with at least 60 days in between each visit; and • were prescribed antiretroviral therapy for at least 6 months; and • had a viral load test during the measurement year
Patient Exclusions:	None
Data Element:	1. Does the patient, regardless of age, have a diagnosis of HIV/AIDS? (Y/N) a. If yes, did the patient have at least two medical visits during the measurement year with at least 60 days in between each medical visit? (Y/N) i. If yes, was the patient prescribed antiretroviral therapy for at least 6 months? (Y/N) 1. If yes, was a viral load test drawn? (Y/N) a. If yes, did the patient have viral load below limits of quantification[1] on the last test? (Y/N) i. If yes, list date.
Data Sources:	• Ryan White Program Services Report (RSR) questions 47 (date of first outpatient/ambulatory care visit); 48 (outpatient/ambulatory care visits dates); 50 (viral load counts); and 52 (ART prescription) • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	**National HIVQUAL Data:** [2]

	2003	2004	2005	2006	2007	2009
Top 10%	76.2%	83.3%	86.5%	87.0%	90.9%	95.1%
Top 25%	70.3%	76.5%	80.0%	82.0%	85.7%	89.9%
Median*	61.7%	66.7%	70.0%	72.7%	79.5%	81.8%

*from HAB data base

Kaiser Permanente:[3] 88.8%
Veterans Administration[4]: 73%
HIV Research Network (HIVRN)[5]: 70%

Basis for Selection and Placement in Group 1:

The primary goal of antiretroviral therapy (ART) is to reduce HIV-associated morbidity and mortality. This is best accomplished by using antiretroviral therapy to maximally inhibit HIV replication, as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays. [6]

Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission. Data collection is currently feasible and measure has a strong evidence base supporting the use.

HAB HIV Core Clinical Performance Measures

US Public Health Service Guidelines:
ART should be initiated in all patients with a history of an AIDS-defining illness or with a CD4 count <500 cells/mm^3. The primary goal of ART is to reduce HIV-associated morbidity and mortality. This is best accomplished by using antiretroviral therapy to maximally inhibit HIV replication, as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays. [6] Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART)…Thus, viral load testing serves as a surrogate marker for treatment response and can be useful in predicting clinical progression.[6] Optimal viral suppression is generally defined as a viral load persistently below the level of detection (<20–75 copies/mL, depending on the assay used). In addition, low-level positive viral load results (typically <200 copies/mL) appear to be more common with some viral load assays than others, and there is no definitive evidence that patients with viral loads quantified as <200 copies/mL using these assays are at increased risk for virologic failure. For the purposes of clinical trials the AIDS Clinical Trials Group (ACTG) currently defines virologic failure as a confirmed viral load >200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability.[6]
References/Notes:
[1]"Below limits of quantification" is defined as < 200 copies/mL. The Department of Health and Human (DHHS) guidelines and the AIDS Clinical Trials Group define virologic failure as a confirmed viral load >200 copies/mL. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf [2] HIVQUAL-US Indicator: Percent of patients on ART whose last viral load was ≤400 copies/mL who had at least 2 viral loads completed http://hivqualus.org/index.cfm/22/9842 and https://www.ehivqual.org/ [3]Horberg, M. et al HIV quality performance measures in a large integrated healthcare system *AIDS Patient Care and STDs*. January 2011, 25(1): 21-28. [4]Backus, L., et al National Quality Forum performance measures for HIV/AIDS Care The Department of Veterans Affairs' Experience. *Arch Intern Med*; 2010; 170(14): 1239-1246. [5]HIV Research Network (HIVRN) data includes patients on at least 1 ART drug in CY2009 whose viral load was undetectable. Available at: https://cds.johnshopkins.edu/hivrn/index.cfm?do=sens.content&page=data_reports.html [6]Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. January 10, 2011; pp. 9, 27-28. http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf
Corresponding National Quality Forum (NQF) Endorsed Measure:
NQF #: 0407 Title: HIV RNA control after six months of potent antiretroviral therapy Description: Percentage of patients with viral load below limits of quantification OR patients with viral load not below limits of quantification who have a documented plan of care Status: Endorsed (Original Endorsement Date: July 31, 2008) Available at: http://www.qualityforum.org/Measures_List.aspx

Accessibility
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Attachment Q – Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Additional Performance Measures
Four (4) additional metrics from Groups 2, 3, and Medical Case Management Group required, with at least one (1) metric from each group:

Group 2
Defined as of August 2008 unless otherwise noted

- Adherence Assessment and Counseling
- Cervical Cancer Screening
- Hepatitis B Screening (defined as of December 2011)
- Hepatitis B Vaccination
- Hepatitis C Screening
- HIV Risk Counseling
- Lipid Screening
- Oral Exam
- Syphilis Screening
- TB Screening

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

U.S. Department of Health and Human Services HRSA Health Resources and Services Administration

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 2

Performance Measure: Adherence Assessment & Counseling	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection on ARVs who were assessed and counseled[1,2] for adherence two or more times in the measurement year	
Numerator:	Number of HIV-infected clients, as part of their primary care, who were assessed and counseled for adherence two or more times at least three months apart
Denominator:	Number of HIV-infected clients on ARV therapy who had a medical visit with a provider with prescribing privileges[3] at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during last six months of the year 2. Patients who initiated ARV therapy during last six months of the year
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, was the client on ARVs?(Y/N) i. If the client was on ARVs, did he/she receive adherence counseling during the measurement year? (Y/N). 1. If yes, list the quarters of these visits.
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	IHI Goal: 90%[4] National HIVQUAL Performance Data:[5]

	2003	2004	2005	2006
Top 10%	95.8%	92.0%	97.5%	98.4%
Top 25%	82.7%	79.2%	88.3%	91.6%
Mean*	57.5%	39.7%	46.8%	55.7%

*from HAB data base

Outcome Measures for Consideration:	○ Percent of undetectable viral loads among patients on ARV in the measurement year ○ Percent of patients with ARV-resistance developed during therapy in the measurement year ○ Mortality rates ○ Incidence of HIV-related hospitalizations in the clinic population ○ Incidence of clients with progression to AIDS in the clinic population
Basis for Selection and Placement in Group 2:	
"Adherence is a key determinant in the degree and duration of virologic suppression. Among studies reporting on the association between suboptimal adherence and virologic failure, nonadherence among patients on HAART was the strongest predictor for failure to achieve viral suppression below the level of detection. HIV viral suppression, reduced rates of resistance, and improved survival have been correlated with high rates of adherence to antiretroviral therapy.	

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

Prior to writing the first prescriptions, clinicians need to assess the patient's readiness to take medication. Patients need to understand that the first regimen is the best chance for long-term success. Resources need to be identified to assist in success. Interventions can also assist with identifying adherence education needs and strategies for each patient."[6] Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Although discussions of the importance of adherence to ARVs is important to begin prior to initiation of treatment, there is no standard of care for discussions to occur every 6 months for patients who may be years away from ARV treatment.
US Public Health Guidelines:
"...adherence counseling and assessment should be done at each clinical encounter"[7] (10/10/06)
References/Notes:
[1]Assessment of adherence includes: 1) patient reports of adherence by: a) quantifiable scales, e.g. missed 3 out of 10 doses; b) qualitative scale, e.g. Likert scale; or 2) quantification such as pharmacy dispensing records, pill counts or direct observation therapy. [2]Adherence counseling can be provided by any member of the multidisciplinary primary care team. [3]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [4]IHI Measure reads, "Percent of Patients/Clients Assessed for Adherence to Antiretroviral (ARV) Therapy in the Past 4 Months" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsClientsAssessedforAdherencetoAntiretroviralARVTherapyinthePast4Months.htm) [5](http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [6]Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents [April 7, 2005] (http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL04072005001.pdf) [7]Ibid

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

Performance Measure: Cervical Cancer Screening	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of women with HIV infection who have a Pap screening in the measurement year	
Numerator:	Number of HIV-infected female clients who had Pap screen results documented in the measurement year
Denominator:	Number of HIV-infected female clients who: • were ≥18 years old[1] in the measurement year or reported having a history of sexual activity , and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients who were < 18 years old and denied history of sexual activity 2. Patients who have had a hysterectomy for non-dysplasia/non-malignant indications
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, is the client female? (Y/N) i. If yes, is she ≥ 18 years or reports having a history of sexual activity? (Y/N) 1. If yes, was the pap screening completed during the measurement year?
Data Sources:	• Ryan White Program Data Report, Section 5, Items 42 and 52 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[3] National HIVQUAL Data:[4]

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	84.3%	86.7%	87.0%	89.2%
Mean*	70.5%	67.7%	71.8%	70.8%

*from HAB data base

Outcome Measures for Consideration	○ Incidence of cervical cancer in the female HIV-infected clinic population
Basis for Selection and Placement in Group 2:	
Human Papillomavirus (HPV) is a common infection in the general population. Current evidence suggests that over 50% of sexually active adults have been infected with one or more HPV types. According to population-based prospective studies, HPV precedes the development of cervical cancer.[5]	

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

Cervical cancer may be the most common AIDS-related malignancy in women. Although not a common diagnosis in women in the general population, according to New York City AIDS Surveillance data from 1990 to 1995, the observed cervical cancer cases in HIV-positive women were two to three times higher than the expected number of cases.[6,7] Findings such as these resulted in the inclusion of cervical cancer in the Centers for Disease Control and Prevention (CDC) expanded definition of AIDS.[8]

When compared with HIV-negative women, HIV-positive women with invasive cervical cancer present at more advanced stages and with cancer metastasizing to unusual locations. HIV- positive women have poorer responses to standard therapy and have higher recurrences and death rates, as well as shorter intervals to recurrence or death.[9,10]

The CDC currently recommends that HIV-positive women have a complete gynecologic evaluation, including a Pap smear, as part of their initial HIV evaluations, or upon entry to prenatal care, and another Pap smear six months later. If both smears are negative, annual screening is recommended thereafter in asymptomatic women. The CDC further recommends more frequent screenings (every six months) for women with symptomatic HIV infection, prior abnormal Pap smears, or signs of HPV infection. [11,12]

Cervical cancer can often be prevented or detected in its earliest stages through effective screening with a Pap smear and avoidance of known risk factors. This accentuates the importance of routine gynecological care, which includes Pap smears for HIV-infected women.[13]

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

US Public Health Guidelines:

"In accordance with the recommendation of the Agency for Health Care Policy and Research, the Pap smear should be obtained twice during the first year after diagnosis of HIV infection and, if the results are normal, annually thereafter"[14] (6/14/02).

References/Notes:

[1]Onset of sexual activity is not reliably reported or recorded. The age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.
[2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.
[3]IHI Measure reads, "Percent of Female Patients/Clients with an Annual Papanicolaou (Pap) Test" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithPAPSmearinLastSixMonths.htm)
[4]National HIVQUAL data looks at the percent of clients who have an annual pelvic exam. (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf)
[5]Davis, AT. Cervical dysplasia in women infected with the human immunodeficiency virus (HIV): A correlation with HIV viral load and CD4 count. Gynecologic Oncology. 2001; 80(3):350–354.
[6]Approximately 16,000 new cases of cervical cancer are diagnosed each year, and about 4,800 women die from this disease annually. Clinical Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force. Chapter 9.
[7]Chiasson, MA. Declining AIDS mortality in New York City. New York City Department of Health. Bull

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

NY Acad. Med. 1997; 74:151–152.
[8]Centers for Disease Control and Prevention (CDC). 1993. Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. MMWR. 1992; 41(RR-17). (http://www.cdc.gov/mmwr/preview/mmwrhtml/00018871.htm)
[9] Ibid.
[10]U.S. Department of Health and Human Services. Anderson, JA, editor. Guide to the Clinical Care of Women with HIV; 2005.
[11]http://www.niaid.nih.gov/factsheets/womenhiv.htm
[12]The interval for each patient should be recommended by the physician based on risk factors, i.e., early onset of sexual history, a history of multiple sex partners, low socioeconomic status, and, for women infected with HIV, more frequent screening, according to the established guidelines.
[13]Kjaer, S. Type specific persistence of high risk human papillomavirus (HPV) as indicator of high grade cervical squamous intraepithelial lesions in young women: population based prospective follow-up study, Brit Med J. 2002; 325: 572–578.
[14]Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51(No. RR-8) (http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf or http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf)

HAB HIV Core Clinical Performance Measures

HAB HIV Core Clinical Performance Measures
Hepatitis B Screening
November 2011

Performance Measure: Hepatitis B Screening	
Percentage of patients, regardless of age, for whom Hepatitis B screening[1] was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection[2] or immunity[3]	
Numerator:	Number of patients for whom Hepatitis B screening was performed at least once since the diagnosis of HIV/AIDS or for whom there is documented infection[2] or immunity[3]
Denominator:	Number of patients, regardless of age, with a diagnosis of HIV/AIDS and who had at least two medical visits during the measurement year, with at least 60 days in between each visit
Patient Exclusions:	None
Data Elements:	1. Does the patient, regardless of age, have a diagnosis of HIV/AIDS? (Y/N) a. If yes, did the patient have at least two medical visits during the measurement year, with at least 60 days in between each visit? (Y/N) i. If yes, is there evidence of documented Hepatitis B infection[2] or immunity[3] in the patient medical record? (Y/N) 1. If no, was Hepatitis B screening performed at least once since diagnosis of HIV infection? (Y/N) a. If yes, list date.
Data Sources:	• Ryan White Program Services Report (RSR) question 56 (Hep B screening) • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	Veterans Administration: 97%[4]
Basis for Selection and Placement in Group 2:	
Hepatitis B virus (HBV) is the leading cause of chronic liver disease worldwide. In countries with low prevalence of endemic chronic HBV infection, HBV is transmitted primarily through sexual contact and injection drug use. Although risk factors are similar, HBV is transmitted more efficiently than HIV.[5] HIV infection is association with more rapid progression of viral hepatitis-related liver disease, including end stage liver disease and cirrhosis. Antiretroviral (ARV) drugs active against both HIV and HBV may prevent the development of significant liver disease by directly suppressing HBV replication. Data suggest earlier treatment of HIV infection in persons coinfected with HBV may reduce the risk of liver disease progression.[6] The measure is placed in Group 2 because of the emphasis on Hepatitis screening as outlined in the National Viral Hepatitis Strategy.[7]	
US Department of Health and Human Services Guidelines:	

HAB HIV Core Clinical Performance Measures

"HIV-infected persons should be tested for HBV infection. Initial testing...should be performed because these will identify the majority of patients with chronic hepatitis B [who should be further assessed for HBV treatment and antiretroviral therapy] or who need vaccination to prevent infection."[5]

Baseline evaluation for each HIV-infected patient entering into care should include serology for hepatitis B virus. If HBsAg is positive at baseline or prior to initiation of ART, TDF+ (FTC or $_3$TC) should be used as part of ARV regimen to treat both HBV and HIV infections. If HBsAg and HBsAb are negative at baseline, hepatitis B vaccine series should be administered.[6]

"The majority of HIV-infected patients with isolated anti-HBc are not immune to HBV infection and should be vaccinated with a complete primary series of hepatitis B vaccine. Certain specialists would test for HBV DNA to rule out occult chronic HBV infection before administering a complete primary series of hepatitis B vaccine."[5]

References/Notes:

[1]Screening can be completed in two ways: 1) Test for Hepatitis B surface antibody (anti-HBs) and if negative, proceed to Hepatitis B surface antigen (HBsAg) and Hepatitis B core antibody total (anti-HBc); or 2) complete all three tests as once.
[2]Documented infection includes any patient with active or chronic Hepatitis B infection (see chart below)
[3]Documented immunity includes patients immune to Hepatitis B due to natural infection or Hepatitis B vaccination (see chart below).

Interpretation of the Hepatitis B Panel
Source: Centers for Disease Control and Prevention. Hepatitis B Information for Health Professionals. http://www.cdc.gov/hepatitis/HBV/HBVfaq.htm. Accessed on November 30, 2011.

