Section 1915(b) Waiver
Proposal For
MCO, PIHP, PAHP, PCCM Programs
And
FFS Selective Contracting Programs

2013-2018

Note: June 30, 2013: CMS granted approval for two years. Waiver Renewal Period 8 is therefore July 1, 2013-June 30, 2015

September 24, 2013

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Attachments

Note: All of the attachments to this document are provided electronically in a separate file. Additionally, many are available on the web. Hyperlinks have been provided for web based attachments.

1. **Memo to California Indian Health Programs and Urban Indian Organizations dated February 12, 2013**

1(a) Memo to California Indian Health Programs and Urban Indian Organizations dated September 11, 2013

2. **Mental Health Plans (MHP)/Department of Health Care Services (DHCS) Boilerplate Contract**

3. **Letter from CMS dated April 26, 2005 (Waiver Renewal Approval)**

4. **Letter from CMS dated August 22, 2003 (Response to Request to Waive Certain Provisions of the Medicaid Managed Care Regulations)**

5. **DHCS and APS HealthCare MidWest Contract for External Quality Review Organization (EQRO) Activities Work Plan**

6. **EQR schedules for FY 2012 - 2013**
   http://caeqro.com/webx?293@780.zhxhaibQmK9.1@.ee8556f

7. **DMH Information Notice No. 11-07 "Threshold Languages"**
   http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice11-07.pdf

8. **DMH Information Notice No. 02-03 Addendum for "Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services -- Cultural Competence Plan Requirements"**
   http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03.pdf

9. **DMH Information Notice No. 10-02 "The 2010 Cultural Competence Plan Requirements"**
   http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf

10. **DMH Information Notice No. 10-17 "The 2010 Cultural Competence Plan Requirements Modification"**
    http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf

11. **Mental Health Services Division (MHSD) Information Notice No. 12-05 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2012-2013" Enclosure 1**

http://www.dhcs.ca.gov/formsandpubs/MHCCY/Enclosure1-FINAL_PROTOCOL_FY2012-13.pdf

12. **MHSD Information Notice No. 12-05 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2012-2013" http://www.dhcs.ca.gov/formsandpubs/MHCCY/MHSD-InforNotice-12-05-AnnualReviewProtocol.pdf**

13. **MHSD Information Notice No. 12-05 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2012-2013" Enclosure 4 Reasons for Recoupment http://www.dhcs.ca.gov/formsandpubs/MHCCY/Enclosure4_ReasonsforRecoup_FY12-13.pdf**

14. **DMH Information Notice No. 97-06 "Implementation plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services" http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice97-06not.pdf**

15. **DMH Letter No. 10-04 "Provider Site Certification Protocol for County Owned or Operated Short-Doyle/Medi-Cal Organizational Provider Sites" http://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr10-04.pdf**

16. **Short-Doyle/Medi-Cal Acute Psychiatric Inpatient Hospital Review Results**

17. **2013 Summary of Department of Mental Health Specialty Mental Health Services by Race/Ethnicity**

Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet
Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The State **of California requests an amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.**

The name of the waiver program **is Medi-Cal Specialty Mental Health Services (SMHS) Consolidation. (Please list each program name if the waiver authorizes more than one program).**

Type of request. **This is an:**
___ initial request for new waiver. All sections are filled.
_X_ amendment request for existing waiver, which modifies Section/Part
__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
X_ Document is replaced in full
___ renewal request
__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
__ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
Section A is replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Program Description from the previous waiver period.
___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is __ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Monitoring Plan from the previous waiver period.
___ assures there are no changes in the Monitoring Plan from the previous waiver period.
___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in

attached replacement pages

Effective Dates: **This waiver/renewal/amendment is requested for a period of 5 years; effective July 1, 2013 and ending June 30, .2018. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)**

State Contact: **The State contact person for this waiver is Dina Kokkos-Gonzales, Department of Health Care Services (DHCS), who can be reached by telephone at (916) 552-9055 or fax at (916) 440 7620, or e-mail at dina.kokkos@dhcs.ca.gov. (Please list for each program).**

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The state is required to seek advice from designees of Indian Health Programs and Urban Indian Organizations on matters having a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations per the American Recovery and Reinvestment Act of 2009 (ARRA). The DHCS must solicit the advice of designees prior to submission to the Centers for Medicare and Medicaid Services (CMS) of any waiver renewal. On September 11, 2013 a memorandum was provided to California Tribal Chairpersons, Indian Health Programs, and Urban Indian Organizations to inform them of this waiver amendment proposal (see attachment 1a). The State requested that comments be provided within 30 days of the date of the memo. As of the date of this submission, no written comments have been received by DHCS from federally recognized tribes or other tribal organizations in California.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Overview of Request for Waiver Renewal

California is requesting renewal of the Medi-Cal SMHS Consolidation waiver. The specifics of the renewal request begin in Section A: Program Description, Part I: Program Overview, Section A. Statutory Authority.

Section 1915 (b) waivers relevant to specialty mental health services have been in effect in California since 1995. The current request refers to the eighth renewal of the SMHS waiver and, if granted will be effective from July 1, 2013 to June 30, 2018 .

Program Design for Medi-Cal Mental Health Managed Care

The design of managed care for California's Medi-Cal mental health program was phased in over several years. Medi-Cal Psychiatric Inpatient Hospital Services Consolidation was the first phase, based on the authority granted by the freedom of choice waiver approved by the Centers for Medicare and Medicaid Services (CMS) effective March 17, 1995. The second phase was Medi-Cal SMHS Consolidation,

based on the renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver, which was approved by CMS on September 5, 1997. This phase has been in place continuously since September 5, 1997.

The State's enabling legislation for this waiver is set forth at Welfare and Institutions (W&I) Code, Sections 14680-14685.1 and 14700-14726 .

History/Key Events and Timeline Relevant to Mental Health services in California:

1957: California passed legislation creating the Short-Doyle Program, a delivery system for community mental health services managed by counties through directly operated and contract providers.

July 1965: Congress passed Title XVIII Medicare legislation and Title XIX Medicaid legislation as amendments to the Social Security Act (the Act) expanding the scope of health benefits to persons eligible for federal grants: for persons 65 years of age and over, (Medicare) and providing federal matching funds to states that implemented a comprehensive health care system for the poor under the administration of a single state agency (Medicaid).

1966: The California Medical Assistance Program (Medi-Cal) was established to provide for medical services to eligible federal cash grant welfare recipients. The specialty mental health services reimbursed by this program included psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists.