Tests	Results	Interpretation
HBsAg anti-HBc anti-HBs	negative negative negative	Susceptible
HBsAg anti-HBc anti-HBs	negative positive positive	Immune due to natural infection
HBsAg anti-HBc anti-HBs	negative negative positive	Immune due to Hepatitis B vaccination
HBsAg anti-HBc IgM anti-HBc anti-HBs	positive positive positive negative	Acutely infected
HBsAg anti-HBc IgM anti-HBc anti-HBs	positive positive negative negative	Chronically infected
HBsAg anti-HBc anti-HBs	negative positive negative	Interpretation unclear; four possibilities: 1. Resolved infection (most common) 2. False-positive anti-HBc, thus susceptible 3. "Low level" chronic infection 4. Resolving acute infection

HAB HIV Core Clinical Performance Measures

[4]Backus et al., National Quality Forum performance measures for HIV/AIDS care: The Department of Veterans Affairs' Experience. *Arch Intern Med.* 2010;170(14):1239-1246. [5]Centers for Disease Control and Prevention. *Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. MMWR 2009; 58 (no. RR-4): 1-207.* http://aidsinfo.nih.gov/contentfiles/Adult_OI_041009.pdf [6] Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 10, 2011; 1-166. http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf [7]US Department of Health & Human Services. *Combatting the Silent Epidemic of Viral Hepatitis. Action Plan for the Prevention, Care & Treatment of Viral Hepatitis: 1-84.* http://www.hhs.gov/ash/initiatives/hepatitis
Corresponding National Quality Forum (NQF) Endorsed Measure:
NQF #: 0411 Title: Hepatitis B Screening Description: Percentage of patients for whom Hepatitis B screening was performed at least once since the diagnosis of HIV infection or for whom there is documented immunity Status: Endorsed (Original Endorsement Date: July 31, 2008) Available at: http://www.qualityforum.org/Measures_List.aspx

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HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

Performance Measure: Hepatitis B Vaccination	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection who completed the vaccination series for Hepatitis B	
Numerator:	Number of HIV-infected clients with documentation of having ever completed the vaccination series for Hepatitis B[1,2]
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[3] at least once in the measurement year
Patient Exclusions:	1. Patients newly enrolled in care during the measurement year 2. Patients with evidence of current HBV infection (Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody or Hep B DNA) 3. Patients with evidence of past HBV infection with immunity (Hep B Surface Antibody without evidence of vaccination)
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, does the client have documentation of Hepatitis B immunity or is HBV-infected? (Y/N) i. If no, is there documentation that the client has completed the vaccine series for Hepatitis B?(Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	Published data from the HIV Outpatient Study (HOPS) reports 17% of patients with HIV infection who were eligible for vaccination received at least 3 doses of vaccine.[4] "Hepatitis B vaccination coverage among adults at high risk…[was] 45% in 2004."[5]
Outcome Measures for Consideration:	○ Incidence of Hepatitis B infection in the clinic population
Basis for Selection and Placement in Group 2:	
Hepatitis B virus (HBV) is the leading cause of chronic liver disease worldwide. In developed countries, HBV is transmitted primarily through sexual contact and injection-drug use. Even though risk factors are similar, HBV is transmitted more efficiently than HIV-1. Although up to 90% of HIV-1–infected persons have at least one serum marker of previous exposure to HBV, only approximately 10% have chronic hepatitis B, as evidenced by the detection of hepatitis B surface antigen (HBsAg) in the serum persisting for a minimum of 6 months.[6] HIV-1 infection is associated with an increased risk for the development of chronic hepatitis B after HBV exposure. Limited data indicate that co-infected patients with chronic hepatitis B infection have higher HBV DNA levels and are more likely to have detectable hepatitis B e antigen (HBeAg), accelerated loss of	

HAB HIV Core Clinical Performance Measures: Adult/Adolescent Clients Group 2

protective hepatitis B surface antibody (anti-HBs), and an increased risk for liver-related mortality and morbidity.[7,8] There is a protective antibody response in approximately 30%-55% of healthy adults aged ≤40 years after the first dose of vaccine. After age 40, the proportion of persons with a protective antibody response after a 3-dose vaccination regimen declines. In addition to age, other host factors (e.g., smoking, obesity, genetic factors, and immune suppression) contribute to decreased vaccine response. Response to hepatitis B vaccination also is reduced in other immunocompromised persons (e.g., HIV-infected persons, hematopoietic stem-cell transplant recipients, and patients undergoing chemotherapy). Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.
US Public Health Guidelines:
"Several liver-associated complications that are ascribed to flares in HBV activity or toxicity of antiretroviral agents can affect the treatment of HIV in patients with HBV coinfection. Therefore, providers should know the HBV status of all patients with HIV. For patients who are HBV negative, prophylaxis is recommended. This consists [of] 3 doses of vaccine for "all susceptible patients (i.e., antihepatitis B core antigen-negative)."[9] (6/14/02)
References/Notes:
[1]Patients in the middle of the vaccination series on 12/31/x would not be captured in the numerator in year x. They would, if the series was completed on schedule, be captured in year x+1. [2]Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: Recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004; 53(No. RR-15). (http://aidsinfo.nih.gov/ContentFiles/TreatmentofOI_AA.pdf). [3]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [4]Tedaldi EM, Baker RK, Moorman AC, Wood KC, Fuhrer J, McCabe RE, Holmberg SD; HIV Outpatient Study (HOPS) Investigators. Hepatitis A and B vaccination practices for ambulatory patients infected with HIV. Clinical Infectious Diseases. 2004 May 15;38(10):1478-84. (http://www.journals.uchicago.edu/CID/journal/issues/v38n10/32448/32448.web.pdf) [5]Centers for Disease Control and Prevention. Hepatitis B Vaccination Coverage Among Adults —United States, 2004. MMWR 2006;55:509-11 (http://www.cdc.gov/mmwr/PDF/wk/mm5518.pdf) [6]Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004; 53(No. RR-15). (http://aidsinfo.nih.gov/ContentFiles/TreatmentofOI_AA.pdf) [7] Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 29, 2008. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf) Accessed April 2, 2008. [8]Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51(No. RR-8) (http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf or http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf)

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[9]Centers for Disease Control and Prevention. Treating opportunistic infections among HIV-infected adults and adolescents: recommendations from CDC, the National Institutes of Health, and the HIV Medicine Association/Infectious Diseases Society of America. MMWR 2004;53(No. RR-15).

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Performance Measure: Hepatitis C Screening	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV infection	
Numerator:	Number of HIV-infected clients who have documented HCV status in chart[1]
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	None
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation of the client's Hepatitis C status in the medical record? (Y/N)
Data Sources:	• Ryan White Program Data Report, Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 95%[3] National HIVQUAL Performance Data[4]

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	99.4%	100%	100%	100%
Mean*	86.2%	88.8%	90.5%	90.9%

*from HAB data base

Outcome Measures for Consideration:	○ Hepatitis C- related mortality rates in the clinic population

Basis for Selection and Placement in Group 2:

Chronic hepatitis C infection is common in persons with HIV infection, and although it is a source of substantial morbidity and mortality, it may be amenable to treatment. HIV/ hepatitis C co-infection may predispose HIV-infected patients to liver toxicity from HAART[5] and HCV treatment may exacerbate the side effects of some ARV medications.[6]

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

US Public Health Guidelines:

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"All HIV-infected patients should be screened for HCV infection"[7] (6/14/02)
References/Notes:
[1]Unless there is concern about ongoing exposure (e.g., via active injection drug use), annual re-screening is not generally recommended. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [3]IHI Measure reads, "Percent of Patients/Clients with Known Hepatitis C Status" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsClientswithKnownHepatitisCStatus.htm) [4](http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [5]AIDS Institute, New York State Department of Health. Criteria for the Medical Care of Adults with HIV Infection, Hepatitis C Virus Updated September 2004 *[Text taken from the NYSDOH AI publication - "Criteria for the Medical Care of Adults with HIV Infection"]* (http://www.hivguidelines.org/public_html/hep-c/hepc.pdf) [6]Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf) [7]Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51(No. RR-8) (http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf or http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf)

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Performance Measure: HIV Risk Counseling	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of clients with HIV infection who received HIV risk counseling[1] within the measurement year	
Numerator:	Number of HIV-infected clients, as part of their primary care, who received HIV risk counseling
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	None
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client receive HIV risk counseling at least once during the measurement year with appropriate feedback to the provider?(Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcome Measures for Consideration:	○ Incidence of new HIV infection ○ Incidence of STD cases in clinic population ○ Rates of substance abuse counseling and referrals
Basis for Selection and Placement in Group 2:	
Reducing transmission of human immunodeficiency virus (HIV) in the United States requires new strategies, including emphasis on prevention of transmission by HIV-infected persons. Through ongoing attention to prevention, risky sexual and needle sharing behaviors among persons with HIV infection can be reduced and transmission of HIV infection prevented. Medical care providers can substantially affect HIV transmission by screening their HIV-infected patients for risk behaviors; communicating prevention messages; discussing sexual and drug-use behavior; positively reinforcing changes to safer behavior; referring patients for services such as substance abuse treatment; facilitating partner notification, counseling, and testing; and identifying and treating other sexually transmitted diseases.[3] Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.	
US Public Health Guidelines:	

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"HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks." [4] (7/18/03)
References/Notes:
[1]HIV risk counseling includes assessment of risk, counseling and as necessary, referrals. Counseling occurs in the context of comprehensive medical care and can be provided by any member of the multidisciplinary primary care team. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [3]Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003;52 (No. RR-12) (http://www.cdc.gov/mmwr/PDF/rr/rr5212.pdf or http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare_TB.pdf) [4]Ibid

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Performance Measure: Lipid Screening	**OPR-Related Measure:** No
Percentage of clients with HIV infection on HAART who had a fasting lipid panel[1] during the measurement year	
Numerator:	Number of HIV-infected clients who: • were prescribed HAART, and • had a fasting lipid panel in the measurement year
Denominator:	Number of HIV-infected clients who are on HAART and who had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	None
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, was the client on HAART?(Y/N) i. If the client was on HAART, did he/she have a fasting lipid panel during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison:	National HIVQUAL Data:[3]

	2003	2004	2005	2006
Top 10%	100%	100%	100%	100%
Top 25%	100%	100%	97.9%	100%
Mean*	80.7%	79.1%	80.2%	84.7%

*From HAB database

Outcome Measures for Consideration:	○ Incidence of cardiovascular events in clinic population ○ Incidence of metabolic syndrome in the clinic population

Basis for Selection and Placement in Group 2:

Changes in body shape, fat distribution & metabolism occur with frequency among HIV-infected patients, particularly those prescribed HAART. Metabolic changes that have been observed include hypertriglyceridemia, low high-density-lipoprotein (HDL) cholesterol and changes in LDL cholesterol.

Although rates of prevalence vary, studies have found the rate of prevalence for metabolic syndrome to be almost 25% in a population of patients taking HAART[4], where metabolic syndrome is defined as the presence of at least 3 of the following: hypertriglyceridemia, low high-density lipoprotein cholesterol, hypertension, abdominal obesity or high serum glucose.[5]

All patients should receive a lipid profile at least once a year in order to monitor general health. For patients on HAART, lipid level monitoring is important to detect side effects and to identify patients who may require

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treatment.

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

US Public Health Guidelines:

As part of pretreatment evaluation: "The following laboratory tests should be performed for each new patient during initial patient visits:…and serum lipids if considered at risk for cardiovascular disease and for baseline evaluation prior to initiation of combination antiretroviral therapy (AIII)…"[6]

References/Notes:

[1]A fasting lipid panel consists of fasting cholesterol, HDL, calculated LDL and triglycerides.

[2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.

[3](http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) The HIVQUAL indicator includes all patients on ARV therapy.

[4] Jacobson DL, Tang AM, Spiegalman D. Incidence of Metabolic Syndrome in a Cohort of HIV-Infected Adults and Prevalence Relative to the US Population (National Health and Nutrition Examination Survey).. J Acquir Immune Defic Syndr. 2006 Sep 14

[5] Jacobson DL, Tang AM, Spiegalman D. Incidence of Metabolic Syndrome in a Cohort of HIV-Infected Adults and Prevalence Relative to the US Population (National Health and Nutrition Examination Survey).. J Acquir Immune Defic Syndr. 2006 Sep 14

[6] Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 29, 2008, p. 3, 82. Available at http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf) Accessed April 2, 2008.

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Performance Measure: Oral Exam	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percent of clients with HIV infection who received an oral exam by a dentist at least once during the measurement year	
Numerator:	Number of clients who had an oral exam by a dentist during the measurement year, based on patient self report or other documentation
Denominator:	Number of clients with HIV infection who had a medical visit with a provider with prescribing privileges[1] at least once in the measurement year
Patient Exclusions:	None
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client receive an oral exam by a dentist during the measurement year?(Y/N)
Data Sources:	• Ryan White Program Data Report, Section 3, Item 33c may provide data useful in establishing a baseline for this performance measure[2] • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 75%[3] National HIVQUAL Data:[4]

	2003	2004	2005	2006
Top 10%	66.7%	78.5%	66.7%	77.4%
Top 25%	46.7%	62.2%	53.6%	56.4%
Mean*	34.6%	39.7%	37.3%	39.4%

*from HAB data base

Outcome Measures for Consideration:	Rates of dental disease and oral pathology.

Basis for Selection and Placement in Group 2:

Oral health care is an important component of the management of patients with HIV infection. A poorly functioning dentition can adversely affect the quality of life, complicate the management of medical conditions, and create or exacerbate nutritional and psychosocial problems.[5] When the oral cavity is compromised by the presence of pain or discomfort, maintaining adherence to complicated antiretroviral therapy regimens becomes more difficult.[6]

There is limited evidence on the risks of oral procedures among persons with HIV/AIDS. Evidence for the utility of selected oral lesions as markers for seroconversion is limited to a single study of a single oral condition—candidiasis.[7] In the later stages of HIV disease, greater numbers of oral lesions and aggressive

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periodontal breakdown are more likely; therefore, oral health care visits should be scheduled more frequently.[8] Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Completing an oral health exam at least every 12 months is not specified in the PHS guidelines but is accepted as good practice.
US Public Health Guidelines:
Primary health care providers should make an initial dental referral for every HIV/AIDS patient under their care. Oral health care providers should examine all patients on a semiannual basis for dental prophylaxis and other appropriate preventive care. As HIV-related medications may affect dental treatment and cause adverse effects, the patient's oral health care provider should review all medications being used by the patient and should understand the potential for these medications to affect oral health care.[9]
References/Notes:
[1]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [2]RDR does not provide number of dental exams, preventive, curative treatments and/or surgeries. It only provides information on the number of clients and number of visits in the "Oral health care" service category. [3]IHI Measure reads, "Percent of Patients Receiving an Annual Dental Exam" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsReceivinganAnnualDentalExam.htm) [4]http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf [5]US DHHS Oral Health in America: A Report of the Surgeon General http://www2.nidcr.nih.gov/sgr/sgrohweb/welcome.htm [6]http://www.hivguidelines.org/public_html/center/clinical-guidelines/oral_care_guidelines/oral_health_book/oral_health_supp_pages/oral_health_chap1.htm#references [7]http://www.ahrq.gov/clinic/epcsums/denthivsum.htm [8]http://www.hivguidelines.org/public_html/center/clinical-guidelines/adult_hiv_guidelines/supplemental_pages/oral_health_adults/pdf/adults_oral_health.pdf [9]New York State Dept of Health AIDS Institute *Oral Health Care for People With HIV Infection* http://www.hivguidelines.org/Content.aspx?pageID=263

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Performance Measure: Syphilis Screening	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement year	
Numerator:	Number of HIV-infected clients who had a serologic test for syphilis performed at least once during the measurement year
Denominator:	Number of HIV-infected clients who: • were ≥18 years old in the measurement year[1] or had a history of sexual activity < 18 years, and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients who were < 18 years old and denied a history of sexual activity
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, is the client ≥ 18 years or reports having a history of sexual activity? (Y/N) 1. If yes, was the client screened for syphilis during the measurement year?
Data Sources:	• Ryan White Program Data Report , Section 5, Items 42 and 48 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[3] National HIVQUAL Data:[4]

	2003	2004	2005	2006
Top 10%	99.0%	100%	100%	100%
Top 25%	90.4%	92.2%	95.7%	95.6%
Mean*	73.7%	78.5%	82.1%	80.0%

*from HAB data base

Outcome Measures for Consideration	○ Incidence of neurosyphilis in the clinic population

Basis for Selection and Placement in Group 2:

HIV-1 infection appears to alter the diagnosis, natural history, management, and outcome of *T. pallidum* infection.

Measure reflects important aspect of care that impacts HIV-related morbidity and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

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US Public Health Guidelines:
"HIV-infected patients should be screened for behaviors associated with HIV transmission by using a straightforward, nonjudgmental approach. This should be done at the initial visit and subsequent routine visits or periodically, as the clinician feels necessary, but at a minimum of yearly. Any indication of risky behavior should prompt a more thorough assessment of HIV transmission risks. Screening for STDs should be repeated periodically (i.e., at least annually) if the patient is sexually active or if earlier screening revealed STDs. Screening should be done more frequently (e.g., at 3–6-month intervals) for asymptomatic persons at higher risk.[5] (7/18/03)
References/Notes:
[1] Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [3]IHI Measure reads, "Percent of Patients with Annual Syphilis Screen" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientswithAnnualSyphilisScreen.htm) [4](http://www.hivguidelines.org/public_html/center/quality-of-care/hivqual-project/hivqual-workshop/03-04-natl-score-top10-25.pdf) [5]Centers for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. MMWR 2003;52 (No. RR-12) (http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare_TB.pdf or http://aidsinfo.nih.gov/ContentFiles/HIVPreventionInMedCare_TB.pdf)

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Performance Measure: TB Screening	**OPR-Related Measure:** No
Percentage of clients with HIV infection who received testing with results documented for latent tuberculosis infection (LTBI) since HIV diagnosis	
Numerator:	Number of clients who received documented testing for LTBI with any approved test (tuberculin skin test [TST] or interferon gamma release assay [IGRA]) since HIV diagnosis
Denominator:	Number of HIV-infected clients who: • do not have a history of previous documented culture-positive TB disease or previous documented positive TST or IGRA[1]; and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year.
Patient Exclusions	None
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, has the client ever had previous documented culture-positive TB disease or previous documented positive TST or IGRA? (Y/N) i. If no, has the client ever been tested for LTBI with a TST or IGRA since his/her HIV diagnosis? (Y/N) 1. If yes, are the results documented? (Y/N)
Data Sources:	• Ryan White Program Data Report, Section 5, Item 47 may provide data useful in establishing a baseline for this performance measure • Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data:[3]

	2003	2004	2005	2006
Top 10%	88.9%	91.7%	88.8%	92.2%
Top 25%	77.4%	73.5%	74.8%	78.2%
Mean*	58.8%	56.0%	57.1%	56.2%

*from HAB data base

Outcome Measures for Consideration	° Incidence of TB disease in the clinic population
Basis for Selection and Placement in Group 2:	

HIV is the most important known risk factor for progression to TB disease from latent TB infection (LTBI) after exposure to infectious TB patients. There is a 2% to 8% TB risk per year within 5 years after LTBI for HIV-infected adults[4,5] versus an 8% TB risk over 60 years for adults with LTBI but not HIV[6]. The TB risk for HIV-infected persons remains higher than for HIV-uninfected persons, even for HIV-infected persons who are taking antiretroviral medications.[7,8] TB disease is an AIDS-defining opportunistic condition that can be deadly. McCombs found a 3 times adjusted odds of being diagnosed with TB at death and a 5 times adjusted

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odds of dying during TB treatment for HIV-infected TB patients compared with other patients from 1993 through 2001.[9] Immunologic and virologic evidence now indicates that the host immune response to *M. tuberculosis* enhances HIV replication and might accelerate the natural progression of HIV infection.[10]

Providers should screen all HIV infected patients for TB and LTBI as soon as possible after HIV diagnosis. TB and LTBI testing should be conducted among HIV-infected persons regardless of duration of infection since they are at increased risk for progressing to TB disease. Thus, an HIV-infected person having a prior positive TST for which he/she did not complete treatment is still eligible for treatment. However, early identification and treatment of TB disease improves outcomes and reduces the risk of transmission. TB should be suspected in any patient who has had a persistent cough for more than 2 to 3 weeks, especially if the patient has at least one additional symptom, including fever, night sweats (sufficient to require changing of bed clothes or sheets), weight loss, or hemoptysis (coughing up blood). Identification of LTBI and completion of LTBI treatment reduces the risk of development of TB disease by 70 to 90 percent.[11] Measure reflects important aspect of care that impacts HIV-related morbidity and mortality and focuses on treatment decisions that affect a sizable population. Measure has a strong evidence base supporting the use.

US Public Health Guidelines:

Guidelines for TB services for HIV-infected persons, such as those jointly published by the Public Health Service and the Infectious Diseases Society of America[12] or by the Centers for Disease Control and Prevention (CDC)[13] call for:

- provision of a TST when HIV infection is first recognized,
- annual or periodic TSTs for HIV-infected persons who are initially TST-negative and belong to groups at substantial risk for TB exposure or if they experience immune reconstitution,
- chest radiographs and clinical evaluations to rule out active TB among those who are TST positive (reactions ≥ 5 mm) or who have symptoms (regardless of TST result), and
- LTBI treatment (once active TB has been excluded) for those having a positive TST or for those who are recent contacts of persons with infectious active TB[14].

References/Notes:

[1]Previous documented culture-positive TB disease or previous documented positive TST or IGRA occurred prior to HIV diagnosis.
[2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy.
[3]"PPD screening" (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf
[4]Markowitz N, Hansen NI, Hopewell PC, et al. Incidence of tuberculosis in the United States among HIV-infected persons. Annals of Internal Medicine. 1997;126:123-32.
[5]Selwyn PA, Hartel D, Lewis VA, et al. A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. New England Journal of Medicine. 1989;320:545-50.
[6]Aronson NE, Santosham M, Comstock GW, et al. Long-term efficacy of BCG vaccine in American Indians and Alaska Natives: A 60-year follow-up study. Journal of the American Medical Association. 2004;291(17):2086-91.
[7]The Antiretroviral therapy cohort collaboration. Incidence of tuberculosis among HIV-infected patients receiving highly active antiretroviral therapy in Europe and North America. Clinical Infectious Diseases. 2005;41:1772-1782.

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[8]Jones JL, Hanson DL, Dworkin MS, DeCock KM, and the Adult/Adolescent Spectrum of HIV Disease Group. HIV-associated tuberculosis in the era of highly active antiretroviral therapy. International Journal of TB and Lung Disease. 2000;4(11):1026-1031.
[9]McCombs SB. Tuberculosis mortality in the United States, 1993-2001. Oral presentation at CDC. Atlanta. December 2003.
[10] Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR Recomm Rep 1998 Oct 30;47(RR-20):1-58.
[11]American Thoracic Society/Centers for Diseases Control and Prevention/Infectious Diseases Society of America. Treatment of tuberculosis. Am J Respir Crit Care Med 2003;167:603-662
[12] Centers for Disease Control and Prevention. Guidelines for Preventing Opportunistic Infections Among HIV-Infected Persons — 2002 Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. MMWR 2002;51 (No. RR-8) (http://www.cdc.gov/mmwr/PDF/rr/rr5108.pdf or http://aidsinfo.nih.gov/ContentFiles/OIpreventionGL.pdf)
[13] Centers for Disease Control and Prevention. Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations. MMWR Recomm Rep 1998 Oct 30;47(RR-20):1-58.
[14]Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR December 16, 2005 / Vol. 54 / No. RR-15

Attachment Q – Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Group 3

Defined as of April 2009

- Chlamydia Screening
- Gonorrhea Screening
- Hepatitis/HIV Alcohol Counseling
- Influenza Vaccination
- MAC Prophylaxis
- Mental Health Screening
- Pneumococcal Vaccination
- Substance Use Screening
- Tobacco Cessation Counseling
- Toxoplasma Screening

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Performance Measure: Chlamydia Screening	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection at risk for sexually transmitted infections (STI) who had a test for chlamydia within the measurement year	
Numerator:	Number of HIV-infected clients who had a test for chlamydia
Denominator:	Number of HIV-infected clients who: • were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months, and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients who were < 18 years old[3] and denied a history of sexual activity
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is the client new to care, sexually active or had a STI within the last 12 months? (Y/N) i. If yes, was the client tested for chlamydia during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcome Measures for Consideration:	• Incidence of STIs in the clinic population • Incidence of pelvic inflammatory disease in the clinic population
Basis for Selection and Placement in Group 3:	
Early detection and treatment of STIs may reduce the risk for STI and HIV transmission. Providers should screen for STIs to treat infections and decrease HIV transmission to sexual partners. Many STIs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV infection.[4] STIs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.[5,6] STIs in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.[7] Susceptibility to transmission may therefore be enhanced. Chlamydia infection in women may often be asymptomatic but like other STIs can also increase the risk for	

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HIV transmission and enhance transmission susceptibility. Providers should test women for cervical chlamydial infection at least annually to treat infections and to decrease the risk of chlamydia and HIV transmission.

Identification and treatment of STIs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks). [8]

The measure was placed in Group 3 because it focuses on similar aspects of care (STI marker) previously captured in measures included in Groups 1 & 2. There are currently no guidelines that delineate routine annual testing for chlamydia.

US Public Health Guidelines:

"During the first visit, consider testing all patients for urogenital chlamydial infection. For subsequent routine visits, repeat tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk. Presence of any of the following factors may support more frequent than annual periodic screening: 1) multiple or anonymous sex partners; 2) past history of any STD; 3) identification of other behaviors associated with transmission of HIV and other STDs; 4) sex or needle-sharing partner(s) with any of the above-mentioned risks; 5) developmental changes in life that may lead to behavioral change with increased risky behaviors; or 6) high prevalence of STDs in the area or in the patient population." [9]

References/Notes:

[1] "Clients" includes all clients aged 13 years and older.
[2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications.
[3]Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.
[4]Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. Lancet 1998;351(suppl 3):5-7.
[5] Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS.* 2004 Oct 21;18(15):2075-9.
[6]CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV". July 18, 2003/52(RR12);1-24.
[7] DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection, *Sex Transm Infect* 75 (1999), pp. 3–17.
[8]CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV". July 18, 2003/52(RR12);1-24.
[9]Ibid.

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Performance Measure: Gonorrhea Screening	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection at risk for sexually transmitted infections (STIs) who had a test for gonorrhea within the measurement year	
Numerator:	Number of HIV-infected clients who had a test for gonorrhea
Denominator:	Number of HIV-infected clients who: • were either: a) newly enrolled in care; b) sexually active; or c) had a STI within the last 12 months; and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients who were ≤ 18 years old[3] and denied a history of sexual activity
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is the client new to care, sexually active or had a STI within the last 12 months? (Y/N) i. If yes, was the client tested for gonorrhea during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcome Measures for Consideration:	• Incidence of STIs in the clinic population
Basis for Selection and Placement in Group 3:	
Early detection and treatment of STIs may reduce the risk for STD and HIV transmission. Providers should screen for STIs to treat infections and decrease HIV transmission to sexual partners. Many STIs increase the number of HIV-infected white blood cells in the genital area and increase the risk of transmitting HIV infection.[4] STIs can also enhance the risk of transmitting HIV by increasing the viral burden in genital secretions.[5] STIs in seronegative partners increase the risk for acquiring HIV because they increase the volume of white blood cells, including those that are targeted by HIV, in the genital region, and may cause ulcerative lesions, increasing the likelihood of infection.[6] Susceptibility to transmission may therefore be enhanced.	

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Identification and treatment of STIs can reduce the potential for spread of these infections among high-risk groups (i.e., sex or drug-using networks).[7]

The measure was placed in Group 3 because it focuses on similar aspects of care (STI marker) previously captured in measures included in Groups 1 & 2. There are currently no guidelines that delineate routine annual testing for gonorrhea.

US Public Health Guidelines:

"During the first visit, consider testing all patients for urogenital gonorrhea. For subsequent routine visits, repeated tests periodically (i.e. at least annually) for all patients who are sexually active. More frequent periodic screening (e.g. at 3-month to 6-month intervals) may be indicated for asymptomatic persons at higher risk. Presence of any of the following factors may support more frequent than annual periodic screening: 1) multiple or anonymous sex partners; 2) past history of any STD; 3) identification of other behaviors associated with transmission of HIV and other STDs; 4) sex or needle-sharing partner(s) with any of the above-mentioned risks; 5) developmental changes in life that may lead to behavioral change with increased risky behaviors; or 6) high prevalence of STDs in the area or in the patient population."[8]

References/Notes:

[1] "Clients" includes all clients aged 13 years or older.
[2] A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications.
[3] Onset of sexual activity is not reliably reported or recorded. The lower age bracket of 18 years is selected for performance measurement purposes only and should not be interpreted as a recommendation about the age at which screening should begin to occur.
[4] Cohen MS. Sexually transmitted diseases enhance HIV transmission: no longer a hypothesis. Lancet 1998;351(suppl 3):5-7.
[5] Buchacz K, Patel P, Taylor M, et al. Syphilis increases HIV viral load and decreases CD4 cell counts in HIV-infected patients with new syphilis infections. *AIDS.* 2004 Oct 21;18(15):2075-9.
[6] DT Fleming and JN Wasserheit, From epidemiological synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection, *Sex Transm Infect* 75 (1999), pp. 3–17.
[7] CDC. Recommendations and Reports: "Incorporating HIV Prevention into the Medical Care of Persons Living with HIV". July 18, 2003/52(RR12);1-24.
[8] Ibid

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Performance Measure: Hepatitis/HIV Alcohol Counseling	**OPR-Related Measure:** No
Percentage of clients[1] with HIV and Hepatitis B (HBV) or Hepatitis C (HCV) infection who received alcohol counseling[2] within the measurement year	
Numerator:	Number of HIV-infected clients who received alcohol counseling
Denominator:	Number of HIV-infected clients who: • were co-infected with HBV[3] or HCV; and • had a medical visit with a provider with prescribing privileges[4] at least once in the measurement period
Patient Exclusions:	None
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is the client HBV or HCV-positive? (Y/N) i. If yes, did the client receive alcohol counseling during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison	None available at this time.
Outcome Measures for Consideration:	• Hepatitis-related mortality rates in the clinic population
Basis for Selection and Placement in Group 3:	
Discussion of substance use allows the clinician to either provide counseling or make referrals to substance and alcohol treatment centers. A study of HIV positive veterans showed that hazardous drinking and alcohol diagnoses were associated with HIV disease progression and/or hepatic co-morbidity and anemia. It also concluded that alcohol problems are often missed by providers thus increasing the need for routine screening.[5] Long-term studies of patients with chronic HCV infection show that between 2%-20% develop cirrhosis in 20 years. This rate of progression increases with older age, alcoholism and HIV infection.[6] The measure is placed in Group 3 because the definition of "counseling" varies considerably across grantees.	

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The variation in definition impacts the feasibility of data collection.
US Public Health Guidelines:
"All patients with HIV/HCV infection should be advised to avoid or limit alcohol consumption…"[7]
References/Notes:
[1] "Clients" refers to all clients aged 13 years and older. [2] For the purposes of this measure, alcohol counseling refers to counseling provided by the primary care team that emphasizes the need to avoid or limit alcohol intake due to the impact on the liver. [3] Markers of Hepatitis B infection include Hep B Surface Antigen, Hep B e Antigen, Hep B e Antibody or Hep B DNA. [4] A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [5] Joseph Conigliaro, Adam J. Gordon, Kathleen A. McGinnis, Linda Rabeneck, and Amy C.; How Harmful Is Hazardous Alcohol Use and Abuse in HIV Infection: Do Health Care Providers Know Who Is at Risk?; Journal of Acquired Immune Deficiency Syndromes 33:521–525. [6] Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. (http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf)

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Performance Measure: Influenza Vaccination	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection who have received influenza vaccination within the measurement period[2]	
Numerator:	Number of HIV-infected clients who received influenza vaccination within this time frame
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[3] at least once in the measurement period
Patient Exclusions:	1. Patients allergic to vaccine components
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation[4] in the health record that the client received influenza vaccine in the past 12 months? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcome Measures for Consideration:	• Mortality rates of bacterial pneumonia in the clinic population
Basis for Selection and Placement in Group 3:	
Influenza viruses cause disease among all age groups. While rates of infection are highest among children, rates of serious illness and death are highest among persons aged ≥ 65 years, children less than 2 years and persons of any age who have medical conditions that place them at increased risk for complications of influenza, including HIV.[5] Influenza vaccination is the most effective method for preventing influenza and its severe complications. Vaccination has been demonstrated to produce substantial antibody titers against influenza among vaccinated HIV-infected persons who have minimal AIDS-related symptoms and high CD4+ T-lymphocyte cell counts.[6] The measure is placed in Group 3 because it overlaps and focuses on similar aspects of care (vaccination) that were previously captured in measures included in Group 2. In addition, the data collection process is more	

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complex because of the timing of the vaccination.
US Public Health Guidelines:
"Annual vaccination against influenza is recommended for….adults and children who have immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus)."[7]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2] Due to the unique nature of this measure, the measurement period runs from April 1-March 31. [3] A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [4] Evidence of vaccination could include personal, school, physician, or immunization records or registries. [5] Centers for Disease Control and Prevention. Prevention and Control of Influenza: Recommendations from the Advisory committee on Immunization Practices (ACIP). MMWR 2007; 56(RR#6)[1-60]. Available at: http://www.cdc.gov/mmwr/PDF/rr/rr5606.pdf. [6] Ibid. [7] Ibid.

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Performance Measure: MAC Prophylaxis	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection with CD4 count < 50 cells/mm^3 who were prescribed *Mycobacterium avium* Complex (MAC) prophylaxis[2] within the measurement year	
Numerator:	Number of HIV-infected clients with CD4 count < 50 cells/mm^3 who were prescribed MAC prophylaxis
Denominator:	Number of HIV-infected clients who had a: • CD4 count < 50 cells/mm^3 ; and • medical visit with a provider with prescribing privileges[3] at least once in the measurement year
Patient Exclusions:	1. Patients who have disseminated MAC
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, was the CD4 count < 50 cells/mm^3? (Y/N) i. If yes, was MAC prophylaxis subsequently prescribed?
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	National HIVQUAL Data:[4]

	2003	2004	2005	2006	2007
Top 10%	100%	100%	100%	100%	100%
Top 25%	100%	100%	100%	100%	100%
Mean*	86.5%	84.7%	85.7%	83.1%	84.6%

*from HAB data base

Outcome Measures for Consideration:	• Incidence of MAC disease in the clinic population • MAC-related mortality rates in the population assessed

Basis for Selection and Placement in Group 3:

MAC disease is an opportunistic infection that can cause severe illness in people with advanced AIDS but rarely affects others. The risk of disseminated MAC (DMAC) is directly related to the severity of immunosuppression. DMAC typically occurs in persons with CD4 counts < 50 cells/mm^3 and its frequency increases as the CD4 count declines. In the absence of antibiotic prophylaxis, DMAC occurs in up to 40% of AIDS patients with CD4 counts of < 50 cells/mm.[5]

The measure was placed in Group 3 because it focuses on similar aspects of care (prophylaxis) previously

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captured in measures included in Groups 1 & 2.
US Public Health Guidelines:
"Adults and adolescents who have HIV infection should receive chemoprophylaxis against disseminated MAC disease if they have CD4 count < 50 cells/mm.[3]"[6]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2]Current regimens for preventing MAC can be found at: Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. (http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf) [3]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [4] MAC Prophylaxis (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [5] National AIDS Education & Training Centers (2006). Clinical Manual for Management of the HIV-Infected Adult. [6]Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. (http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf)

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Performance Measure: Mental Health Screening	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of new clients[1] with HIV infection who have had a mental health screening	
Numerator:	Number of HIV-infected clients who received a mental health screening
Denominator:	Number of HIV-infected clients who: • were new during the measurement year, and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	None
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, was the client new to the program during the measurement year? (Y/N) i. If yes, did the client receive mental health screening during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data:[3]

	2003	2004	2005	2006	2007
Top 10%	100%	100%	80.6%	86.7%	100%
Top 25%	93.0%	89.5%	35.1%	52.4%	84.0%
Mean*	68.2%	58.5%	21.9%	28.1%	42.0%

*from HAB data base

Outcome Measures for Consideration:	• Rate of mental health referrals • Mental health-related hospitalizations • Rate of suicide in the clinic population • Rate of mental health disorders being treated in the clinic population
Basis for Selection and Placement in Group 3:	
Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. The ability to cope with these issues can dramatically impact management of the disease. The initial evaluation should include an assessment of substance abuse, economic factors, social	

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support, mental illness and co-morbidities.[4] The measure was placed in Group 3 because feasibility of data collection can vary considerably across grantees.
US Public Health Guidelines:
"Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and to alter outcomes. Once evaluated, these factors should be managed accordingly."[5]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [3] The components of the mental health indicator were broken down and implemented for the 2005-2007 data. The Mental Health/Substance Use Subcommittee of the National HIVQUAL Clinical Advisory Committee include the following components for an annual Mental Health Screening for people with HIV: Cognitive function assessment, including mental status; Depression screening; Anxiety screening; Sleeping habits assessment; Appetite assessment; Domestic violence screening; Post Traumatic Stress Disorder screening; Psychiatric history (optional); Psychosocial assessment (optional). (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf [4]Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Department of Health and Human Services. January 29, 2008; 1-128. (http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf) [5]Ibid

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Performance Measure: Pneumococcal Vaccination	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection who ever received pneumococcal vaccine	
Numerator:	Number of HIV-infected clients who ever received pneumococcal vaccine
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients with CD4 counts < 200 cells/mm^3 within the measurement year
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation[3] in the health record that the client ever received the pneumococcal vaccine? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data:[4]

	2003	2004	2005	2006	2007
Top 10%	100%	95.8%	97.5%	100%	100%
Top 25%	92.6%	90.8%	93.0%	93.8%	95.1%
Mean*	79.9%	73.0%	77.1%	79.8%	80.9%

*from HAB database

Outcome Measures for Consideration:	• Incidence of pneumococcal infection in the clinic population

Basis for Selection and Placement in Group 3:

Bacterial pneumonia is a common cause of HIV-associated morbidity and appears with greater incidence in HIV-infected persons than in the non-infected population. Several risk factors are associated with an increased risk of bacterial pneumonia including CD4 count, injection drug use and smoking.[5]

The measure was placed in Group 3 because it overlaps and focuses on similar aspects of care (vaccination) that were previously captured in measures included in Group 2.