1971: California added Short-Doyle community mental health services into the scope of benefits of the Medi-Cal program. This change enabled counties to obtain federal matching funds for their costs of providing Short-Doyle community mental health services to persons eligible for Medi-Cal. This program came to be known as Short-Doyle/Medi-Cal (SD/MC). SD/MC services included many of the services provided by the Short-Doyle program, but not all. Socialization, vocational rehabilitation, residential services and services for homeless persons, for instance, were not benefits under the SD/MC program.

At this point in time, mental health services were provided by two co-existing programs: the SD/MC program and the Fee-for-Service/Medi-Cal (FFS/MC) program which provided psychiatric inpatient hospital services, professional services provided by psychiatrists and psychologists and nursing facility services. However, the SD/MC program provided a much broader range of mental health services, using a wider group of service delivery personnel, than were offered under FFS/MC.

October 1989: A Medicaid State Plan Amendment (SPA) added targeted case management for individuals with mental illness to the scope of benefits offered under the SD/MC system.

July 1993: A SPA added mental health services available under the Rehabilitation Option to the SD/MC scope of benefits and broadened the range of personnel who could provide services and the locations at which services could be delivered.

March 17, 1995: Based on approval of a Section 1915(b) Freedom of Choice waiver, the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver, California consolidated psychiatric inpatient hospital services provided through the SD/MC and the FFS/MC programs. Through this consolidation, county mental health departments became responsible for both SD/MC and FFS/MC psychiatric inpatient hospital systems for the first time. The Health Care Financing Administration (HCFA) (now CMS) approved SPA 95-016, which described the reimbursement methodology used for psychiatric inpatient hospital services under the consolidated program. The initial Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver period was March 17, 1995 until the waiver was renewed on September 5, 1997.

February 1995: A separate Section 1915(b) waiver was also approved for the Medi-Cal Mental Health Care Field Test (San Mateo County) to field test various aspects of a fully integrated and consolidated Mental Health Plan (MHP) for Medi-Cal beneficiaries. The field test included the provision of both psychiatric inpatient hospital services and other specialty mental health services.

August 1997: A first waiver renewal request for the San Mateo Field test was submitted. It was approved by CMS on June 1998.

- **San Mateo County continued the systems put in place during the initial waiver period and began field testing federal reimbursement based on a six-level case rate, with three levels of payment for children and three levels for adults.**
- **San Mateo County MHP assumed the authorization and management of pharmacy and related laboratory services when prescribed by a psychiatrist for a mental health condition. FFP is claimed for these services based on fee-for-service payments to the Pharmacy Benefits Management contractor and the MHP administrative costs for the services.**

The first waiver renewal/modified waiver was in effect from September 5, 1997 through November 19, 2000.

- **September 1997: California requested and was granted a renewal, modification and renaming of the Medi-Cal Psychiatric Inpatient Hospital Service Consolidation waiver program to include both inpatient hospital and outpatient, professional, case management and other specialty mental health services under the responsibility of a single MHP in each county. The renewed waiver (approved by CMS September 5, 1997) was called Medi-Cal SMHS Consolidation. The services provided through the SMHS waiver program**

mirrored the services provided under the SD/MC program and it also included mental health services originally provided through the FFS/MC program such as psychiatric inpatient hospital services, psychiatrist services and psychologist services. Nursing facility services (which were provided through the FFS/MC) were not consolidated into the SMHS waiver program; thus, psychiatric nursing facility services is not considered to be a service provided through the SMHS waiver.

Although the SMHS waiver consolidated services provided through the SD/MC and the FFS/MC programs, the term "SD/MC services" remained in general usage to describe the services provided under the SMHS waiver which are now called "specialty mental health services." The State is in the process of eliminating the usage of the term "Short-Doyle services" and "SD/MC services" when referring to specialty mental health services.

- **November 1, 1997 through July 1, 1998: Implementation of the renewed waiver, referred to as "Phase II" implementation, was phased in, depending on the readiness of a single entity (the MHP) in each county.**
  - **MHPs became responsible for authorization and payment of professional specialty mental health services that were previously reimbursed through the FFS/MC claiming system.**
  - **Both inpatient hospital and professional Medi-Cal specialty mental health services previously reimbursed through FFS/MC and SD/MC claiming systems became the responsibility of the MHPs.**

November 20, 2000, through November 19, 2002: This was the second waiver period for the SMHS waiver program.

July 30, 2001 through July 25, 2003: This was the second waiver period for the San Mateo field test to continue to field test the elements described above.

April 28, 2003 through April 27, 2005: This was the third waiver period for the SMHS waiver program.

July 24, 2003: To permit California to continue to operate the Field Test for San Mateo County from July 26, 2003, through July 25, 2005, CMS approved California's request for a two-year continuation of the Medi-Cal Mental Health Care Field Test (San Mateo County), under Section 1915(b) (4) of the Act, to continue to field test the elements described above. This approval included a waiver of the following sections of the Act: 1902(a) (1) Statewideness, 1902(a) (10) (B) Comparability of Services, and 1902(a) (23) Freedom of Choice. This was the last renewal request for the San Mateo Field Test.

The fourth waiver period for the SMHS waiver was in effect April 1, 2005 through March 31, 2007.

July 1, 2005: San Mateo County was fully incorporated into California's SMHS waiver program.

- **As a component of the Medi-Cal SMHS waiver program, the State continued the laboratory and pharmacy aspect of the San Mateo field test since this had proven effective for the San Mateo MHP and its beneficiaries.**
- **The State did not propose that other MHPs cover these services.**

July 1, 2005: The State added Solano County MHP to the Medi-Cal SMHS waiver program and contracted with the Solano County Mental Health Department to serve as the MHP for the provision of some specialty mental health services. The Solano MHP maintained its status as a subcontractor to Solano's managed care plan (Partnership HealthPlan of California). Partnership HealthPlan was responsible for the specialty mental health services covered through its managed care contract with DHCS. In turn, Partnership HealthPlan contracted with the Solano MHP and Kaiser Permanente to provide some specialty mental health services for Partnership HealthPlan enrollees.

The fifth waiver period for the SMHS waiver was in effect April 1, 2007 through June 30, 2009.

- **DMH Contracts with MHPs**
  Effective Fiscal Year (FY) 06/07, the contract between DMH and MHPs was in effect for three years rather than being renewed annually as had previously been the case.