US Public Health Guidelines:

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"HIV-infected adults and adolescents who have a CD4+ count of ≥ 200 cells/*u*L should be administered a single dose of 23-valent polysaccharide pneumococcal vaccine (PPV) unless they have received this vaccine during the previous five years (AII)". Revaccination can be considered for patients who were initially immunized when their CD4 T lymphocyte counts were < 200 cells/*u*L in response to HAART (CIII).[6]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [3] Evidence of vaccination could include physician or immunization records or registries. [4]Pneumococcal vaccine http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [5]Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. (http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf) [6]Ibid

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Performance Measure: Substance Use Screening	**OPR-Related Measure:** Yes www.hrsa.gov/performancereview/measures.htm
Percentage of new clients[1] with HIV infection who have been screened[2] for substance use (alcohol & drugs) in the measurement year	
Numerator:	Number of new HIV-infected clients who were screened for substance use within the measurement year
Denominator:	Number of HIV-infected clients who: • were new during the measurement year, and • had a medical visit with a medical provider with prescribing privileges[3] at least once in the measurement year
Patient Exclusions:	None
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, was the client new to the program during the reporting period? (Y/N) i. If yes, was the client screened for substance use during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison	IHI Goal: 90%[4] National HIVQUAL Performance Data:[5]

	2003	2004	2005	2006	2007
Top 10%	100%	100%	100%	100%	100%
Top 25%	92.3%	100%	100%	100%	100%
Mean*	73.4%	76.5%	78.9%	81.4%	80.6%

*from HAB data base

Outcome Measures for Consideration:	• Substance use-related mortality rates • Rate of substance use-related hospitalizations • Rate of substance use referrals
Basis for Selection and Placement in Group 3:	
Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues.	

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The measure was placed in Group 3 because the feasibility of data collection can vary considerably across grantees.
US Public Health Guidelines:
"Patients living with HIV infection must often cope with multiple social, psychiatric, and medical issues. Thus, the (initial) evaluation should also include assessment of substance abuse, economic factors, social support, mental illness, co-morbidities, and other factors that are known to impair the ability to adhere to treatment and to alter outcomes. Once evaluated, these factors should be managed accordingly."[6]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2] The purpose of screening is to identify past or current substance use that negatively impacts linkage to care and health care in general. A substance use screen includes documentation of past and current substance use and treatment in the HIV primary care record. Screening can be provided by any member of the multidisciplinary primary care team. [3]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [4] IHI Measure reads, "Percent of Patients/Clients Assessed for Substance Use and/or Tobacco Use in the Past 12 Months" (http://www.ihi.org/IHI/Topics/HIVAIDS/HIVDiseaseGeneral/Measures/PercentofPatientsClientsAssessedforSubstanceUseandorTobaccoUseinthePast12Months.htm) [5]Substance Use Screening (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [6]Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents (p. 13) (http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf)

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Performance Measure: Tobacco Cessation Counseling	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection who received tobacco cessation counseling within the measurement year	
Numerator:	Number of HIV-infected clients who received tobacco cessation counseling
Denominator:	Number of HIV-infected clients who: • used tobacco products within the measurement year; and • had a medical visit with a provider with prescribing privileges[2] at least once in the measurement year
Patient Exclusions:	1. Patients who deny tobacco use throughout the measurement year
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client use tobacco during the reporting period? (Y/N) i. If yes, did the client receive tobacco cessation counseling during the measurement year? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker, or other electronic data base • HIVQUAL reports on this measure for grantee under review • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison	National HIVQUAL Data:[3]

	2003	2004	2005	2006	2007
Top 10%	100%	100%	100%	100%	100%
Top 25%	93.3%	97.8%	98.4%	100%	100%
Mean*	69.3%	75.0%	76.8%	81.8%	83.8%

* HAB database

Outcome Measures for Consideration:	• Rate of head & neck and lung cancer • Rate of tobacco use in the clinic population

Basis for Selection and Placement in Group 3:

A recent study has shown that lung cancer rates are 2.7 times greater for people living with HIV.[4] As tobacco use among HIV-infected patients poses significant health risks, tobacco-dependent patients should be provided assistance to enroll in smoking cessation programs. Various studies have shown that brief interventions by the clinician to encourage tobacco cessation and offer substitution programs can decrease smoking rates[5] and tobacco use.[6] Cessation reduces the risk of incidence or the progression of tobacco-related diseases and increases life expectancy.[7,8,9] HIV care providers should provide cessation assistance in the form of counseling, pharmacotherapy or referral to cessation programs.

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The measure was placed in Group 3 because the feasibility of data collection can vary considerably across grantees.
US Public Health Guidelines:
"The U.S. Preventive Services Task Force strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products."[10]
References/Notes:
[1] "Clients" includes all clients aged 13 years and older. [2] A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [3]Tobacco Use (http://www.hivguidelines.org/admin/files/qoc/hivqual/proj%20info/HQNatlAggScrs3Yrs.pdf) [4]Philips, Abs 8, CROI, Boston, 2008. [5] Page AR, Walters DJ, Schlegel RP, Best JA. Smoking cessation in family practice: The effects of advice and nicotine chewing gum prescription. Addict Behav 1986;11(4):443-6. [6] Demers RY, Neale AV, Adams R, Trembath C, Herman SC. The impact of physicians' brief smoking cessation counseling: A MIRNET study. J Fam Pract 1990;31(6):625-9. [7] Rigotti NA. Treatment of tobacco use and dependence. N Engl J Med 2002;346:506-512. [8] Lancaster T, Stead L, Silagy C, Sowden A. Effectiveness of interventions to help people stop smoking: findings from the Cochrane Library. BMJ 2000;321:355-8. [9] Methods, Successes, and Failures of Smoking Cessation Programs E B Fisher Jr,, E Lichtenstein, D Haire-Joshu, G D Morgan, H R Rehberg Annual Review of Medicine, February 1993, Vol. 44, Pages 481-513. [10] Agency for Healthcare Research and Quality. The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force, June 2006, p. 120.

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Performance Measure: Toxoplasma Screening	**OPR-Related Measure:** No
Percentage of clients[1] with HIV infection for whom Toxoplasma screening[2] was performed at least once since the diagnosis of HIV infection[3]	
Numerator:	Number of HIV-infected clients who have documented Toxoplasma status in health record
Denominator:	Number of HIV-infected clients who had a medical visit with a provider with prescribing privileges[4] at least once in the measurement year
Patient Exclusions:	1. Patients with known toxoplasmic disease, e.g. *Toxoplasma gondii* encephalitis
Data Elements:	1. Is the client HIV-infected? (Y/N) a. If yes, is there documentation of the client's Toxoplasma status in the health record? (Y/N)
Data Sources:	• Electronic Medical Record/Electronic Health Record • CAREWare, Lab Tracker or other electronic data base • Medical record data abstraction by grantee of a sample of records • Billing records
National Goals, Targets, or Benchmarks for Comparison:	None available at this time
Outcomes Measures for Consideration:	• Toxoplasmosis-related mortality rates in the clinic population • Incidence of Toxoplasmosis in the clinic population
Basis for Selection and Placement in Group 3:	
Toxoplasmic disease appears to occur almost exclusively because of reactivation of latent tissue cysts. Clinical disease is rare among patients with CD4 counts >200 cells/*u*L. The greatest risk is among patients with a CD4 cell count < 50/*u*L. HIV-infected patients with *Toxoplasma gondii* encephalitis (TE) are almost uniformly seropositive for anti-toxoplasma IgG antibodies.[5] The measure is placed in Group 3 because it overlaps and focuses on similar aspects of care (prophylaxis) previously captured in measures included in Group 1. Certain geographic regions have lower rates of toxoplasmic disease.	
US Public Health Guidelines:	
"HIV-infected persons should be tested for immunoglobulin G (IgG) antibody to Toxoplasma soon after the diagnosis of HIV infection to deter latent infection with *T. gondii* (strength of recommendation: BIII)."[6] "*Toxoplasma*-seronegative persons who are not taking a PCP prophylactic regimen known to be active	

HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients: Group 3

against TE should be retested for IgG antibody to *Toxoplasma* when their CD4+ counts decline to <100/*u*L to determine whether they have seroconverted and are therefore at risk for TE (strength of recommendation: CIII)."[7]
References/Notes:
[1] "Clients" refers to all clients aged 13 years and older. [2]Toxoplasma screening refers to testing for the presence of anti-toxoplasma immunoglobulin G (IgG) antibodies to detect latent infection with *Toxoplasma gondii*. [3]Unless there is concern about ongoing exposure, annual re-screening is not generally recommended. [4]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe medications. [5]Centers for Disease Control and Prevention. Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents. June 18, 2008; 1-134. (http://aidsinfo.nih.gov/contentfiles/Adult_OI.pdf) [6]Ibid [7]Ibid

Attachment Q – Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Medical Case Management Group

Defined as of November 2009

- Care Plan
- Medical Visits

HAB HIV Performance Measures: Medical Case Management

Performance Measure: Medical Case Management: Care Plan	
Percentage of HIV-infected medical case management clients[1] who had a medical case management care plan developed and/or updated two or more times in the measurement year.	
Numerator:	Number of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times which are at least three months apart in the measurement year.
Denominator:	Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year.
Patient Exclusions:	1. Medical case management clients who initiated medical case management services in the last six months of the measurement year. 2. Medical case management clients who were discharged from medical case management services prior to six months of service in the measurement year.
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client have a medical case management encounter in the measurement year? (Y/N) i. If yes, is there a case management plan developed and/or updated two or more times at least three months apart during the measurement year? (Y/N) 1. If yes, list the dates of these care plans and/or care plan updates.
Data Sources:	Data reports required by HRSA/HAB, such as the Ryan White Data Report (RDR) and Ryan White HIV/AIDS Program Services Report (RSR), may provide useful data regarding the number of clients identified as receiving medical case management. Electronic databases, such as CAREWare, Provide, ARIES, Lab Tracker, Electronic Medical Record/Electronic Health Record. Case management record[2] chart abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison:	None available at this time.
Outcome Measures for Consideration:	Percent of patients who are retained in medical care in the measurement year. Percent of patients on antiretroviral therapy for whom it is indicated in the measurement year. Percent of patients who are adherent to their treatment regimen in the measurement year.
Basis for Selection:	
The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (P.L. 109-415) indicates that medical case management is a core medical service. Additionally, medical case management services increase access to and retention in medical care. Definition: "Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical	

HAB HIV Performance Measures: Medical Case Management

Performance Measure: Medical Case Management: Care Plan
treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services."[3] Case Management is beneficial in dealing with complex needs of people living with HIV/AIDS: Reduce cost of care by decreasing hospitalization[4] Clients enrolled in case management are 1.5 times more likely to follow drug regimens[5] Improve chances of newly diagnosed HIV-infected persons entering care.[5]
US Public Health Service Guidelines:
None
References/Notes:
[1] "Clients" includes all medical case management clients regardless of age. [2] The client's medical record may be used if case management documentation is located in the client's medical record. [3] "Ryan White HIV/AIDS Program Services Report Instruction Manual, Version 1.3, page 6. [4] Cruise, P.L. & Liou, K.T. (1993). AIDS Case management: a study of an innovative health service [5] Gardner, L.I. Metsch, L.R., Anderson-Mahoney, P., Loughlin, A.M. Et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. AIDS 2005 Mar 4; 19(4): 423-31.

HAB HIV Performance Measures: Medical Case Management

Performance Measure: Medical Case Management: Medical Visits	
Percentage of HIV-infected medical case management clients[1] who had two or more medical visits in an HIV care setting in the measurement year.	
Numerator:	Number of HIV-infected medical case management clients who had a medical visit with a provider with prescribing privileges[2] two or more times at least three months apart in the measurement year that is documented in the medical case management record[3].
Denominator:	Number of HIV-infected medical case management clients who had at least one medical case management encounter in the measurement year.
Patient Exclusions:	1. Medical case management clients who initiated medical case management services in the last six months of the measurement year. 2. Medical case management clients who were discharged from medical case management services prior to six months of service in the measurement year.
Data Element:	1. Is the client HIV-infected? (Y/N) a. If yes, did the client have a medical case management encounter in the measurement year? (Y/N) i. If yes, did the medical case manager document in the medical case management record[3] that the client had two or more medical visits at least three months apart in an HIV care setting in the measurement year? (Y/N) 1. If yes, list the dates of these medical visits.
Data Sources:	Data reports required by HRSA/HAB, such as the Ryan White Data Report (RDR) and Ryan White HIV/AIDS Program Services Report (RSR), may provide useful data regarding the number of clients identified as receiving medical case management. Electronic databases, such as CAREWare, Provide, ARIES, Lab Tracker, Electronic Medical Record/Electronic Health Record Medical case management record[3] chart abstraction by grantee of a sample of records.
National Goals, Targets, or Benchmarks for Comparison	None available at this time.
Outcome Measures for Consideration	Percent of patients who are retained in medical care in the measurement year. Percent of patients on antiretroviral therapy for whom it is indicated in the measurement year. Percent of patients who are adherent to their treatment regimen in the measurement year.
Basis for Selection:	
The Ryan White HIV/AIDS Treatment and Modernization Act of 2006 (P.L. 109-415) indicates that medical case management is a core service. Additionally, medical case management services increase access to and retention in medical care. Definition: "Medical Case management services (including treatment adherence) are a range of client-	

HAB HIV Performance Measures: Medical Case Management

Performance Measure: Medical Case Management: Medical Visits
centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services."[4] Case Management is beneficial in dealing with complex needs of people living with HIV/AIDS: Reduce cost of care by decreasing hospitalization[5] Clients enrolled in case management are 1.5 times more likely to follow drug regimens[6] Improve chances of newly diagnosed HIV-infected persons entering care.[6]
US Public Health Service Guidelines:
None
References/Notes:
[1]"Clients" includes all medical case management clients regardless of age. [2]A "provider with prescribing privileges" is a health care professional who is certified in their jurisdiction to prescribe ARV therapy. [3] The client's medical record may be used if case management documentation is located in the client's medical record. [4] "Ryan White HIV/AIDS Program Services Report Instruction Manual, Version 1.3, page 6. [5] Cruise, P.L. & Liou, K.T. (1993). AIDS Case management: a study of an innovative health service program in Palm Beach County, Florida. Journal of Health & Human Resources Administration, 16, 96-110. [6] Gardner, L.I. Metsch, L.R., Anderson-Mahoney, P., Loughlin, A.M. Et al. Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. AIDS 2005 Mar 4; 19(4): 423-31.

Attachment Q - Supplement 1
Delivery System Reform Incentive Pool (DSRIP) Metrics
Category 5 – HIV Transition Projects

Attachment R - County Listing for MLTSS Eligible Beneficiary Enrollment

Authorized counties for the MLTSS Eligible Beneficiary Enrollment

County Expansion for the MLTSS Eligible Beneficiary program is anticipated to start three years after the initial implementation.

County Name	Plan Model			Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	
Alameda	X			X
Contra Costa				
Fresno				
Kern				
Kings*				
Los Angeles	X			X
Madera*				
Marin**				
Mendocino**				
Merced				
Monterey				
Napa				
Orange			X	X
Riverside	X			X
Sacramento				
San Bernardino	X			X
San Diego		X		X
San Francisco				
San Joaquin				
San Luis Obispo				
San Mateo			X	X
Santa Clara	X			X
Santa Barbara				
Santa Cruz				
Solano				
Sonoma				
Stanislaus				
Tulare				
Ventura*				
Yolo				

Attachment S
Healthy Families Transition to MediCal DHCS Monitoring and Oversight Plan

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of approximately 863,000 Healthy Families Program (Healthy Families) subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. The Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Department of Managed Health Care's (DMHC) focus is to work collaboratively to facilitate a smooth transition, minimize disruption in access to services, maintain existing eligibility gateways, and maintain access to and continuity of care.

This document serves as the framework for the monitoring activities DHCS will undertake during the transition timeline. This will include the collection and reporting of performance metrics and monitoring activities. The performance metrics are consistent with the provisions outlined in the enabling statute for the transition. The efforts undertaken by the Department will provide a process for ongoing data collection, analysis and a means by which DHCS can make adjustments to transition schedules in order to ensure access to and continuity of care. The monitoring will focus on the extent to which the health, dental and mental health plans are meeting the needs of the transitioned children and the extent to which eligibility is maintained for these children.

The monitoring plan also contains the statutorily required performance measures that will be reported monthly or quarterly by a date certain as determined by DHCS. There is overlap with this information and that which will also factor into the monitoring and oversight activities. This information collectively will help DHCS determine the extent to which transitioned children or new applicants under the Optional Targeted Low-Income Children's Program are experiencing difficulties accessing needed healthcare services. This collective data will help to inform DHCS of the extent to which identified issues are plan/county specific, regional or statewide and the needed risk mitigation strategies it must employ. DHCS will use this information to determine the extent to which it must delay transition into a health plan system and/or a given phase until it resolves issues and institutes additional monitoring and oversight activities specific to the identified problem.

PERFORMANCE METRICS AND REPORTING REQUIREMENTS

The following eligibility performance metrics will be reported to DHCS monthly and will be publicly reported.

- Number of applications processed
- Final disposition of each application including information on approved Medi-Cal program and the federal poverty level
- Average number of days to make final eligibility determination for application submitted directly to the county and from the single point of entry (SPE)

The health and dental plans must report the following information, as frequently as determined by DHCS, on a county level basis:

- Grievances related to access to care reported quarterly per the current Medi-Cal managed care contract.
- Continuity of care requests and outcomes reported monthly

- Changes to provider networks, including provider enrollment and disenrollment changes reported quarterly per the current Medi-Cal managed care contract

HEALTH PLAN METRICS

The following plan measures will be used to ensure plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law and will be publicly reported in summary format. As Medi-Cal managed care plan members, transitioning Healthy Families children, as well as newly enrolled children in the Optional Targeted Low-Income Children's Program, will be entitled to all of the same protections and assurances as all other current Medi-Cal beneficiaries.

- Office of the Ombudsman Calls
- Quarterly Health Plan Call Center Reports – tracks the types of calls received from Medi-Cal beneficiaries, trends within each plan and for various
- Annual performance measures – Performance measures cover Health plan Employer Data and Information Set (also known as HEDIS®), utilization management, consumer satisfaction surveys, and Quality Improvement Projects. For 2013, DHCS has incorporated Healthy Families performance measures that were not currently required or covered in Medi-Cal.
- Quarterly Grievance Reports – tracks what kind of grievances were submitted by Medi-Cal members, how the plan resolved them, and in what timeframe. As mentioned above, this report will be used to track grievances submitted by the Healthy Families/Targeted Low-Income Children's Program population.
- Quarterly Provider Network Reports – submitted to both DHCS and DMHC, lists all current providers and track additions and deletions from the last quarterly report and will be used to track enrollment and disenrollment of former Healthy Families providers.

DENTAL PROGRAM METRICS

The following dental program metrics will be used to ensure the provision of covered dental services and will be publicly reported in summary format. The dental plans will be required to provide covered Medi-Cal dental services to their members in accordance with State and federal law. Transitioning Healthy Families children, as well as newly enrolled children in the Optional Targeted Low-Income Children's Program, will be entitled to all of the same protections and assurances as all other current Medi-Cal beneficiaries when seeking covered Medi-Cal dental services under dental managed care or Denti-Cal.

Dental Managed Care Plans:

- Performance Measures/ Utilization Rates (***Attachment I***) reported quarterly.
- Grievances related to access to care reported monthly.
- Continuity of care requests and outcomes reported monthly.

- Changes to provider networks, including provider enrollment and disenrollment changes reported monthly.
- Requests for beneficiary dental exception reporting monthly.

Denti-Cal:

- Performance Measures/ Utilization Rates (***Attachment I***) reported quarterly.
- Grievances related to access to care reported monthly.
- Continuity of care request and outcomes reported monthly.
- Changes to provider networks, including provider enrollment and disenrollment changes reported monthly.
- Beneficiary requests for provider referrals reported monthly.
- Changes to provider referral list online by county reported monthly.

MONITORING PROVISIONS AND RISK MITIGATION STRATEGIES

The following areas will be closely monitored and are in addition to existing efforts currently used by DHCS in these program areas as listed above. These elements for monitoring are specific to the Healthy Families Transition proposal for children who are either transitioned from the Healthy Families Program or are newly eligible under the Optional Targeted Low-Income Children's Program. Children in either circumstance can be tracked by aid code assignment. Such monitoring shall commence upon the effective start date of the transition and shall be in place until June 30, 2014. The identified risk mitigation strategies will be employed to help ensure a smooth transition, minimize disruption in access to services, maintain existing eligibility gateways, and maintain access to and continuity of care.

Health Plans

DHCS currently has an established monitoring and reporting system for its health plans. These monitoring activities are completed regularly to ensure that plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law. As Medi-Cal managed care plan members, transitioning Healthy Families children, as well as children who are part of the new coverage group, the Optional Targeted Low-Income Children's Program, will be entitled to all of the same protections and assurances as all other current Medi-Cal beneficiaries.

- Health Plan Provider Assignments – plans will maintain the primary provider during and after the transition, to the extent possible; for members required to change their primary care doctor, plans will report monthly summary information in the Continuity of Care reports.

- Continuity of Care requests and outcomes – will be reported to DHCS on a monthly basis and will be used to monitor each plan's ability to continue to provide services without disruption of care.

- Time and distance requirements for primary care providers (Geo Access) – used as a component of each plan's provider network adequacy review. Plans that show issues with meeting their time and distance standards for the transition must work closely with both DHCS and DMHC to show increased provider enrollment before transition into the plan will be approved. DHCS and DMHC can request refreshed provider network data at any time.

- Health Plan Grievances/Appeals related to access to care – shall include grievances made to both DMHC and/or to DHCS and shall be evaluated based on significant increases in such activities beyond current trends once the transition begins.

- Member Rights and Program Integrity audits – DHCS performs annual audits on its health plans regarding a plan's record on fulfilling its obligations to its members regarding providing access, responding to grievances, and supplying information.

- Office of the Ombudsman – health plan members that are experiencing difficulties are able to call the Ombudsman's office to report these issues, as well as receive help and guidance. DHCS tracks each call that comes in and is able to run reports on what issues are being reported and by which members of the Medi-Cal population. This helps DHCS to track trends and identify problems by health plan, area, and member category and will be used to track issues with the Healthy Families/Targeted Low-Income Children's Program population.

Dental

Dental Managed Care

DHCS currently has an established monitoring and reporting system for its dental plans. These monitoring activities are completed regularly to ensure that plans are fulfilling their obligation to provide covered Medi-Cal dental services to their members in accordance with State and federal law. As Medi-Cal dental plan members, transitioning Healthy Families children, as well as children who are part of the new coverage group, the Optional Targeted Low-Income Children's Program, will be entitled to all of the same protections and assurances as all other current Medi-Cal beneficiaries.

Dental plans will have the responsibility to ensure continuity of care and access to services. Throughout the transition, DHCS will monitor the transition into these dental plans through a variety of activities. Specifically DHCS will be assessing:

- Provider/Beneficiary customer service lines call volumes.
- Utilization of services by dental plan.
- Dental plan provider utilization.
- Changes to provider assignments for transitioning beneficiaries.
- Patterns in grievances with regard to provider, county, and/or region.
- Substantial shifts in provider networks for counties.

- Call volume and patterns with regards to the Beneficiary Dental Exception process (Sacramento County only).

New dental plan contracts begin in 2013 and include a provision to withhold up to 13 percent of their capitation payment until their annual review is completed. This annual review looks at all performance measures and the degree to which the plan met benchmarks as well as timely submission of deliverables. DHCS will have the ability to issue Corrective Action Plans for deficiencies that are identified with recurring issues based on grievances.

Denti-Cal

As children transition from Healthy Families into the Denti-Cal program, they will begin to receive dental services through an enrolled Denti-Cal provider. The Denti-Cal program will honor prior authorizations from Healthy Families dental plans to ensure continuity of care. Throughout this transition DHCS will monitor grievances, continuity of care requests, changes to the Denti-Cal provider network and provider referral list as well as the Beneficiary Customer Service Line used to beneficiaries in locating an available Denti-Cal provider. Specifically DHCS will be assessing Denti-Cal for:

- Provider/Beneficiary customer service lines call volumes.
- Utilization of services.
- Patterns in grievances with regard to provider, county, and/or region.
- Substantial shifts in provider networks for counties.
- Provider feedback via surveys.
- Beneficiary requests for a provider referral with regard to county and/or region.

In addition to the oversight activities noted above, DHCS also regularly meets with the California Dental Association (CDA) to look at the current Denti-Cal administrative processes for ongoing improvement. Currently DHCS and CDA are working closely to improve the claims adjudication and provider enrollment functions. The Denti-Cal contractor Delta Dental and the department meet regularly on current workload to ensure all activities are implemented in a timely fashion as well as looking at current process improvement.

Dental Communication

DHCS routinely meets with stakeholders in both Los Angeles and Sacramento County to discuss access to care issues and solutions and also held throughout the course of the transition monthly dental transition webinars for the public to convey the updates to the changes to the program with regard to Healthy Families. Lastly, DHCS convenes a dental all-plan meeting to discuss implementation of new dental contracts as well as the HFP transition to ensure there are no concerns from the dental plans.

Behavioral Health

Mental Health Services

Healthy Families children with the most serious mental health illnesses are already known to and served by the county mental health plans (MHPs) given the MHPs' current role in serving the Healthy Families program; in this case, the children will continue to be served by their current providers. The county MHPs will also receive new referrals of former Healthy Families enrollees from Medi-Cal managed care plans or self-referrals for specialty mental health services. Several of the Medi-Cal managed care plans have indicated that for purposes of continuity of care, they will continue to serve former Healthy Families enrollees needing non-specialty mental health services; however, where this does not apply the health plans have the responsibility to refer these children to providers in the Medi-Cal fee-for-service system. Throughout this transition, DHCS will monitor the following:

- Number of new enrollees in county MHPs either referred by managed care plans or self-referred
- Utilization of mental health services by former Healthy Families enrollees as identified by the newly established aid codes
- County MHP enrollment of new providers for specialty mental health services if necessary to meet the needs of new enrollees in county MHPs, and DHCS enrollment of new providers in the Medi-Cal fee-for-service system.

DHCS meets regularly with representatives of the California Mental Health Directors Association (CMHDA) and county mental health plans on at least a weekly basis, and these meetings provide a vehicle to discuss the progress of the transition, any identified problems and their resolution. On a less frequent basis, DHCS also meets with providers of specialty mental health services, and these meetings can also facilitate discussion of the Healthy Families transition from the provider perspective. DHCS will also convene a monthly call with counties, providers and other stakeholders to obtain input on the Healthy Families transition.

Alcohol and Drug Treatment Services

The Drug Medi-Cal program constitutes the major component of the Medi-Cal delivery system for alcohol and drug treatment services, and it provides services through a contracted system that is primarily county administered. DHCS has a small number of direct contracts with Drug Medi-Cal providers. There is flexibility within existing contracts that permits increases in the number of persons served by current county or private providers; therefore, it may not be necessary to add additional Drug Medi-Cal providers to the delivery system. Several of the Medi-Cal managed care plans have indicated that for purposes of continuity of care, they will continue to serve former Healthy Families enrollees needing alcohol and drug treatment services; however, where this does not apply the health plans have the responsibility to refer these children to county alcohol and drug programs. In addition to the health plan referrals, county alcohol and drug programs may also receive self-referrals of former Health Families enrollees. Throughout this transition, DHCS will monitor the following:

- Admissions to Drug Medi-Cal treatment provided by counties, their subcontracted providers or direct contract providers.

- New provider enrollments for Drug Medi-Cal

DHCS meets regularly with representatives of the County Alcohol and Drug Program Administrators Association of California (CADPAAC) and county alcohol and drug programs on at least a weekly basis, and these meetings provide a vehicle to discuss the progress of the transition, any identified problems and their resolution. On a less frequent basis, DHCS also meets with several major alcohol and drug provider associations, and these meetings can also facilitate discussion of the Healthy Families transition from the provider perspective. DHCS will also convene a monthly call with counties, providers and other stakeholders to obtain input on the Healthy Families transition.

Eligibility and Enrollment

DHCS has established and will maintain current efforts for monitoring and oversight of the eligibility and enrollment transitional activities as well as implementation of the new Optional Targeted Low-Income Children's program for new applicants. The primary goal of the eligibility and enrollment processes is to track the number of applications received during the transition, the processing time of such applications (renewals for transitioned cases and new applications) and assisting families to ensure they maintain their eligibility status. These strategies include the following:

- Regular meetings with stakeholders, advocates, counties, county consortia, Certified Application Assistors (CAAs) and MAXIMUS to focus on best practices for retaining children in Medi-Cal.
- Receipt of and analyzing monthly reports related to application processing, annual renewals and disenrollments/terminations.
- Conducting onsite program reviews with counties for adherence to Medicaid Eligibility Quality Control requirements for timeliness and accuracy of Medi-Cal eligibility determinations.
- Maintaining toll free telephone numbers to offer assistance through MAXIMUS, the counties and the State.
- Developing effective strategies with CAA's, health plans ,advocate groups and counties for purposes of outreach and education to ensure families are well informed regarding the transition to Medi-Cal and what it means for them in terms of coverage, their rights and responsibilities and due process protections when dissatisfied with an eligibility determination/premium calculation.

Disenrollment

DHCS has developed transition and ongoing aid codes for children transitioning from Healthy Families and for newly eligible children under the Optional Targeted Low Income Children's Program. The use of aid codes allows DHCS to effectively track these children for purposes of eligibility, enrollment, retention, utilization and cost sharing. DHCS will be tracking the performance measures as well as disenrollment information on a regular basis with interested

stakeholders include counties, county consortia staff, and MAXIMUS, the DHCS administrative vendor responsible for maintaining the Single Point of Entry and premium collection.

Tracking of Disenrollment of Children
Using data from the county consortia and/or the Medi-Cal Eligibility Data System (MEDS), DHCS will be able to analyze the number of children who are disenrolled, the reason for the disenrollment and the extent to which the disenrollment is avoidable versus not. Based on the reason for and the volume of avoidable disenrollment's will allow DHCS to create effective strategies for preventing them. Such strategies could include following up with families who have not returned their annual redetermination paperwork, providing additional assistance to families in gathering any necessary documentation, or providing follow up informational notices to families regarding the necessary actions the family must take to remain eligible.

Key Monitoring Measures
The following measures will be used by DHCS to monitor the transition efforts:

- Network adequacy for health and dental plans
- Primary care assignments for health and dental plan providers
- Ombudsman inquiries for health plans
- Beneficiary/Provider call center inquiries for dental services
- Continuity of care referrals and outcomes
- Grievances and appeals
- Beneficiary satisfaction phone survey
- Disenrollments

DEPARTMENT OF HEALTH CARE SERVICES – HEALTHY FAMILIES PROGRAM TRANSITION TO MEDI-CAL MONITORING OBJECTIVES AND EXPECTED OUTCOMES

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
ELIGIBILITY PROVISIONS				
Objective 1: Transitioning children to Medi-Cal will maintain access to health care coverage				
Enrollment status Upon completion of the transition and effective March 1, 2014, enrollment status to reflect number/percent of children enrolled as AIM-linked infants only.	Number/percent of children enrolled in Medi-Cal by Phase	Monthly	MEDS data	All identified children, per each Phase, will be successfully transitioned from the Healthy Families Program to Medi-Cal.
Disenrollment (other than at annual renewal)	Number/percent of children disenrolled by reason by Phase	Monthly – beginning in February 2013 to allow for the State's noticing process by the counties to the beneficiaries	MEDS data	Disenrollments will be consistent with what was experienced by the Healthy Families Program prior to the transition. Disenrollment results will be used to inform trend analysis and for solutions for future outreach efforts.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Annual renewal	Number/percent of children undergoing annual renewal and determined to be eligible and not eligible by Phase	Monthly, beginning 1/1/13	Counties	Ineligibility at annual renewal will be consistent with what was experienced by the Healthy Families Program prior to the transition. Ineligible results for Medi-Cal can be used as a quality assurance measure for eligibility determination processes.
Maintaining coverage Upon completion of the transition and effective March 1, 2014, enrollment status to reflect number/percent of children enrolled as AIM-linked infants only.	Number/percent of children with disruption of coverage at renewal followed by reenrollment within 3 months, per each applicable Phase	Semi-annually	Counties and MEDS data	Number of children who have a disruption of coverage will be consistent with current reenrollments experienced by the Healthy Families Program. Reenrollment data will be used to inform future outreach efforts.
Complaints/Appeals	Number/percent of appeals or complaints received regarding renewal process or determination	Monthly, beginning 2/1/13 to allow for the data of 1/1/13 to come in and to be tabulated	Counties	Complaints/appeals will be consistent with what was experienced by the Healthy Families Program prior to the transition. Complaints/Appeals will be categorized regarding eligibility processes and will be used to inform future areas of need for additional training of county staff and/or clarification of eligibility processes.
Objective 2: Children applying for coverage under the Optional Targeted Low Income Coverage Program will be correctly and quickly enrolled into Medi-Cal				

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
New applicants	Number of applications/children processed by the counties as received through the Single Point of Entry	Monthly	Counties/MEDS data/ Administrative Vendor	Applications and numbers of child applicants received will be consistent with average numbers experienced by the Healthy Families Program prior to the transition (Average monthly applications are approximately 25,000)
New applicants – approved by aid code	Number/percent of children approved under one of the applicable Optional Targeted Low-Income Children's Program by Aid Code	Monthly on the last day of the month following the data collection month to allow the 58 counties and their three consortia to gather, tabulate, and report the data.	Counties/MEDS data	New Medi-Cal eligibles in the Targeted Low-Income Children's Program will be consistent with enrollments experienced by the Healthy Families Program prior to the transition.
New applicants -- Access to care	Range and average number of days to determine final eligibility for applications submitted to the counties.	Monthly on the last day of the month following the data collection month to allow the 58 counties and their three consortia to gather, tabulate, and report the data.	Counties	Final determination made by county on 90 percent of all cases received within the county offices within 45 days of receipt of a complete application pursuant to county guidance in All County Welfare Directors Letter (ACWDL) 12-33: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
New Applicants -- Access to care	Range and average number of days to determine final eligibility for applications not granted Accelerated Enrollment (AE) by the Single Point of Entry (SPE).	Monthly on the last day of the month following the data collection month to allow the 58 counties and their three consortia to gather, tabulate, and report the data.	Counties	Final determination made by county on 90 percent of all cases received from SPE that did not receive AE within 10 days of receipt of a complete application pursuant to county guidance in ACWDL 12-33: http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/12-33.pdf
ACCESS TO HEALTH CARE SERVICES				
Objective 3: Transitioning children will maintain access to medical care through Medi-Cal managed care plans.				
Children assigned to a primary care provider (PCP) Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Number/percent of children assigned to a PCP per Phase	Monthly	Continuity of Care (COC) Report from Managed Care Health Plans	100 percent of children are assigned to a PCP.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Children maintaining health plan Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Number/percent of children, per applicable Phase (phases 1a, 1b, 1c, and 2), enrolled in same plan following transition	Monthly	Enrollment reports/ Medi-Cal Eligibility Data System (MEDS) data	Children, auto-assigned to Medi-Cal health plan, are able to maintain their current health plan
Children changing health plan, due to access to care or continuity of care concerns	Number/percent of children, for Phase 1A, 1B, 1C, and Phase 2 enrolling in a different plan following transition	Monthly	Enrollment reports/MEDS data	No more than 10 percent of children auto-assigned to a Medi-Cal health plan, change their current health plan due to access to care or continuity of care concerns. (*Phases 1A, 1B and 1C are a transition of members who are in a Healthy Families plan that is also a Medi-Cal managed care plan; thus there should not be many, if any that show as changing health plans due to the transition unless they requested to change*)

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Children unable to remain with primary care provider (PCP) at the time of transition. Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Number/percent of children, for Phase 1A, 1B, 1C, and Phase 2 unable to remain with their PCP at the time of transition	Monthly	Continuity of Care (COC) Report from Managed Care Health Plans	No more than 15 percent of children, auto-assigned to a Medi-Cal health plan, are unable to remain with their PCP at the time of the transition and who must be reassigned to a new contracted PCP.
Provider network changes	Additions/deletions of participating providers by plan	Quarterly	Managed Care Health Plans submit quarterly reports to both DHCS and DMHC	The overall provider network of the plan remains consistent with the network assessed during readiness.
Continuity of Care	Number of continuity of care requests and outcomes for children, per Phase, by plan	Monthly	Managed Care Health Plans	Plans will report all cases of transitioning children receiving or requesting continuity of care.
Consumer satisfaction with health plan	Health Plan call center reports for children, by Phase, by type of inquiry	Quarterly	Managed Care Health Plan Call Center reports submitted to both DHCS and DMHC	The number of complaints and types of complaints related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
	Grievance reports for children, by Phase, by type, resolution and timeframes to resolution	Quarterly	Managed Care Health Plans quarterly reports submitted to both DHCS and DMHC	The number of grievances related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition. . The plans are able to resolve grievances related to access under required timeframes.
	Office of Ombudsman calls from children (including new enrollees), per Phase, by type and by outcome	Quarterly	Call Center Reports	Tracking of calls with reports specific to identified issues and trends, by member category, health plan, and service area Calls related to the HF transition will show minimal access to care issues.
Annual Performance Measures	Results of audit performed by DHCS	Annual	Member Right and Program Integrity Audits	