- **Conlan Law Suit**
  During the fifth waiver period, the State implemented the California Court of Appeal's August 15, 2005 decision in the case of *Conlan v. Shewry* (2005) 131 Cal.App.4th 1354. In this case, the court determined that under 42 U.S.C. Section 1396a(a)(10)(B) (the "comparability provision") DHCS was required to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for covered services for which they paid during the three months prior to applying for Medi-Cal coverage (the "retroactivity period"). DMH implemented procedures to process specialty mental health services beneficiary reimbursement claims.

- **The Mental Health Services Act (MHSA)**
  In November 2004, the voters of California approved Proposition 63- a ballot initiative, which enacted the Mental Health Services Act (MHSA). The MHSA imposes a 1 percent income tax on personal income in excess of $1 million to fund county mental health programs. The Act establishes a prevention, and early intervention program and funds innovative programs and infrastructure, technology and training to support the mental health system.

- **Katie A. Lawsuit**

Katie A. v. Diana Bonta **is a class action lawsuit that was filed in 2002 against the California Department of Social Services (CDSS) and the California DHCS wherein the plaintiffs alleged that foster children and children "at imminent risk of foster care placement" are not receiving adequate mental health services. Citing the time and effort needed to resolve the complex issues in this case, in March 2009, the court appointed a Special Master.**

- **Therapeutic Behavioral Services (TBS)**
  As the result of the court order in *Emily Q. v. Bonta*, an EPSDT supplemental specialty mental health service (as defined in Title 9, CCR, Section 1810.215) called TBS has, since 1999, been provided under the SMHS waiver to Medi-Cal eligible children under 21 years of age who meet the class definition and demonstrate medical necessity under the waiver for the service. In November 2008, the federal court adopted a Nine-Point Plan to increase access and to improve delivery of TBS. Additionally, it created a comprehensive set of requirements for settling the *Emily Q v. Bonta* lawsuit and ending the Court's jurisdiction in December 2010.

The sixth waiver period for the SMHS waiver was in effect October 1, 2009 through June 30, 2011:

- **The MHPs continued to function under a contract with DMH. DMH and MHP representatives met to identify needed changes to the contract.**

- **Emily Q vs. Bonta lawsuit**
  On December 16, 2010 with concurrence from the special master, the Court found that DMH had implemented Points One through Eight of the Nine Point Plan. On December 21, 2010, the court issued an additional order stating that the special master's appointment shall end on April 29, 2011 and the court's jurisdiction will end on May 6, 2011.

- **Katie A Lawsuit**
  The special master engaged in settlement negotiations with the parties to accomplish the tasks set forth in the court's order.

- **DMH implemented the requirements of Senate Bill 785 (Chapter 469, Statutes of 2007) related to provision of specialty mental health services to children in a foster care, KinGAP, or Aid to Adoptive Parents aid codes.**

- **SPA #10–012B relative to Targeted Case Management was approved on December 20, 2010 for an effective date of July 1, 2010. The SPA updates language on the "Mentally Disabled" target group to reflect current practice and align with federal regulations.**

- **SPA #10-016 which updates the State Plan service descriptions for Rehabilitative Mental Health Services and Psychiatric Inpatient Hospital Services), was**

submitted to CMS on December 29, 2010. CMS approved this SPA on March 21, 2011. The effective date for SPA #10-016 was October 1, 2010.

During the seventh waiver renewal July 1, 2011 – June 30, 2013, the SMHS consolidation waiver program included the following new and/or updated projects/processes.

- **Pursuant to Assembly Bill (AB) 102 Chapter 29 (Statutes of 2011), no later than July 1, 2012, the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions was transferred from DMH to DHCS. An amendment to the SMHS waiver necessary to reflect this change in administration was approved effective July 1, 2012. Modifications to the waiver document were made to reflect DHCS' assumption of responsibilities for FY 2012-2013 while retaining language indicating DMH's responsibilities for FY 2011-2012.**

  The SMHS program was transferred as it currently exists with no interruption in services. An extensive stakeholder process was conducted to provide information and to seek input on the transition. In order to retain the expertise necessary for optimal program functioning and administration, staff from DMH transitioned to DHCS. Further, all DMH regulations, notices, letters, etc. related to the program remain in place until amended, repealed, or readopted by DHCS. For this reason all references to DMH letters and/or information notices were retained in the waiver amendment.

- **As part of the 2011-2012 Governor's budget proposal, effective July 1, 2012, funding was realigned to the counties derived from dedicated funding sources rather than from the State's General Fund (SGF) which is allocated through the budget process. It is not anticipated that this change in funding source will have an impact on the current SMHS delivery system.**

- **MHP Contract**
  Because of the timing of the transfer of administration of mental health from DMH to DHCS, DHCS, DMH and the MHPs entered into three –party contracts. . the contracts went into effect April 2012 and will remain in effect for one year, through April 2013.

- **The EQRO contract was executed by DMH for FY 2009/10 through June 30, 2012 with an option to extend the contract for two additional one year extension periods covering FY 2012-2013 and FY 2013-2014. The State exercised the option of extending the contract. Effective July 1, 2012 the EQRO was under contract with DHCS rather than DMH.**

- **Transfer of responsibility for San Mateo pharmacy benefit**
  Effective July 1, 2010 the fiscal responsibility for the Medi-Cal pharmacy benefit was transferred from the San Mateo MHP to the Health Plan of San Mateo.

- **SD/MC Phase II (SD/MC II) Electronic Claims Processing System**
  The SD/MC Claims Processing System adjudicates Medi-Cal specialty mental health service claims from California's county MHPs. This new system began operations on February 11, 2010. The old system was phased out on March 31, 2010. The goals of the new SD/MC II system are to adjudicate Health Insurance Portability and Accountability (HIPAA) compliant claims in near "real time" in order to pay MHPs reimbursement funds more quickly and to return denied claims for correction within hours of being received. Another significant statewide system update took place during the 7th waiver period to comply with the federal HIPAA 5010 Transactions and Code Sets regulations.

- **SPA #09-004 which updates the State Plan reimbursement sections for Specialty Mental Health Services was submitted to CMS on March 31, 2009. The purpose of this SPA is to update the reimbursement sections to reflect current practice, align with federal regulations, and conform to CMS' financial management reviews. This SPA is currently "off the clock" and the State continues to work with CMS on the revisions proposed through this SPA. The effective date for SPA #09-004 is January 1, 2009.**

During the eighth waiver renewal which will cover the time period July 1, 2013 – June 30, 2018, the SMHS consolidation waiver program will include the following new and/or updated projects/processes.

- **In accordance with California Senate Bill X1-1, which modified the Medi-Cal program to include benefits for the Medicaid adult optional expansion population as specified in Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)), and modified the existing Medi-Cal benefit package to include certain mental health services provided in the essential health benefits package selected by California and approved by the federal Secretary of Health and Human Services pursuant to the Patient Protection and Affordable Care Act and 42 U.S.C. Sec 18022, Medi-Cal Managed Care Plans will provide those mental health benefits added to the State Plan to the extent such services are not provided through the SMHS waiver. SMHS will be provided to Medi-Cal enrolled optional adult expansion beneficiaries by the county MHPs. These changes will be effective January 1, 2014.**

- **MHP Contract**
  The State has finalized standard contract language between DHCS and the MHPs. The effective date of the contract is May 1, 2013. This contract will be in place for a period of five years and two months extending to June 30, 2018.

- **The EQRO contract was secured by the State for FY 2009/10 - June 30, 2012 with an option to extend the contract for two additional one year extension periods. The State exercised the option of extending the contract through FY**

2012-2013. The State is in the process of extending the contract for FY 2013-2014. During waiver period 8, the State will conduct a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E commencing with Section 438.10.

- **AB 1297 (Chapter 651, Statutes of 2011), enacted July 1, 2012, required the Department to 1) Develop a reimbursement methodology, that is consistent with federal Medicaid requirements 2) Require counties to certify that public expenditures have been incurred prior to reimbursement of federal funds and 3) Require MHPs to submit claims for federal reimbursement to the State within time frames that are consistent with federal Medicaid requirements. All of these provisions will be in effect during the 8th waiver period.**

  The new methodology establishes county interim rates that limit the interim reimbursement for services provided by county owned and operated providers. Claims for the cost of specialty mental health services provided by county owned and operated providers is limited to the lower of the amount claimed or the interim rate established for the service provided. The MHP may establish a county contract rate to limit interim reimbursement for services provided by contract providers. Claims seeking reimbursement for the cost of specialty mental health services provided by a contract provider are limited to the lower of the amount claimed or the county contract rate, if one has been established. All interim reimbursement is subject to retrospective cost settlement.

- **Healthy Families Program Transition**
  On December 31, 2012 California received federal approval from CMS to begin transitioning children from the Healthy Families Program (HFP) to the Medi-Cal program in phases pursuant to AB 1494 (Chapter 28 Statutes of 2012). The overarching goals of the transition include a smooth transition of HFP enrollees to Medi-Cal, minimizing any disruption in service, maintaining existing eligibility gateways, ensuring access to care and maintaining continuity of care.

  The first two groups of children transitioned from HFP to Medi-Cal on January 1, 2013 and March 1, 2013. Continued federal approval for the transition is contingent on meeting Special Terms and Conditions (STC) specified by CMS. Many of the STCs involve mental health related activities including, monitoring the mental health aspects of the HFP transition; coordinating with MHPs, Medi-Cal managed care plans, and mental health stakeholders; coordinating with other DHCS Divisions; collecting and analyzing data; and preparing reports for CMS.

  HFP, administered by the Managed Risk Medical Insurance Board (MRMIB), provides health (including mental health), dental, and vision coverage to over 863,000 children. Children transitioning from the HFP to Medi-Cal will continue to receive health, dental, and vision benefits. MHPs will be responsible

for all Specialty Mental Health Services including psychiatric inpatient hospitalization for beneficiaries that meet medical necessity criteria.. Historically, MHPs served HFP members that were seriously emotionally disturbed (SED), which accounted for about 1 percent of all HFP members.

DHCS anticipates that MHPs will continue to serve SED HFP members when they become Medi-Cal beneficiaries, as well as other HFP members, and will serve new beneficiaries who enroll in Medi-Cal under the new Targeted Low Income Children's Program, the optional Medicaid program in which transitioning HFP members and new eligible enrollees will be assigned in Medi-Cal. Once the transition is complete, DHCS estimates that approximately 3.5 percent of the total number of transitioned and new Targeted Low Income Children's Program beneficiaries will receive SMHS. Beneficiaries that do not meet medical necessity criteria to receive SMHS may receive mental health services from their primary care physicians, within the primary care physician's scope of practice. Beneficiaries with mental health needs beyond those that a primary care physician care treat within their scope of practice, but that don't meet medical necessity criteria for SMHS will be referred by their Medi-Cal managed care plan to a fee-for-service/Medi-Cal provider to receive mental health services.

- **Katie A Lawsuit**
  Katie A v. Bonta is a class action lawsuit filed in federal district court in 2002 concerning the availability of intensive mental health services to children in California who are either in foster care or at imminent risk of entering the foster care system. In December 2011, a settlement agreement was reached to accomplish a systemic change for mental health services to children and youth by promoting, adopting, and endorsing three new service approaches: Intensive Care Coordination (ICC), Intensive Home Based Service (IHBS) and Therapeutic Foster Care (TFC): It has been determined that ICC and IHBS fall within in the parameter of existing SMHS. The Department is in the process of determining the model for TFC as well as discussing potential funding sources. It is anticipated that a decision on this matter will be reached during the 8th waiver period. An Implementation Plan was approved by the court in December 2012. The SD/MC II System was modified effective January 1, 2013 to allow MHPs to claim for ICC and IHBS using a new procedure code. Full implementation of ICC and IHBS on a statewide basis is planned during the 8th waivier period

- **Performance and Outcomes System Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Mental Health Services**
  Senate Bill (SB) 1009 (Chapter 34, Statutes of 2012) added Section 14707.5 to the California Welfare and Institutions Code (WIC). It requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission and a stakeholder advisory committee to develop a plan for a

performance outcomes system for EPSDT specialty mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. The purpose of the system is to improve beneficiary outcomes and inform decisions regarding the purchase of services.

The system will include objectives related to quality and access, individual, program and system level improvements, minimization of costs using existing resources, and collection of timely and reliable data.

The legislation requires DHCS to provide an initial plan (for the performance outcomes system) to the Legislature by October, 2013 and to propose how to implement that plan no later than January 2014.

- **Solano County**
  Effective July 1, 2012, the Solano MHP terminated its previous contractual relationship with Partnership HealthPlan and assumed responsibility to provide or arrange for the provision of the full array of Medi-Cal specialty mental health services to eligible Medi-Cal beneficiaries, with the exception of Partnership HealthPlan enrollees who are Kaiser Permanente members. Partnership HealthPlan will continue to capitate Kaiser Permanente for specialty mental health services provided to Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership HealthPlan and Kaiser Permanente. Solano County MHP will use 2011 Realignment funds to reimburse the Department for payments it made to Partnership HealthPlan for specialty mental health services to Kaiser Permanente members..