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
	Health Plan Performance Measures - Health plan Employer Data and Information Set (also known as HEDIS®), utilization management, consumer satisfaction surveys, and Quality Improvement Projects. For 2013, DHCS has incorporated Healthy Families performance measures that were not currently required or covered in Medi-Cal.	Annual	Variety of reports submitted to DHCS from the Managed Care Health Plans	
ACCESS TO DENTAL SERVICES				

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
OBJECTIVE 4: Transitioned children will maintain access to dental care through Medi-Cal Denti-Cal (Medi-Cal dental fee-for-service delivery system)				
Utilization Rates	Annual dental visits	Annually	Denti-Cal Claims Data	Transitioned children will have at least one annual dental visit to the same or higher degree than when enrolled in the Healthy Families Program .
Appointment scheduling timeframes	Number Range and average of days from call to scheduled appointment for HFP transitioning beneficiaries.	Monthly	Denti-Cal Beneficiary Call Center	Ensuring that HFP beneficiaries are receiving timely access to care.
Provider capacity of Denti-Cal	Additions/deletions of participating providers	Monthly	Denti-Cal Provider Enrollment Files	Provider to beneficiary ratios will be maintained/exceed levels as identified in network analysis prior to each transition phase. Denti-Cal/DHCS to implement concentrated provider outreach strategies to ensure adequate number of providers if provider to beneficiary ratios decrease. Denti-Cal will assess the network using the Knox-Keene requirement of 1:2000.
	Percent of Denti-Cal participating providers accepting referrals	Monthly	Denti-Cal Provider Files	

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
	Change in number of providers on provider referral list online by county Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Monthly	Denti-Cal Provider Enrollment Files	Denti-Cal/DHCS to implement concentrated provider outreach strategies to ensure adequate number of providers that can accept new referrals and are added to lists if the online provider referral lists by county start to decrease.
	Number of beneficiary requests for provider referrals by outcome	Monthly	Denti-Cal Beneficiary Call Center	Beneficiaries will have a positive dental experience when locating a dental provider. Additional follow up and claims data assessment with beneficiaries and providers who utilize this service will measure the success of making active appointments. Concentrated outreach to providers will occur to ensure adequate numbers of providers to accept new referrals if areas of concern are identified. Newly enrolled providers will be added to the online referral list.
	Number/percent and county of HFP transitioning children receiving referral to a provider in another county	Monthly	Denti-Cal Beneficiary Call Center	Ensure beneficiaries are receiving care in a timely manner and that they are able to access providers within their geographic location. Utilize results to increase provider outreach in the given areas of concern.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Continuity of Dental Care	Monthly number/percentage of HFP transitioning children with warm transfers resulting in a successful referral to a dentist and percentage resulting in a first appointment	Monthly	Denti-Cal Beneficiary Call Center	Assessing the success of the warm transfer process as well as analyzing the areas in which appointments were unable to be made.
	The number of approved HFP prior authorizations for treatments and services that transfer from HFP dental providers to Denti-Cal Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Quarterly	Denti-Cal Claims Services	Ensure that providers are utilizing the use of previous prior authorizations for the transitioning members.
Consumer Satisfaction with Denti-Cal	Number and reason for Beneficiary Customer Service calls	Monthly	Denti-Cal Beneficiary Call Center	Beneficiary Customer Service line tracks all Denti-Cal beneficiary calls by category. DHCS will report on the customer service line, if cannot report by aid code (this is not done today) then will report for the line on the whole and will include the HFP population.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
	Number of monthly dental related appeals	Monthly	Denti-Cal Claims Processing	Number of appeals to assess the number of denied services to providers who claim services. This will allow us to assess the process for providers.
	Number and reason for requested grievances	Monthly	Denti-Cal Grievances	Types of grievances reported will be assessed to make necessary changes and outreach for current phases as well as future phases.
Performance Measures	Eleven performance measures will be measured on an ongoing basis.	Quarterly	Denti-Cal Claims Data	All performance measures are met based on established standards Corrective action plans implemented for non-adherence Measures are reviewed/revised annually.
Objective 5: Transitioned children will maintain access to dental care through Medi-Cal dental managed care plans.				
Utilization Rates	Annual dental visit	Annually	Dental Managed Care Plans	Transitioned children will have the ability to access dental services for an annual dental visit.
Provider capacity of dental plans	Additions/deletions of participating providers by plan	Monthly	Dental Managed Care Plans	Provider to beneficiary ratios will be maintained/exceed levels as identified in network analysis prior to each transition phase. Dental plans to implement concentrated provider outreach strategies to ensure adequate number of enrolled providers if provider to beneficiary ratios decrease beyond expected standards.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Continuity of Dental Care Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Number of continuity of care requests and outcomes for Phases 1B, 2 and 3 children, by plan. The number of prior authorizations for treatments and services that transfer from HFP dental providers to Dental Managed Care	Monthly	Dental Managed Care Plans Consumer Satisfaction Survey	Continuity of care requests and outcomes will be monitored monthly. Dental plans will develop care plans for transitioning beneficiaries that will not continue treatment with current Primary Care Dentists after transitioning to Medi-Cal. Beneficiary consumer surveys will demonstrate positive experiences with Medi-Cal dental managed care plans
Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Beneficiary dental exception (BDE) requests - call center reports for Phase 1B and 3 children	Monthly	Sacramento County Dental Managed Care Plans	Transitioned children will have access to dental services within Sacramento County within prescribed timelines and will not move into Denti-Cal. The BDE process is only available for those beneficiaries in a Sacramento dental managed care plan given the fact that individuals are mandatorily enrolled in dental managed care in this county it is not needed for Phase 2 plans in LA County as LA County for purposes of dental managed care allows for voluntary enrollment into the plan.
Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting.	Grievance reports on access to care.	Monthly	Dental Managed Care Plans	Grievances will be assessed for access to care issues. lf an area(s) of concern is identified, dental plans will perform concentrated provider outreach to ensure adequate number of enrolled providers to service beneficiaries.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Performance Measures	Eleven performance measures for Phase 1B, 2 and 3 children (see Attachment I)	Quarterly	Dental Managed Care Plans	All performance measures are met based on established standards Corrective action plans implemented for non-adherence Measures are reviewed/revised annually.
ACCESS TO MENTAL HEALTH SERVICES				
OBJECTIVE 6: Transitioned children will maintain access to mental health services				
HFP children and youth receiving specialty mental health services	Number of transitioned HFP children and youth receiving services from the county MHPs.	Monthly	Bi-Weekly Calls & Short Doyle Claim History (which will have a lag)	The number of unique HFP children and youth receiving care from the county MHPs will be similar to the number served before the transition. All referral process issues, access, transition issues, barriers, best practices, and other transition issues will be facilitated by DHCS through bi-weekly calls with county mental health directors.
Consumer Satisfaction - Ombudsman Calls	Number and outcome of calls associated with transitioned HFP children and youths access to services	Monthly	DHCS Mental Health Ombudsman tracking system	Assist with problems accessing county MHP services Monitor resolutions to beneficiaries' difficulties accessing services, finding a provider, and general questions/issues with the HFP transfer.
MHP Claims	Number of claims with a transitioned or Optional Targeted Low Income Children's Program Aid Code	Monthly (with initial two-month lag)	Shorty-Doyle/Medi-Cal Claims system	Use of SMHS services

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Calls with the California Mental Health Directors Association (CMHDA) and County MHPs Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting as long as ad hoc calls can be scheduled as needed.	Number of calls	Monthly	Weekly calls	Learn the progress of the transition, any identified problems and determine their resolution Convene meetings as necessary or serve as liaisons between county MHPs and Medi-Cal managed care plans to address issues of coordination and provide a feedback loop to ensure resolution of any concerns

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Calls with county MHPs, providers, stakeholders and CMS Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting as long as ad hoc calls can be scheduled as needed.	Number of calls	Monthly	Monthly calls	Obtain input on the Healthy Families transition Identify any real or perceived problems and determine steps for resolution
ACCESS TO ALCOHOL AND SUBSTANCE USE SERVICES				
OBJECTIVE 7: Transitioning children will maintain access to alcohol and substance use services				
HFP children and youth receiving SUD treatment services	Number of transitioned HFP children and youth receiving SUD services the county alcohol and drug programs.	Monthly	Bi-Weekly Calls & Short-Doyle claim history (which will have a lag)	Able to account how many beneficiaries seek SUD treatment services, from county alcohol and drug programs. All referral process issues, access, transition issues, barriers, best practices, and other transition issues will be facilitated by DHCS through bi-weekly calls with county alcohol and drug program administrators. In working with Department of Alcohol and Drug Programs, the number of complaints to the Alcohol and Other Drug service system complaint phone lines will be consistent with what normally experienced.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Number of DMC Providers	Number of DMC certified providers	Monthly	DHCS DMC Tracking log	New DMC providers
Drug Medi-Cal (DMC) Claims	Number of claims with a transitioned or Optional Targeted Low Income Children's Program Aid Code	Monthly (with initial two-month lag)	Shorty-Doyle/Medi-Cal Claims system	Use of DMC services
Calls with County Alcohol and Drug Program Administrators Association of California (CADPAAC) and county alcohol and drug program administrators Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting as long as ad hoc calls can be scheduled as needed.	Number of calls	Monthly	Weekly calls	Learn the progress of the transition, any identified problems and determine their resolution Convene meetings as necessary or serve as liaisons between county alcohol and drug program administrators and Medi-Cal managed care plans to address issues of coordination and provide a feedback loop to ensure resolution of any concerns

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Calls with county alcohol and drug program administrators, providers, stakeholders and CMS Upon completion of the transition and effective March 1, 2014, this information can be omitted from reporting as long as ad hoc calls can be scheduled as needed.	Number of calls	Monthly	Monthly calls	Receive input on the Healthy Families transition Identify any real or perceived problems and determine steps for resolution

The following health plan measures will be used for 6 months after implementation to ensure plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Office of the Ombudsman Calls
Monthly Health Plan Call Center Reports – tracks the types of calls received from Medi-Cal beneficiaries and trends within each plan

Monthly Grievance Reports – tracks what kind of grievances were submitted by Medi-Cal members, how the plan resolved them, and in what timeframe.
Quarterly Provider Network Reports – submitted to both DHCS and DMHC, lists all current providers and track additions and deletions from the last quarterly report.

Health Plans

DHCS currently has an established monitoring and reporting system for its health plans. These monitoring activities are completed regularly to ensure that plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal law.

Health Plan Provider Assignments – plans will assign new enrollees within the contractual timeframes and allow member choice of Primary Care Providers.

Continuity of Care requests and outcomes – will be reported to DHCS on a monthly basis and will be used to monitor each plan's ability to continue to provide services without disruption of care.

Time and distance requirements for primary care providers (Geo Access) – used as a component of each plan's continued provider network adequacy review. Plans that show issues with meeting their time and distance standards for the transition must work closely with both the State to show provider access and/or alternative access as part of the monitoring

Health Plan Grievances/Appeals related to access to care – shall include grievances made to the State and shall be evaluated, including evaluating trends, s once the transition begins.

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Office of the Ombudsman – health plan members that are experiencing difficulties are able to call the Ombudsman's office to report these issues, as well as receive help and guidance. DHCS tracks each call that comes in and is able to run reports on what issues are being reported and by which members of the Medi-Cal population.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
ENROLLMENT PROVISIONS: To be collected and reported for 6 months after transition				
Objective 1: Transitioning beneficiaries to Medi-Cal managed care will maintain access to health care coverage				
Enrollment status	Number/percent of beneficiaries enrolled in Medi-Cal Managed Care Identify choosers vs. those defaulted (non COHS only) Identify those who were defaulted who were linked (non COHS only)	Monthly[a]	MEDS data	Accurate count of the number of beneficiaries enrolled by health plan and county
MERs(non COHS only)	Number submitted Number approved/denied Number pending/ Number pending for greater than 60 days	Monthly[a]	DHCS tracking system	Number of MERs submitted will trend downward after the transition begins
ACCESS TO HEALTH CARE SERVICES: To be collected and reported for 6 months after transition				

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Objective 2: Transitioning beneficiaries will maintain access to medical care through Medi-Cal managed care plans.				
Beneficiaries assigned to a primary care provider (PCP)	Number/percent of beneficiaries assigned to a PCP	Monthly[a]	Continuity of Care (COC) Report from Managed Care Health Plans	100 percent of beneficiaries are assigned to a PCP within 30 days of enrollment.
PCP changes by plan	Number of beneficiaries who change PCP within plan	Monthly[a]		Expect less than 10% after the first quarter of transition
Beneficiaries changing health plan, due to access to care or continuity of care concerns for counties that have two plans	Number/percent of beneficiaries enrolling in a different plan after month 1 and reason for change Compare beneficiaries who were auto-enrolled vs. those who their chose health plan, where applicable	Monthly[a]	Enrollment reports/MEDS data	No more than 10 percent of beneficiaries auto-assigned to a Medi-Cal health plan, change their current health plan due to access to care or continuity of care concerns.
Provider network changes	Additions/deletions of participating providers by plan	Quarterly[b]	Managed Care Health Plans submit quarterly reports	The overall provider network of the plan remains consistent with the network assessed during readiness.
Continuity of Care	Number of continuity of care requests and outcomes for beneficiaries, by plan	Monthly[a]	Managed Care Health Plans	Plans will report all cases of transitioning beneficiaries receiving or requesting continuity of care.

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
Consumer satisfaction with health plan	Health Plan call center reports for beneficiaries by type of inquiry	Monthly[a]	Managed Care Health Plan Call Center reports submitted	The number of calls and types of calls related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition.
Grievance reporting	Grievance reports for beneficiaries, by type, resolution and timeframes to resolution	Monthly[a]	Managed Care Health Plans quarterly reports submitted	The number of grievances related to access to care and continuity of care with consideration of the transition taken into account. The expectation is that there will be a decrease each month following the transition. . The plans are able to resolve grievances related to access under required timeframes.
	Office of Ombudsman calls from beneficiaries (including new enrollees), by type and by outcome	Monthly[a]	Call Center Reports	Tracking of calls with reports specific to identified issues and trends, by member category, health plan, and service area Calls related to the 2013 managed care transition will show minimal access to care issues.
PROVIDER CREDENTIALING SCREENING: To be collected and reported for at least 6 months after each transition				
Objective 3: Plans shall follow administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse				

CRITERIA	METRIC	FREQUENCY	DATA SOURCE	EXPECTED OUTCOME
All cases of suspected fraud and/or abuse	Number of cases of suspected fraud and/or abuse, including 1) Source of complaint, 2) Type of provider, 3) Nature of complaint, 4) Approximate dollars involved, and 5) Legal and administrative disposition of the case.	Monthly[a]	Fraud and Abuse Reporting by Plans	All allegations of suspected fraud should be tracked and triaged by the state.

[a]Due 15 days from end of the calendar month. Upon completion of the transition and effective March 1, 2014, these items are due 20 days after the end of the reported calendar month.
[b]Due 21 days after close of the quarter

Attachment U - CCI Enrollment Timeline by Population and County

The following dates reflect the earliest date that Coordinated Care Initiative (CCI) enrollment may take effect in each CCI county. CMS and the state can mutually agree at any time to modify this timeline and structure as necessary.

In general, Cal MediConnect enrollment begins no earlier than April 2014 with passive enrollment in San Mateo; and "opt-in" in Riverside, San Bernardino, San Diego and Los Angeles counties. CCI will begin no earlier than April 2014 in Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo and no earlier than January 2015 in Santa Clara counties. Orange County is on hold, until DHCS has completed an audit of CalOptima's Medicaid Plan Orange County. At that time, CMS and the state will update this attachment to establish an appropriate timeline for enrollment in Orange County. Alameda County is also on hold and CMS and the state will update this attachment in the future to establish an appropriate timeline for enrollment in Alameda County.