- **SD/MC Phase II (SD/MC II) Electronic Claims Processing System**
  The SD/MC Claims Processing System adjudicates Medi-Cal specialty mental health service claims from California's county MHPs. The goals of the SD/MC II system are to adjudicate Health Insurance Portability and Accountability (HIPAA) compliant claims in near "real time" in order to pay MHPs reimbursement funds more quickly and to return denied claims for correction within hours of being received.

  In waiver renewal Period 8, it is anticipated that the SD/MC system will be enhanced to support upcoming mandatory HIPAA and Affordable Care Act standards, including but not limited to:
  - **Standards and operating rules for electronic funds transfer (EFT)**
  - **Operating rules for electronic remittance advice (ERA) transactions**
  - **Use of the National Health Plan ID**
  - **Replacement of the International Classification of Diseases, 9th Revision, (ICD-9) code set with the ICD-10 code set for the purposes of recording diagnoses**
  - **Standards and operating rules for health claims**
  - **Operating rules for health claims and equivalent encounter information**

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**
  The department is aware of the upcoming release of DSM-5 and has implemented a workgroup to study the changes to the diagnostic classification system and to make any recommendations which are necessitated by those changes. Any proposed substantive changes will be submitted to CMS for its approval prior to implementation.

- A. Statutory Authority

1. Waiver Authority. **The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):**

a.___ 1915(b)(1) – **The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.**

b. ___ 1915(b)(2) - **A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.**

c. ___ 1915(b)(3) - **The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.**

d. _**X**_ 1915(b)(4) - **The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).**

The 1915(b)(4) waiver applies to the following programs

___ MCO
_X_ PIHP
___ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. Sections Waived. **Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):**

a. X Section 1902(a)(1) - **Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.**

b. X Section 1902(a)(10)(B) - **Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.**
The State requests a waiver of these two sections, if determined necessary, based on the facts below:

The SMHS Consolidation Program waiver population is defined as all Medi-Cal beneficiaries and therefore includes special needs populations defined as adults who have a serious mental disorder (California W&I Code Section 5600.3(b)) and children with a serious emotional disturbance (California W&I Code Section 5600.3(a)).

All Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to the services provided through the waiver if they meet the medical necessity criteria for SMHS ~~as~~ described below:

A. For Medi-Cal reimbursement for psychiatric inpatient hospital services, the beneficiary shall meet the following medical necessity criteria:

(1) Have one or more of the following diagnoses
(A) Pervasive Developmental Disorders ; (B) Disruptive Behavior and Attention Deficit Disorders; (C) Feeding and Eating Disorders of Infancy or Early Childhood ; (D) Tic Disorders; (E) Elimination Disorders; (F) Other Disorders of Infancy, Childhood, or Adolescence; (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood); (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder; (I) Schizophrenia and Other Psychotic Disorders; (J) Mood Disorders; (K) Anxiety Disorders; (L) Somatoform Disorders; (M) Dissociative Disorders; (N) Eating Disorders; (O) Intermittent Explosive Disorder; (P) Pyromania; (Q) Adjustment Disorders; (R) Personality Disorders
(2) Meet both of the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and
(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either 1 or 2 below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.
b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.
c. Present a severe risk to the beneficiary's physical health.
d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:

a. Further psychiatric evaluation.
b. Medication treatment.
c. Other treatment that can reasonably be provided only if the patient is hospitalized.

B. For Medi-Cal Reimbursement for out of hospital SMHS, the beneficiary shall meet the following medical necessity criteria:

(1) Diagnosis. Medi-Cal beneficiaries must have one or more of the following diagnoses: (A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder;(R) Medication-induced movement disorders related to other included diagnoses.

(2) Have at least one of the following impairments resulting from the above included diagnoses.

(A) A significant impairment in an important area of life functioning;
(B) A reasonable probability of significant deterioration in an important area of life functioning or;
(C) For children under 21, a reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness or condition of a child.

(3) Meet each of the-intervention criteria listed below:
(A) the focus of the proposed intervention is to address the impairment/condition identified above;
(B) The expectation is that the proposed intervention will
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Allow the child to progress developmentally as individually appropriate.
(C) The condition would not be responsive to physical health case based treatment.

C.-Medical Necessity Criteria for Medi-Cal Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements for outpatient SMHS as described above. All of the following criteria must be met.

(1) The beneficiary has one ore more of the following diagnoses: A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder;(R) Medication-induced movement disorders related to other included diagnoses.
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and

(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

All Medi-Cal beneficiaries are enrolled in the SMHS waiver and have access to the services provided through the waiver if they meet the medical necessity criteria for SMHS ~~as~~ described below:

A. For Medi-Cal reimbursement for psychiatric inpatient hospital services, the beneficiary shall meet the following medical necessity criteria:
The beneficiary must:

(1) Have one or more of the following diagnoses: (A) Pervasive Developmental Disorders ; (B) Disruptive Behavior and Attention Deficit Disorders; (C) Feeding and Eating Disorders of Infancy or Early Childhood ; (D) Tic Disorders; (E) Elimination Disorders; (F) Other Disorders of Infancy, Childhood, or Adolescence; (G) Cognitive Disorders (only Dementias with Delusions, or Depressed Mood); (H) Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder; (I) Schizophrenia and Other Psychotic Disorders; (J) Mood Disorders; (K) Anxiety Disorders; (L) Somatoform Disorders; (M) Dissociative Disorders; (N) Eating Disorders; (O) Intermittent Explosive Disorder; (P) Pyromania; (Q) Adjustment Disorders; (R) Personality Disorders;

(2) Meet both of the following criteria:

(A) Cannot be safely treated at a lower level of care, except that a beneficiary who can be safely treated with crisis residential treatment services or psychiatric health facility services for an acute psychiatric episode shall be considered to have met this criterion; and

(B) Requires psychiatric inpatient hospital services, as the result of a mental disorder, due to the indications in either1.or 2. below:

1. Has symptoms or behaviors due to a mental disorder that (one of the following):

a. Represent a current danger to self or others, or significant property destruction.

b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter.

c. Present a severe risk to the beneficiary's physical health.
d. Represent a recent, significant deterioration in ability to function.

2. Require admission for one of the following:
a. Further psychiatric evaluation.
b. Medication treatment.
c. Other treatment that can reasonably be provided only if the patient is hospitalized.

B. For Medi-Cal reimbursement for out of hospital SMHS, the beneficiary shall meet the following medical necessity criteria
The beneficiary must:

(1) Have one or more of the following diagnoses: (A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder;(R) Medication-induced movement disorders related to other included diagnoses.

(2) Have at least one of the following impairments resulting from the above included diagnoses.
(A) A significant impairment in an important area of life functioning;
(B) A reasonable probability of significant deterioration in an important area of life functioning; or
(C) For children under 21, a reasonable probability that the child will not progress developmentally as individually appropriate or when specialty mental health services are necessary to correct or ameliorate a defect, mental illness or condition of a child.

(3) Meet each of the intervention criteria listed below:
(A) the focus of the proposed intervention is to address the mpairment/condition identified above;
(B) The expectation is that the proposed intervention will
1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or
3.Allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health case based treatment.

C.Medical Necessity Criteria for Medi-Cal Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements for outpatient SMHS as described above. All of the following criteria must be met.

(1) The beneficiary has one or moreof the following diagnoses (A) Pervasive developmental disorders, except autistic disorders; (B) Disruptive behavior and attention deficit disorders; (C) Feeding and eating disorders of infancy and early childhood; (D) Elimination disorders; (E) Other disorders of infancy, childhood, or adolescence; (F) Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition; (G) Mood disorders, except mood disorders due to a general medical condition; (H) Anxiety disorders, except anxiety disorders due to a general medical condition; (I) Somatoform disorders; (J) Factitious disorders; (K) Dissociative disorders; (L) Paraphilias; (M) Gender Identity Disorder; (N) Eating disorders; (O) Impulse control disorders not elsewhere classified; (P) Adjustment disorders; (Q) Personality disorders, excluding antisocial personality disorder;(R) Medication-induced movement disorders related to other included diagnoses.
(2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
(3) The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

Treatment for the health care conditions of Medi-Cal beneficiaries who do not meet the medical necessity criteria for specialty mental health services (for example, excluded diagnoses as well as all non-mental health medical conditions and services) is therefore not covered under the waiver program. Services for these "excluded" conditions may be provided through other California Medi-Cal

programs – primarily the Fee-for-Service Medi-Cal (FFS/MC) program or Medi-Cal Managed Care Plans (MCPs).

Please note that when a Medi-Cal beneficiary has co-occurring diagnoses, i.e. an included and an excluded diagnosis, the beneficiary will be eligible to receive specialty mental health services from the MHP for the included diagnosis provided that the other components of the specialty mental health services' medical necessity criteria are also present. MHPs coordinate care with other providers delivering services for excluded diagnoses. For example, MHPs may coordinate with primary care physicians, regional centers, community based organizations, etc., depending on the beneficiary's unique needs, to ensure that the beneficiary receives appropriate services to address all aspects of general health and well-being.

SMHS are those State Plan approved services provided through the delivery system authorized by the SMHS waiver to beneficiaries who meet the SMHS medical necessity criteria.

The following are specific distinctions in the mental health care delivery system relative to comparability of services and statewideness.

1. ***DHCS Special projects***
   Enrollees in several small special projects continue to receive most Medi-Cal specialty mental health services through contracts between DHCS and the special projects rather than receiving these services from their respective county MHPs. The special projects involved are the State's projects under the Program for All-Inclusive Care for the Elderly (PACE) and the Senior Care Action Network (SCAN), a health maintenance organization operating under the authority of 1915(a) of the Social Security Act. Enrollees in these programs may receive rehabilitative mental health services under the Medi-Cal SMHS Consolidation waiver program from their county MHPs

2. ***MCP Specialty Mental Health Services Benefit: Sacramento County***
   The specialty mental health services for Kaiser beneficiaries that remain the responsibility of the Sacramento County MHP are the following:
   - **Psychiatric inpatient hospital services in SD/MC hospitals, rehabilitative mental health services, and specialty mental health related targeted case management.**

The 2011 Realignment removed State General Fund as a non-federal funding source for specialty mental health services and provided revenues directly to the counties for the non-federal share of funding. For this reason, the contractual and financial relationships of the

following programs have or will change during the 8th waiver period as described below.

1) Solano County
Effective July 1, 2012, the Solano County MHP is responsible for providing or arranging for the provision of the full array of Medi-Cal specialty mental health services to eligible Medi-Cal beneficiaries, with the exception of Partnership HealthPlan enrollees who are Kaiser Permanente members.

Partnership HealthPlan will continue to capitate Kaiser Permanente for specialty mental health services provided to its Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership HealthPlan and Kaiser Permanente.

Solano County MHP will use 2011 Realignment funds to reimburse the Department for payments it made to Partnership HealthPlan for specialty mental health services to Kaiser Permanente members.

2) Family Mosaic
The contract between the City and County of San Francisco and DHCS for the Family Mosaic Project (a small special project that receives a per-member, per-month capitated rate to provide specialty mental health services to multi-system-involved children and adolescents with serious emotional disturbances (SED) who are at serious risk of out-of-home placement), has been extended through December 31, 2013. As a condition of the contract, San Francisco County, Department of Public Health, Community Behavioral Health Services is at risk for all specialty mental health services with the exception of psychiatric health facility services, adult residential treatment service, crisis residential treatment services and TBS. The San Francisco County MHP is also responsible for all non-contracted services for enrolled members.

Consideration is being given to transitioning children and adolescents with SED receiving SMHS from the Family Mosaic Project to the San Francisco County MHP during waiver period 8.

c. X Section 1902(a)(23) **- Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.**
In the Medi-Cal SMHS Consolidation waiver program, beneficiaries must receive services through a MHP in their county.

d. X__ Section 1902(a)(4) - **To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).**

The State requests that the plan for complying with Title 42, CFR, Section 438.10(f)(3) regarding the distribution of informing materials as specified in a letter from CMS dated April 26, 2005 (see attachment 3) be continued for the duration of the eighth waiver period.

Also attached is a letter from CMS dated August 22, 2003 (see attachment 4) that describes variations from specific regulations for which CMS has indicated that waivers were not required. As has been the case in previous waiver periods, the State plans to use these variations during the eighth waiver period.

e. X__ Other Statutes and Relevant Regulations Waived - **Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.**

1.) Waivers of the following sections of Title 42, CFR, have been requested and granted for the Medi-Cal SMHS Consolidation waiver program in previous waiver renewals. The State requests that these waivers again be granted as circumstances relevant to enrollment and disenrollment remain unchanged.

- **Section 438.56 in its entirety along with waivers of related references to disenrollment in other regulations.**
- **Section 438.52 for enrollment of beneficiaries in a single MHP in each county.**

2) Section 438.10 (f)(3)—Information requirements: This section establishes specific requirements for the types, content and distribution of information describing the MHP program. The State requests that the waiver of the distribution requirements of subsection (f)(3), granted in previous waiver renewal requests, be continued. This allows MHPs to provide informing materials and provider lists that meet the content requirements of Section 438.10 to beneficiaries when they first access SMHS through the MHP and on request. The waiver of subsection (f)(3) would apply to the distribution requirements of the subsection only, not to any other provisions of the subsection except as directly related to the issue of distribution.