	Cal MediConnect (Passive enrollment)				**MLTSS (Mandatory enrollment)**								
	Full Duals Only				**Full Duals in Medi-Cal FFS**			**Full Duals in Medi-Cal Managed Care**			**MSSP**	**Partial Duals/ Medi-Cal**	
Start Date	Full Duals in Medicare FFS enrolled already in Medi-Cal Managed Care plan **(enrolled in one month)**	Full Duals in Medicare FFS and Medi-Cal FFS **(enrolled by birth month)**	MSSP Benes eligible for Cal Medi-Connect **(enrolled in one month)**	Full duals in a MA plan / Part D LIS **(enrolled in one month)**	Opt out of CMC and in Medi-Cal FFS **(enrolled by birth month)**	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal FFS **(enrolled by birth month)**	Full Duals in MA plans or LIS reasignees in Midi-Call FFS **(enrolled in one month)**	Full Duals in Medi-Cal managed care plan **(benefit added in one month)**[1]	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal Managed care **(benefit added in one month)**[1]	MA benes or LIS asignees in Medi-Cal managed care plan **(benefit added in one month)**[1]	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS **(enrolled in one month)**	Partial Dual/SPD already in Medi- Cal managed care **(benefit added in one month)**[1]	Partial Dual/SPD in Medi-Cal FFS **(enrolled by birth month)**
4/1/14	San Mateo		San Mateo					Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	San Mateo (Full Duals in MA plan or excluded CMC)		
5/1/14	Riverside, San Bernardino, and San Diego	Riverside, San Bernardino, and San Diego[2]			Riverside, San Bernardino, and San Diego								

Attachment U - CCI Enrollment Timeline by Population and County

	Cal MediConnect (Passive enrollment)				MLTSS (Mandatory enrollment)								
	Full Duals Only				Full Duals in Medi-Cal FFS			Full Duals in Medi-Cal Managed Care			MSSP	Partial Duals/ Medi-Cal	
Start Date	Full Duals in Medicare FFS enrolled already in Medi-Cal Managed Care plan **(enrolled in one month)**	Full Duals in Medicare FFS and Medi-Cal FFS **(enrolled by birth month)**	MSSP Benes eligible for Cal Medi-Connect **(enrolled in one month)**	Full duals in a MA plan / Part D LIS **(enrolled in one month)**	Opt out of CMC and in Medi-Cal FFS **(enrolled by birth month)**	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal FFS **(enrolled by birth month)**	Full Duals in MA plans or LIS reasignees in Midi-Call FFS **(enrolled in one month)**	Full Duals in Medi-Cal managed care plan **(benefit added in one month)**[1]	Excluded from CMC (ESRD, Kaiser, 1915c waiver) and in Medi-Cal Managed care **(benefit added in one month)**[1]	MA benes or LIS asignees in Medi-Cal managed care plan **(benefit added in one month)**[1]	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS **(enrolled in one month)**	Partial Dual/SPD already in Medi- Cal managed care **(benefit added in one month)**[1]	Partial Dual/SPD in Medi-Cal FFS **(enrolled by birth month)**
7/1/14	Los Angeles	Los Angeles			Los Angeles			Santa Clara	Santa Clara	Santa Clara	San Mateo (Partials and Medi-Cal Only)	Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa	
8/1/14			Los Angeles, Riverside, San Bernardino, & San Diego			Los Angeles, Riverside, San Bernardino, San Diego' and Santa Clara							Los Angeles, Riverside, San Bernardino, San Diego' and Santa Clara
1/1/15	Santa Clara	Santa Clara	and Santa Clara	, Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	Santa Clara		Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara						

1. Enrollees already in a Medi-Cal managed Care plan will receive one notice prior to the change in benefit.

2. There are no FFS Medi-Cal Enrollees in Orange and San Mateo counties.

3. Enrollees with April and May birthdays will be enrolled in May 2014. Then follow enrollment schedule by birth month.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Enrollment Status	The plan selection and mandatory enrollment numbers and percentages for beneficiaries eligible for Managed Long Term Services and Supports (MLTSS) will be tracked in each MLTSS county.	Monthly	MEDS Data	100 percent of beneficiaries eligible for MLTSS will either make a plan selection, or be passively enrolled in each MLTSS county.
Plan Changes	The number of beneficiaries that changed health plans in Geographic Managed Care and wo-Plan model counties.	Monthly	MEDS Data	The number of plan changes by plan and county will be monitored. No more than 10% auto-assigned to a health plan will change plans due to access to care or continuity of care concerns.
Primary Care Provider Assignment	Number of MLTSS beneficiaries assigned to a Primary Care Provider.	Monthly	Monitoring Report from Health Plans	100% of Medi-Cal only and Partial Duals without Medicare Part B beneficiaries that are mandatorily enrolled or make a plan choice will be assigned a primary care provider within 30 days.
Benefit Package	DHCS will ensure, through ongoing surveys and readiness and implementation monitoring, that Health Plans provide for enrollees long-term services and supports in care settings appropriate to their needs.	Quarterly	DHCS	The State will assure compliance with the characteristics of home and community based settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates published in the Federal Register.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Plan Readiness – Initial and Ongoing	The State shall submit to CMS its plan for ongoing monitoring of Health Plans.	Quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter	DHCS	Network adequacy will be verified on a quarterly basis for the first year. Plan readiness will be conducted in similar manner to HF and Geographic Expansion. Readiness assessments will be aligned with the Cal MediConnect reporting where possible. The State will complete a network certification for each county. The State will assess and monitor health plan capacity for the MLTSS population.
Participant Rights and Safeguards – Information – Network Adequacy Requirements	In addition to the network adequacy requirements set forth at 42 CFR 438, the state must: i. Require plan to refer everyone eligible for IHSS to the county social services agency and support member transition. ii. Require plan to refer all IHSS recipients to the Public Authorities network of IHSS workers/providers who will be providing services while the recipient waits for a county IHSS	This information is due to CMS prior to implementation and every 6 months afterward for the term of the demonstration.	DHCS	DHCS will ensure health plans maintain and provide the Public Authority contact information for the adequate network of IHSS workers/providers to support member transition. DHCS will ensure adequate MOUs are in place to ensure access to care between plan, county and MSSP Sites. DHCS will ensure health plans refer all persons eligible for the Multipurpose Senior Services

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	worker or the normal IHSS worker cannot provide services. iii. Have plans submit MOUs between the plan, the counties and MSSP Sites. v. Require plan to offer a care coordinator to everyone on a MSSP waitlist when the MLTSS member is waiting for a MSSP slot with a contracted MSSP Sitevi. Require plan to refer IHSS recipients who are awaiting a caregiver to other HCBS benefits (CBAS, MSSP) or work with community based organizations and resources to help bridge the gap to meet their needs. vii. Require state to identify all nursing facilities that house MLTSS members. viii. Plans should demonstrate adequate capacity in their contracted nursing homes.			Program (MSSP) to all contracted MSSP Sites. Ensure the availability of plan care coordinators for members waiting for Multipurpose Senior Services Program (MSSP) slot. Ensure health plans refer IHSS recipients awaiting a caregiver to other HCBS benefits (CBAS, MSSP) to help meet / bridge their needs. Ensure health plans will work with community based organizations and resources to help IHSS recipients bridge the gap to meet their needs until they begin to receive IHSS. DHCS will monitor the nursing facilities that house MLTSS members and show the percent that have been contracted by each plan. Health plans will track and monitor all facilities that house MLTSS members including the number and percent of facilities contracted per plan to ensure adequate capacity in contracted nursing homes.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Quality Oversight and Monitoring – Measurement Activities	The state shall develop mandatory health plan reports related to the critical elements of MLTSS, including areas such as network adequacy; timeliness of assessments, MLTSS authorizations, service plans and service plan revisions; plan changes; utilization data; call monitoring; quality of care performance measures; fraud and abuse reporting; participant health and functional status; complaint and appeal actions. These reporting requirements must be specified in the health plan contract. DHCS must provide reports to CMS to demonstrate their oversight of the key elements of the MLTSS program. The state shall measure key experience and quality of life indicators for MLTSS participants. The measures must be specific to the needs of MLTSS participants and data must be collected using	Annually	DHCS	DHCS will ensure ongoing monitoring of individual wellbeing and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts DHCS will analyze health plan reports as part of its quality oversight and based on the results, take corrective action as needed to ensure compliance. DHCS will obtain, monitor, evaluate, and make information on key experience and life indicator information including actions taken available to advisory groups for discussion, and publicly post results. DHCS will use performance measures Quality Strategy/reports to develop health plan report cards that are public, transparent, easily-understandable and useful to participants in choosing a health plan.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	best practices for reaching special populations (e.g., phone or in-person as opposed to mail). Results of the surveys must be maintained by the state and report to CMS, along with any action(s) taken or recommended based on the survey findings. The EQRO should validate the survey results for the state. The state must analyze the results, make them available to its stakeholder advisory groups for discussion, publicly post the results on its website, and provide the results in print upon request for individuals without access to a computer.			
Complaints/Appeals	Number/percent of appeals or complaints	Monthly	Managed Care Health Plans	Complaints and grievances will be consistent with what was experienced by MLTSS members prior to transition. The plans must resolve grievances within required timeframes.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
Provider Network Changes	Additions/deletions of participating providers by plan	Quarterly	Managed Care Health Plans submit quarterly reports to DHCS	The overall provider network of the plan will remain consistent with the network assessed during readiness.
Continuity of Care	Number of Continuity of Care requests and outcomes for MLTSS members	Monthly	Managed Care Health Plans	Health plans will report all cases of transitioning MLTSS members receiving or requesting continuity of care.
Consumer Satisfaction with Health Plan	Health Plans Call Center Report for MLTSS members by type of inquiry	Quarterly	Managed Care Health Plans submit quarterly reports to DHCS	Health plans will ensure the number of complaints and types of complaints related to access to care and continuity of care with consideration to the transition taken into account. The expectation is that there will be a decrease each month following the transition.
Support and Retention of Community Placement	Members that are referred to the Home and Community-Based Services (HCBS) waivers are assessed for the HCBS waiver	Quarterly	Health Plans	Health Plans will refer members to appropriate services that support retention of community placement.

Attachment V – MLTSS Monitoring Items

The following health plan measures will be used to ensure plans are fulfilling their obligation to provide covered MLTSS services to their members in Coordinated Care Initiative (CCI) counties in accordance with State and federal law and will be publicly reported in summary format by health plan and by county. CMS and the state can mutually agree at any time to delete, modify or add new metrics to the monthly report, as determined necessary to improve reporting going forward.

Criteria	Metric	Frequency	Data Source	Expected Outcome
	Members that are referred to IHSS are assessed by the county social services agency for IHSS Members newly admitted to nursing facilities without a discharge plan in place were first afforded supports and services in the community Number and proportion of beneficiaries who transitioned to the community from an institution and did not return to the institution, excluding post hospital rehabilitation, within a year. Number and proportion of beneficiaries receiving LTSS in the community along with number and proportion of beneficiaries receiving LTSS in an institution.			Health Plans will track and monitor the number of referrals made to HCBS waivers and the number of completed assessments performed by the HCBS providers Health Plans will track and monitor the number of IHSS referrals made to the county social services agency and the number of completed assessments performed by the county social services agency. Health Plans will track and monitor the number of referrals made to HCBS programs for newly admitted NF residents without discharge plans in place. If the evaluation indicates an increase in NF placement rather than community replacement, the rates will be adjusted to create an incentive to keep beneficiaries in community placement.

Attachment W
Community-Based Adult Services (CBAS)
Provider Standards of Participation

A. General Provider Requirements

To become a Medi-Cal Community-Based Adult Services (CBAS) provider, the prospective provider must first obtain an Adult Day Health Care (ADHC) center license, issued by the California Department of Public Health and apply for certification for enrollment in Medi-Cal to the Department of Health Care Services (DHCS) or its designee*. Upon meeting the criteria for certification and Medi-Cal provider enrollment, the ADHC center licensee will be certified as a CBAS provider. This specific waiver provider designation will afford CBAS providers the opportunity to deliver outpatient CBAS center services to eligible Medi-Cal beneficiaries (referred to as CBAS participants) in a community setting.

CBAS providers shall:

1. Meet all applicable licensing and certification, as well as Medi-Cal and waiver program standards, as described or referenced in this document;
2. Adhere to these waiver Standards of Participation (SOPs);
3. Enter into contracts with Medi-Cal managed care plans within the provider's geographic area to provide CBAS center services to Medi-Cal plan members;
4. Provide services in accordance with the CBAS participant's Individual Plan of Care (IPC);
5. Adhere to the documentation, training, and quality assurance requirements identified in the Centers for Medicare and Medicaid Services (CMS)-approved 1115 waiver (#11-W-00193/9), inclusive of all the Special Terms and Conditions (STCs) contained therein; and
6. Demonstrate ongoing compliance with the requirements specified in these SOPs.

*****The California Department of Aging (CDA) is DHCS' designated representative for the certification of CBAS providers. Future reference in these SOPs will specify CDA.

B. CBAS Center Services

A CBAS provider shall provide services at the ADHC center, pursuant to a CBAS participant's IPC, developed by the center's multidisciplinary team. These services shall include all of the following, as specified in a CBAS participant's IPC, during a minimum of a four-hour stay at the center. Any length of stay under four hours will not be reimbursed. The CBAS provider is responsible for documenting the provision of at least four hours of CBAS to each participant at the center.

1. Core services: each CBAS participant shall receive ALL of these services on each day of attendance at the center:
   a. Professional nursing.
   b. Therapeutic activities.
   c. Social services and/or personal care services.
   d. One meal offered per day.

2. Additional services: each CBAS participant shall receive the following services as needed and as specified in his/her IPC:
   a. Physical therapy.
   b. Occupational therapy.
   c. Speech therapy.
   d. Mental health services
   e. Registered dietitian services.

3. Transportation to and from the center and the participant's place of residence, shall be arranged or provided as needed.

C. Legal Authority and Requirements.

1. CBAS providers shall:
   a. Deliver services in licensed ADHC centers in accordance with Health and Safety (H&S) Codes under Division 2, Chapter 3.3 and shall provide services in accordance with the California Code of Regulations (CCR), Title 22 under Division 5, Chapter 10 and with the CMS-approved waiver document(s).
   b. Be certified and enrolled as Medi-Cal providers and shall meet the standards specified in the Welfare and Institutions Codes under Division 9, Chapter 8.7; in the CCR, Title 22 under Division 3, Chapter 5; and as set forth in these SOPs.
   c. Apply for certification. The application review includes, but is not limited to, evaluation of the provider legal entity and associated individuals to ensure there are no restrictions on their Medi-Cal/Medicaid enrollment status.
   d. Apply for recertification as Medi-Cal providers at least every 24 months and be subject to an application review as specified in Subsection C.1.c. and an onsite review. The onsite review includes, but is not limited to, evaluation of administrative systems and processes, staffing, and the appropriateness and quality of services delivered. Recertification is contingent upon the provider's demonstration of continuing compliance with standards for participation in the Medi-Cal program.

2. If there is a change in adopted laws or regulations governing the licensing of ADHC centers and/or the certification of CBAS providers, these SOPs shall be interpreted in such a manner as to be in conformance with such laws or regulations.

D. Physical Plant and Health and Safety Requirements.

To ensure the health and safety of the CBAS participants, the physical plant of each center shall conform to the requirements of applicable sections of Title 22 of the CCR as described in part by the following:

1. Physical accommodations – Designed, equipped, and maintained to provide for a safe and healthful environment. Each center shall:
   a. Comply with state and local building requirements and codes.
   b. Be maintained in conformity with the regulations adopted by the State Fire Marshal.
   c. Have a working, listed telephone number.

d. Have a working FAX number.
e. Have a working email address.
f. Have electronic equipment, including computers and software, adequate to comply with State CBAS reporting requirements.
g. Have a working heating and cooling system.
h. Have adequate lighting.
i. Have appropriate water supply and plumbing.

2. Space Requirements – Demonstrate all of the following, to include but not be limited to:
   a. Available space sufficient to accommodate both indoor and outdoor activities and store equipment and supplies.
   b. A multipurpose room large enough for all participants to gather for large group activities and for meals.
   c. A secluded area that is set aside for participants who require bed rest and privacy during medical treatments or social service interventions.
   d. Appropriate office area(s).

3. Maintenance and Housekeeping – Be clean, safe, and in good repair at all times; maintenance shall include provisions for cleaning and repair services.

4. Safety – Have appropriate protective devices to guard against hazards by means of supervision, instruction, and installation.

5. Supplies – Maintain sufficient supplies for functional operation and meeting the needs of the participants.

6. Solid Waste – Provide for the storage and disposal of solid waste according to the standards set forth in Title 22.

E. CBAS Eligibility Determination and Authorization

Eligibility determination and authorization for CBAS shall be determined as specified in the CBAS STCs and as follows:

1. A Treatment Authorization Request (TAR) or other agreed upon authorization document shall be prepared by the CBAS provider and submitted to the managed care plan, or to DHCS for beneficiaries exempt from enrolling in a managed care plan, for each beneficiary seeking CBAS. TARs for CBAS must be supported by the participant's IPC.
2. Reauthorization TARs for CBAS must be submitted to the appropriate reviewer at least every six months, or up to 12 months as specified in the STCs, and must continue to be supported by the participant's IPC.

3. Authorization timeframes shall be in accordance with H&S Code 1367.01 and State Medi-Cal regulations and policy.

F. Individual Plan of Care (IPC)

The participant's IPC shall:

1. Be developed by the CBAS center's multidisciplinary team and signed by representatives of each discipline required to participate in the multidisciplinary team assessment.

2. Be the result of a collaborative process among the CBAS provider, the participant, and if applicable, the participant's authorized representative(s) and/or managed care plan.

3. Be signed by either the CBAS provider's physician or the participant's personal health care provider. "Personal health care provider" may include a physician assistant or nurse practitioner within their scope of practice under the appropriate supervision of the physician.

4. Be based on a person-centered planning process and meet the requirements specified in the CBAS STCs.

5. Be based on assessment or reassessment conducted no more than 30 days prior to the start date of the IPC. If the CBAS participant is a Medi-Cal managed care member and the participant's plan requires submission more than 30 days prior to the IPC effective date, the CBAS provider must identify any change in condition requiring IPC amendment prior to implementation and amend it accordingly if a change to the IPC is needed.

G. CBAS Staffing

1. A CBAS provider shall employ or contract with a variety of staff and render required services as described in these SOPs. The staff providing CBAS center services shall meet all licensing requirements as specified in the California Business and Professions Code, as well as these SOPs, as appropriate to the individual staff person. A CBAS provider's staffing requirements shall be based on the provider's hours of service and the average daily attendance (ADA) from the previous three consecutive months. The ADA can also be tied to ADA levels on various days of the week so long as the CBAS provider can demonstrate that the ADA for those days are consistent.
   a. "Hours of service" means the program hours for the provision of CBAS, which shall be no less than 4 hours excluding transportation. The hours of service shall be defined and posted by the adult day health care center.

2. Professional nursing coverage of the center shall include Registered Nurse (RN) staffing at a ratio of one RN for every 40 participants in ADA, or one RN for the first 40 participants and a half-time Licensed Vocational Nurse (LVN) for every increment of 10 in ADA exceeding 40 participants.
   a. There shall be at least one licensed nurse physically present and performing nursing duties at the center at all times during the center's hours of service during which participants are present. The licensed nurse physically present may be an LVN,

providing the LVN is under the supervision of the RN, is working within scope of practice, and the RN is immediately available by phone if needed.

3. Social services staffing must include social workers at a ratio of one medical social worker for every 40 participants in ADA, or one medical social worker for the first 40 participants and a half-time social worker assistant for every increment of 10 in ADA exceeding 40 participants.

4. The program aide staffing shall be at a ratio of one program aide on duty for up to and including 16 participants
   a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
   b. Any number of participants up to the next 16 shall require an additional program aide (for example, 17 participants require two program aides).

5. Participants' needs supersede the minimum staffing requirements specified in these SOPs. The CBAS provider shall be responsible for increasing staffing levels as necessary to maintain the health and safety of all participants and to ensure that services are provided to all participants according to their IPCs.

6. Physical, occupational, and speech therapy, and mental health services shall be provided at a minimum monthly rate of 20 total therapy hours for each increment of five participants in ADA.

H. Organization and Administration

The CBAS center shall be organized and staffed to carry out the services and other requirements specified in the waiver. Such organization shall include:

1. An administrator and full-time program director. An administrator or program director must be on duty at all times

   a. "On duty" means physically present and performing duties at the center at all times during the center's hours of service in which participants are present.
   b. The CBAS provider shall have a written policy for coverage of the administrator and program director during times of absence.

2. Sufficient supportive staff to conduct the CBAS provider's daily business in an orderly manner.

3. CBAS staffing that meets the individual professional requirements specified in relevant state laws and regulations and in these SOPs.