To the extent necessary, the continuation of waivers previously granted are requested of all sections of the these federal regulations that mention the obligation to inform all enrollees,

instead allow informing of all beneficiaries on request and/or when a beneficiary first accesses SMHS though an MHP.

B. Delivery Systems

1. Delivery Systems. **The State will be using the following systems to deliver services:**

a.___ MCO: **Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.**

b._X_ PIHP: **Prepaid Inpatient Health Plan means an entity that:**
(1) **provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.**

__ The PIHP is paid on a risk basis.

_X_ The PIHP is paid on a non-risk basis. The PIHPs are not at risk for FFP for the cost of services.
In 1994, Medi-Cal mental health managed care statutes were enacted (California W&I Code, Sections 5775 et seq (subsequently amended and renumbered as §14712)) and 14680 et seq.). In accordance with these statutes, specialty mental health services are provided by the MHP. Accordingly, the SMHS Consolidation waiver program is administered locally by each county's MHP and each county's MHP provides, or arranges for, specialty mental health services for Medi-Cal beneficiaries.

CMS has indicated that capitation is the definition of "at risk." MHPs are not paid on a capitated basis; instead, MHPs are paid on a fee-for-service basis.

For FY 2013-2014 –FY 2017-2018, counties will utilize realignment funds, MHSA and/or local county funds to pay for services which counties will then certify as public expenditures.

1. Realignment funds: Realignment funds are continuously appropriated to counties and are not subject to appropriation in the

State Budget. Funding is derived from dedicated funding sources. Funding was first realigned to the counties in 1991, through the Bronzan-McCorquodale Act and again as part of the 2011-2012 Governor's budget effective July 1, 2012.

- **1991 Realignment**
  Realignment funds (which originate from a sales tax increase and a vehicle license fee increase) are collected by the State Controller's Office and allocated to various accounts and sub-accounts in a State Local Revenue Fund. Each county has three program accounts: mental health, social services and health. Each month the state distributes funds from the Local Revenue Fund to counties' local health and welfare trust funds for the provision of mental health, social services and health care program(s). State law (W&I Code, Section 14714(j)) specifies that counties must fulfill their Medi-Cal contract obligations before funding other non-Medi-Cal programs with Realignment funds.
- **2011 Realignment**
  Established a Local Revenue Fund 2011 into which a percentage of sales tax and vehicle license fee revenue is deposited. A percentage of sales tax revenue deposited into the Local Revenue Fund 2011 is allocated to a behavioral health subaccount and distributed to counties to provide specialty mental health services, Drug Medi-Cal services, and Substance Use Disorder services.

2. MHSA funds: Enactment of the MHSA in 2004, imposed a 1 percent income tax on personal income in excess of $1 million. To the extent that a county mental health system receives MHSA funds (intended for new and innovative programs), counties may provide services to Medi-Cal beneficiaries through these new or transformed programs. Medi-Cal reimbursable services to eligible beneficiaries may be funded with county MHSA funds, at county discretion. However, the funds may not be used to supplant existing state or county funds utilized to provide mental health services.

3. Other County funds: At county discretion, other county funds may also be used to administer the SMHS waiver program and for the provision of specialty mental health services.

c.___ PAHP: **Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3)**

does not have a comprehensive risk contract. This includes capitated PCCMs.

___ The PAHP is paid on a risk basis.
___ The PAHP is paid on a non-risk basis.

d.___ PCCM: **A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.**

e. ___ Fee-for-service (FFS) selective contracting: **A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:**
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f.___ Other: **(Please provide a brief narrative description of the model.)**

2. Procurement. **The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):**

___ Competitive **procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)**
___ Open **cooperative procurement process (in which any qualifying contractor may participate)**
_X_ Sole source **procurement**
___ Other **(please describe)**

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

_X_ The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of

choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

The State continues to contractually require MHPs to ensure the availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions on a one-hour basis as stated in the MHP Contract (Exhibit A, Attachment 1).

Access continues to be assured and monitored through state regulations (Title 9, CCR, Section 1810.405), the State's review and approval of any amendments to the MHPs implementation plans for the program (Title 9, CCR, Section 1810.310(c)), on-going contract management by the State; and formal triennial reviews of the MHPs.

Beneficiaries are provided with a choice of providers within the MHP and an opportunity to change providers whenever feasible under Title 9, CCR, Section 1830.225. Although the regulation allows MHPs to limit the beneficiary's choice to two (2) providers, the beneficiary may request an additional change if not satisfied. The regulation also states that the opportunity for choice may be limited by feasibility. In most cases, feasibility is linked to the number of providers in the MHP's network. An MHP in a very small county or in any one geographic area may have a limited number of providers for a particular service. If additional providers are not needed to meet general access requirements, MHPs are not obligated to contract with additional providers to provide more choices for an individual beneficiary. In a very small number of cases, the MHP may deny a request for a change of provider when a change is clinically contraindicated.

2. Details. **The State will provide enrollees with the following choices (please replicate for each program in waiver):**

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X_ Other: (please describe) Beneficiaries are automatically enrolled in the single MHP in their county.

3. Rural Exception.

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that

it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f) (1) (ii)):