4. Financial and accounting records that fully disclose the disposition of all funds.

5. The maintenance of appropriate personnel and CBAS participant health records and personnel records.

6. Ability to comply with State reporting requirements as specified through Provider Bulletins, these SOPs, and as applicable, Medi-Cal managed care plan contract requirements. CBAS providers must report the following:
   a. Discharge plan at time of disenrollment from the CBAS center:
      i. Must be reported to CDA for fee-for-service CBAS participants and to the responsible managed care plan for managed care plan members.
   b. Incident reports:
      i. All incidents that threaten the welfare, safety, or health of the participant(s) shall be reported to CDA, and, if applicable, the CBAS participant's managed care plan within 48 hours of the incident and documented in writing in the required format. Such documentation shall be available to appropriate CDA/managed care plan staff at all times.

7. Written policies and procedures for center operations and the provision of services to CBAS participants.

8. Emergency Services – Maintenance of updated written procedures for dealing with emergency situations. Such procedures shall include, at a minimum all of the following:
   a. Use of the local 911 system.
   b. Appropriately trained personnel; at a minimum, all direct care staff shall be trained in first aid and certified in basic life support.
   c. Written permission from all CBAS participants for transfer to and treatment by local hospitals or other treatment facilities as needed, which can be provided for in the participation agreement.

9. Grievance Procedures – A written grievance process whereby participants and family/caregivers can report and receive feedback regarding CBAS services.

10. Civil Rights and Confidentiality – Adherence to all laws and regulations regarding civil rights and confidentiality of both participants and CBAS staff. CBAS providers are subject to Federal and State laws regarding discrimination and abuse and the reporting of such, inclusive of the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Information Practices Act (IPA).

11. Quality Control/Quality Assurance – Quality control/quality assurance reviews that are in accordance with the Quality Assurance Plan, as described in the CMS-approved 1115 waiver (#11-W-00193/9).

12. Training Requirements – Training of all direct care CBAS staff regarding the care appropriate to each participant's diagnoses and his/her individual care needs.

Provision of training to CBAS staff is a requirement to be enrolled in Medi-Cal as a CBAS provider and is not separately reimbursable outside of the CBAS provider's rate by either Medi-Cal or the Medi-Cal managed care plans.

A Training of CBAS staff shall include an initial orientation for new staff; review of all updated policies and procedures; hands-on instruction for new equipment and procedures; and regular updates on State and Federal requirements, such as abuse reporting and fire safety.

b. Training shall be conducted and documented on a quarterly basis and shall include supporting documentation on the information taught, attendees, and the qualifications of the instructor(s).

13. Documentation – Maintenance of a health record for each CBAS participant that shall be available to appropriate DHCS/CDA and managed care plan staff for any scheduled or unscheduled visits.
    a. This health record shall include documentation of all services provided and refused, the current IPC, referral requests and outcomes of said referral(s).

    b. Health record documentation shall be maintained in compliance with applicable Federal and State laws and shall be retained by the CBAS provider for a minimum of seven years. Health records shall be stored so as to protect against loss, destruction, or unauthorized use.

    c. The CBAS provider shall maintain administrative records that document compliance with these SOPs.

A primary goal underlying the ASAM Criteria is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. The ASAM Criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. ASAM Criteria uses six unique dimensions, which represent different life areas that together impact any and all assessment, service planning, and level of care placement decisions. The ASAM Criteria structures multidimensional assessment around six dimensions to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health and mental health services.

The ASAM Criteria provides a consensus based model of placement criteria and matches a patient's severity of SUD illness with treatment levels that run a continuum marked by five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

There are several ASAM training opportunities available for providers and counties. The ASAM eTraining series educates clinicians, counselors and other professionals involved in standardizing assessment, treatment and continued care. One-on-one consultation is also available to review individual or group cases with the Chief Editor of the ASAM Criteria. Additionally, there is a two-day training which provides participants with opportunities for skill practice at every stage of the treatment process: assessment, engagement, treatment planning, continuing care and discharge or transfer. There are also a variety of webinars available.

At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care. A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the State, counties will facilitate ASAM provider trainings.

All residential providers must be designated to have met the ASAM requirements and receive a DHCS issued ASAM designation. DHCS will develop a designation program to certify that all providers of Adult and Adolescent Level 3.1-3.5 Residential/Inpatient Services are capable of delivering care consistent with ASAM Criteria. As part of this designation program, DHCS will develop a tool that includes the elements that define each sublevel of Level 3 services for Levels 3.1-3.5, develop standard program monitoring materials and protocols, and implement the ASAM designation program. After developing the protocol and monitoring tool, DHCS will designate all current residential providers which will require initial paperwork and a DHCS designation. DHCS will then fold the ASAM designation process into the initial licensing process so all new residential providers will have an ASAM designation.

1. Following a county's contract protest procedure, a provider may appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.
2. A provider may appeal to DHCS, following an unsuccessful contract protest, if the provider meets all objective qualifications and it has reason to believe the county has an inadequate network of providers to meet beneficiary need and the provider can demonstrate it is capable of providing high quality services under current rates, and:
    A. It can demonstrate arbitrary or inappropriate county fiscal limitations; or
    B. It can demonstrate that the contract was denied for reasons unrelated to the quality of the provider or network adequacy.
3. DHCS does not have the authority to enforce State or Federal equal employment opportunity laws through this appeal process. If a provider believes that a county's decision not to contract violated Federal or State equal employment opportunity laws, that provider should file a complaint with the appropriate government agency.
4. A provider shall have 30 calendar days from the conclusion of the county protest period to submit an appeal to the DHCS. Untimely appeals will not be considered. The provider shall serve a copy of its appeal documentation on the county. The appeal documentation, together with a proof of service, may be served by certified mail, facsimile, or personal delivery.
5. The provider shall include the following documentation to DHCS for consideration of an appeal:
    a) County's solicitation document;
    b) County's response to the county's solicitation document;
    c) County's written decision not to contract
    d) Documentation submitted for purposes of the county protest;
    e) Decision from county protest; and
    f) Evidence supporting the basis of appeal.
6. The county shall have 10 working days from the date set forth on the provider's proof of service to submit its written response with supporting documentation to DHCS. In its response, the County must include the following documentation: 1) the qualification and selection procedures set forth in its solicitation documents; 2) the most current data pertaining to the number of providers within the county, the capacity of those providers, and the number of beneficiaries served in the county, including any anticipated change in need and the rationale for the change; and 3) the basis for asserting that the appealing Provider should not have been awarded a contract based upon the County's solicitation procedures. The county shall serve a copy of its response, together with a proof of service, to the provider by certified mail, facsimile, or personal delivery.
7. Within 10 calendar days of receiving the county's written response to the provider's appeal, DHCS will set a date for the parties to discuss the respective positions set forth in

the appeal documentation. A representative from DHCS with subject matter knowledge will be present to facilitate the discussion.

8. Following the facilitated discussion, DHCS will review the evidence provided and will make a determination.
9. Following DHCS' determination that the county must take further action pursuant to Paragraph 8 above, the county must submit a Corrective Action Plan (CAP) to DHCS within 30 days. The CAP must detail how and when the county will follow its solicitation procedure to remedy the issues identified by DHCS. DHCS may remove the county from participating in the Waiver if the CAP is not promptly implemented. If the county is removed from participating in the Waiver, the county will revert to providing State Plan approved services.
10. The decision issued by DHCS shall be final and not appealable.

Attachment Z
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Implementation Plan

This document will be used by the Department of Health Care Services (DHCS) to help assess the county's readiness to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and for the counties to determine capacity, access and network adequacy. The tool draws upon the Special Terms and Conditions and the appropriate CFR 438 requirements. DHCS will review and render an approval or denial of the county's participation in the Waiver.

Table of Contents

Part I **Plan Questions**
This part is a series of questions regarding the county's DMC-ODS program.

Part II **Plan Description: Narrative Description of the County's Plan**
In this part, the county describes its DMC-ODS program based on guidelines provided by the Department of Health Care Services.

PART I
PLAN QUESTIONS

This part is a series of questions that summarize the county's DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.

   ☐ County Behavioral Health Agency
   ☐ County Substance Use Disorder Agency
   ☐ Providers of drug/alcohol treatment services in the community
   ☐ Representatives of drug/alcohol treatment associations in the community
   ☐ Physical Health Care Providers
   ☐ Medi-Cal Managed Care Plans
   ☐ Federally Qualified Health Centers (FQHCs)
   ☐ Clients/Client Advocate Groups
   ☐ County Executive Office
   ☐ County Public Health
   ☐ County Social Services
   ☐ Foster Care Agencies
   ☐ Law Enforcement
   ☐ Court
   ☐ Probation Department
   ☐ Education
   ☐ Recovery support service providers (including recovery residences)
   ☐ Health Information technology stakeholders
   ☐ Other (specify) _____

2. How was community input collected?

   ☐ Community meetings
   ☐ County advisory groups
   ☐ Focus groups
   ☐ Other method(s) (explain briefly) _____

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

☐ Monthly
☐ Bi-monthly
☐ Quarterly
☐ Other: _____

Review Note: One box must be checked.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

☐ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

☐ There were no regular meetings previously, but they will occur during implementation.

☐ There were no regular meetings previously, and none are anticipated.

5. What services will be available to DMC-ODS clients under this county plan?

REQUIRED
☐ Withdrawal Management (minimum one level)
☐ Residential Services (minimum one level)
☐ Intensive Outpatient
☐ Outpatient
☐ Opioid (Narcotic) Treatment Programs
☐ Recovery Services
☐ Case Management
☐ Physician Consultation

How will these required services be provided?

☐ All county operated
☐ Some county and some contracted
☐ All contracted.

OPTIONAL
☐ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☐ Recovery Residences
☐ Other (specify) _____

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?

☐ Yes (required)
☐ No. Plan to establish by: _____.

Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

☐ Yes (required)
☐ No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.

☐ Yes (required)
☐ No

PART II
PLAN DESCRIPTION (Narrative)

In this part of the plan, the county must describe certain DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

- Number responses to each item to correspond with the outline.
- Keep an electronic copy of your implementation plan description. After DHCS reviews your plan description, you may need to make revisions.
- Counties must submit a revised plan to DHCS whenever the county requests to add a new level of service.

Narrative Description

1. Collaborative Process. Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

Review Note: Stakeholder engagement is required in development of the implementation plan.

2. Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care. Also describe if there will be timelines established for the movement between one level of care to another.

Review Note: A flow chart may be included.

3. Beneficiary Access Line. For the beneficiary toll free access number, what data will be collected (i.e: measure the number of calls, waiting times, and call abandonment)?

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

5. Coordination with Mental Health. How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

6. Coordination with Physical Health. Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

7. Coordination Assistance. The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- Comprehensive substance use, physical, and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

8. **Access.** Describe how the county will ensure access to all service modalities. Describe the county's efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

- The anticipated number of Medi-Cal clients.
- The expected utilization of services.
- The numbers and types of providers required to furnish the contracted Medi-Cal services.
- Hours of operation of providers.
- Language capability for the county threshold languages.
- Timeliness of first face-to-face visit, timeliness of services for urgent conditions and access afterhours care.
- The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.

9. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

<u>Review Note:</u> Include the frequency of training and whether it is required or optional.

10. Technical Assistance. What technical assistance will the county need from DHCS?

11. Quality Assurance. Describe the quality assurance activities the county will conduct. Include the county monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438 requirements. Please also list out the members of the Quality Improvement committee. Also include descriptions of how each of the quality assurance activities will meet the minimum data requirements.

12. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

13. Assessment. Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?

14. Regional Model. If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

15. Memorandum of Understanding. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 4(i) of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

16. Telehealth Services. If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

17. Contracting. Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

<u>Review Note:</u> A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

18. Additional Medication Assisted Treatment (MAT). If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

19. Residential Authorization. Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

20. One Year Provisional Period. For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC-ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval.

_____	_____	_____
County Behavioral Health Director*	County	Date

(*for Los Angeles and Napa AOD Program Director)

Reserved

Attachment BB
Drug Medi-Cal Organized Delivery System (DMC-ODS)
Tribal Delivery System

In order to participate in the DMC-ODS pilot, tribal providers must deliver care consistent with the American Society of Addiction Medicine (ASAM) Criteria, as well as be part of an organized delivery system (ODS) that coordinates care across the continuum specified by the ASAM criteria. Delivering care consistent with the ASAM Criteria is the applicable standard for provider participation in the DMC-ODS pilot. The state must comply with the statutory exemption from state or local licensure or recognition requirements at Section 1621(t) of the Indian Health Care Improvement Act. After approval of this amendment, DHCS will consult with tribal 638 facilities, Urban Indian Health Programs, tribes and stakeholders to develop the specific process for these tribal and Indian health care providers to participate in Medi-Cal and in the DMC-ODS program. All providers participating in the DMC-ODS pilot must comply with quality reporting and monitoring activities.

Medications to assist with treatment for substance use disorder are available in the DMC-ODS Pilot and in California's larger Medi-Cal system. The reimbursements of these medications are detailed in the following table:

MAT Drug Reimbursement Through the DMC-ODS and Medical System

Medication	TAR* Required	Availability
Methadone	No	Only in NTP/OTP
Buprenorphine	Yes, unless provided in an NTP/OTP	Pharmacy Benefit, NTP/OTP
Naltrexone tablets	No	Pharmacy Benefit, ODF DMC Benefit
Naltrexone long-acting injection	Yes	Pharmacy Benefit, Physician Administered Drug
Disulfiram	No	Pharmacy Benefit, NTP/OTP
Acamprosate	Yes	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit; NTP/OTP

*TAR (Treatment Authorization Request)

There are different doors patients in need of Medication Assisted Treatment (MAT) enter the Medi-Cal system in California. Therefore, California makes the medications and the treatment services available in various settings. Depending on the setting the patient is initially diagnosed with a substance use disorder, the administering and dispensing of MAT will vary. If a patient comes through the county system or directly to a Narcotic Treatment Program (NTP), the program is responsible for the prescribing, ordering, and monitoring service. The NTP also dispenses and administrates the MAT and all of this is reimbursed with a bundled rate. If a client is diagnosed by their non-DMC primary care doctor, the prescribing, ordering, and monitoring of the medication occurs during the office visit. After the office visit, the patient will fill the prescription at a pharmacy. Pharmacies are then reimbursed for the medication and dispensing of the medication. In some cases, the physician may administer the drug in the office. This is termed a "physician administered drug" and the physician is reimbursed for the drug and the administration directly. Patients receiving DMC outpatient services may also be prescribed MAT through a physician working at the program. The patient would then fill the prescription at the pharmacy.

DHCS will report the relevant Medicaid Adult and Children's Quality Measures for individuals with SUD (located at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-core-set.pdf and http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf). These include the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004). To the extent possible, DHCS will also report the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) measure and the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures.

DHCS and UCLA propose to measure the following domains:

Access
Has access to treatment increased in counties that have opted in to the waiver?
Analyses to be performed by county, race, ethnicity, and gender where possible.

- Availability and use of full required continuum of care (CalOMS-Tx)
- Use of medication assisted treatment (DMC Claims, Medi-Cal claims)
- Number of Admissions (DMC Claims, CalOMS-Tx)
- Numbers and trends by type of service (e.g. NTP) (CalOMS-Tx)
- Penetration rates –, analyzed also by primary drug (alcohol/drug) not by demographics
- Adequacy of network
    - First available appointment (UCLA will call and try to make appointments)
    - Average distance to provider (CalOMS, SMART6i)
    - Time from ASAM assessment to admission (county ASAM data, CalOMS)
    - Newly certified sites (SMART 6i)
    - Residential, detoxification capacity (DATAR)
    - Outpatient capacity (in development)
    - Retention in treatment
- Existence of a 24/ 7 functioning beneficiary access number
- Existence of a 24/7 functioning beneficiary access number in languages other than English
- Availability of services in language other than English
- Availability of provider directory to patients

Quality
Has quality of care improved in counties that have opted in to the waiver?

- Appropriate placement:

  - Percent of individuals receiving ASAM criteria-based assessment prior to an admission in level of care.
  - Comparison of ASAM indicated level of care and actual placement and reasons documented for the difference if they do not match.
  - Use of continuing ASAM assessments, appropriate movement
- Appropriate treatment consistent with level of care after placement:
  - ASAM Audits
  - % of referrals with successful treatment engagement (based on length of stay)
- Successful care transitions
- Successful discharge
  - Discharges against medical advice
- Will need to collect supplemental data from Chemical Dependency Recovery Hospitals and free standing psych, since they do not report to CalOMS-Tx (surveys or interviews, OSHPD data).
- Where possible, collect data from county EBP monitoring, assess adequacy of such monitoring
- Data indicator reports
- Follow-up patient surveys and interviews
  - Patient perceptions of care
- Provider surveys and interviews
  - Quality of care, perceptions of system (other providers), measures of patient centered care.
- Outcome Measures
  - CalOMS, Patient surveys
    - AOD use
    - Social support
    - Living arrangements
    - Employment
    - Quality of Life / Functioning
  - Grievance reports
  - Effectiveness of all levels of care
    - Readmissions to withdrawal management, residential and intensive outpatient treatment
  - Effectiveness of Residential treatment
    - Change in health care costs for individuals who receive residential care (pre/post and vs comparable patients placed in other modalities)
      - Change in ED utilization and costs
      - Change in inpatient utilization and costs

- Change in SUD treatment utilization and costs
- Are there differences that result from the use of different treatment modalities in health outcomes and/or costs?
- Are there differences that result from different residential lengths of stay in health outcomes and/or costs?

▪ Differences in health care costs among patients who receive SUD medications versus patients who do not receive SUD medications

<u>Cost</u>

- Is the waiver cost-effective?Total health costs pre/post waiver implementation among comparable patients

<u>Integration and Coordination of Care</u>

Is SUD treatment being coordinated as intended with primary care, mental health, and recovery support services?

- Existence of required MOUs with
  - bidirectional referral protocols between plans
  - availability of clinical consultation, including consultation on medications, the management of a beneficiary's care, including procedures for the exchanges of medical information and a process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved
- Assessment of coordination goals (provider & patient surveys/interviews)
  - Comprehensive substance use, physical, and mental health screening;
  - Beneficiary engagement and participation in an integrated care program as needed;
  - Shared development of care plans by the beneficiary, caregivers and all providers;
  - Care coordination and effective communication among providers;
  - Navigation support for patients and caregivers; and
  - Facilitation and tracking of referrals between systems.
- Quantify referrals to and from primary care and mental health
- Quantify referrals to and from recovery services paid for by the DMC-ODS