4. 1915(b)(4) Selective Contracting

___ **Beneficiaries will be limited to a single provider in their service area (Please Define Service Area)**

___ **Beneficiaries will be given a choice of providers in their service area.**

D. Geographic Areas Served by the Waiver

1. General. **Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.**

_X__ Statewide **-- all Counties, zip codes, or regions of the State**

___ Less than Statewide

2. Details. **Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Alameda	**PIHP**	**Alameda Behavioral Health Care Services**
Alpine	**PIHP**	**Alpine County Behavioral Health Services**
Amador	**PIHP**	**Amador County Mental Health**
Butte	**PIHP**	**Butte County Department of Behavioral Health**
Calaveras	**PIHP**	**Calaveras County Behavioral Health Services**
Colusa	**PIHP**	**Colusa County Department of Behavioral Health Services**
Contra Costa	**PIHP**	**Contra Costa County Mental Health**
Del Norte	**PIHP**	**Del Norte County Mental Health**
El Dorado	**PIHP**	**El Dorado Health and Human Service Agency**
Fresno	**PIHP**	**County of Fresno, Department of Behavioral Health**
Glenn	**PIHP**	**Glenn County Behavioral Health**
Humboldt	**PIHP**	**Humboldt County Health and Human Services**
Imperial	**PIHP**	**Imperial County Behavioral Health Services**
Inyo	**PIHP**	**Inyo County Mental Health**
Kern	**PIHP**	**Kern County Mental Health Services**
Kings	**PIHP**	**Kings County Behavioral Health Administration**
Lake	**PIHP**	**Lake County Mental Health Department**
Lassen	**PIHP**	**Lassen County Health and Social Services**
Los Angeles	**PIHP**	**Los Angeles County Mental Health**
Madera	**PIHP**	**Madera County Behavioral Health Services**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Marin	**PIHP**	**Marin County Community Mental Health Services**
Mariposa	**PIHP**	**Mariposa County Mental Health**
Mendocino	**PIHP**	**Mendocino County Mental Health**
Merced	**PIHP**	**Merced County Mental Health**
Modoc	**PIHP**	**Modoc County Mental Health Services**
Mono	**PIHP**	**Mono County Behavioral Health**
Monterey	**PIHP**	**County of Monterey**
Napa	**PIHP**	**Napa County Health & Human Services**
Nevada	**PIHP**	**Nevada County Behavioral Health**
Orange	**PIHP**	**Orange County Healthcare Agency Behavioral Health Services**
***Placer/Sierra**	**PIHP**	**Placer County Adult Systems of Care**
Plumas	**PIHP**	**Plumas County Mental Health Services**
Riverside	**PIHP**	**Riverside Department of Mental Health**
Sacramento	**PIHP**	**Health & Human Services**
San Benito	**PIHP**	**San Benito County Behavioral Health**
San Bernardino	**PIHP**	**San Bernardino County Behavioral Health**
San Diego	**PIHP**	**San Diego County Behavioral Health Division**
San Francisco	**PIHP**	**San Francisco Community Behavioral Health Services**
San Joaquin	**PIHP**	**San Joaquin County Behavioral Health Services**
San Luis Obispo	**PIHP**	**San Luis Obispo County Behavioral Health Department**
San Mateo	**PIHP**	**San Mateo County Behavioral Health & Recovery Services**
Santa Barbara	**PIHP**	**Santa Barbara County Alcohol, Drug & Mental Health Services**
Santa Clara	**PIHP**	**Santa Clara County Valley Health and Hospital Systems Mental Health Department**
Santa Cruz	**PIHP**	**Santa Cruz County Mental Health and Substance Abuse Services**
Shasta	**PIHP**	**Shasta Mental Health**
Siskiyou	**PIHP**	**Siskiyou County Human Services Agency**
Solano	**PIHP**	**Solano County Health and Social Services**
Sonoma	**PIHP**	**Sonoma County Mental Health**
Stanislaus	**PIHP**	**Stanislaus County Behavioral Health and Recovery Services**
Sutter/Yuba	**PIHP**	**Sutter/Yuba Mental Health Services**
Tehama	**PIHP**	**Tehama County Health Services Agency, Mental Health Division**

City/County/Regions	Type of Program	Name of Entity (for MCO, PIHP, PAHP)
Trinity	**PIHP**	**Trinity County Behavioral Health Services**
Tulare	**PIHP**	**Tulare County Health and Human Services Agency, Mental Health Division**
Tuolumne	**PIHP**	**Tuolumne County Behavioral Health Department**
Ventura	**PIHP**	**Ventura County Behavioral Health Department**
Yolo	**PIHP**	**Yolo County Department of Alcohol, Drug, and Mental Health Services**

*** Please Note: Placer County Adult Systems of Care manages the MHP for both Placer and Sierra counties.**

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. Included Populations. **The following populations are included in the Waiver Program:**

_X_ Section 1931 Children and Related Populations **are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_ X_ Section 1931 Adults and Related Populations **are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Blind/Disabled Adults and Related Populations **are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Blind/Disabled Children and Related Populations **are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.**

X_ Mandatory enrollment
___ Voluntary enrollment

_X_ Aged and Related Populations **are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.**

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ 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.**

X__ Mandatory enrollment
___ Voluntary enrollment

_X__TITLE XXI SCHIP **is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.**
California has operated its CHIP program through a combination of CHIP and Medicaid expansion coverage. The State is in the process of transitioning children from Healthy Families Program (California's CHIP to Medi-Cal as a Medicaid expansion.

__X_ Mandatory enrollment
___ Voluntary enrollment

2. Excluded Populations. **Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:**
Note: Although Medicare Dual Eligible individuals and individuals with other health coverage (OHC) are included in the waiver program, Medi-Cal SMHS delivered by the MHPs reimbursable by either Medicare or OHC will be billed first to Medicare and/or OHC with Medi-Cal being the payer of last resort in accordance with W&I Code section 14005(a)"..

___ Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))**

___ Poverty Level Pregnant Women -- **Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.**

___ Other Insurance--**Medicaid beneficiaries who have other health insurance.**

___ Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).**

___ Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program**

___ Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.**

___ Participate in HCBS Waiver--**Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).**

___ American Indian/Alaskan Native--**Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.**

___ Special Needs Children (State Defined)--**Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.**

___ SCHIP Title XXI Children **– Medicaid beneficiaries who receive services through the SCHIP program.**

___ Retroactive Eligibility – **Medicaid beneficiaries for the period of retroactive eligibility.**

___ Other **(Please define):**

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

__X_ **The State assures CMS that services under the Waiver Program will comply with the following federal requirements:**

- **Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).**
- **Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.**
- **Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b) (Note: Family planning services are not covered by the MHPs.)**

___ **The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).**

_X_ **The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

___ **This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.**

_X_ *The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.*

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. Emergency Services. **In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.**

___ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. Family Planning Services. **In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:**

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
__ Other (please explain):

_X__ Family planning services are not included under the waiver.

4. FQHC Services. **In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:**

__ The program is voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.**

___ **The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:**

_X_ **The program is** mandatory **and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program. Note: FQHC services are not covered by the MHPs under the waiver program.**

5. EPSDT Requirements.

_X_ **The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.**

The Medi-Cal SMHS Consolidation waiver program is a program that covers only specialty mental health services. MHPs, therefore, are not responsible for the screening function of EPSDT. MHPs may perform the diagnosis function through assessments of beneficiaries requesting services. With respect to the requirements of 1902(a)(43), therefore, MHPs are responsible only for subsection C with respect to arranging for or providing "corrective treatment" identified by a screening and referral or by the MHP's own assessment process. MHP informing materials include information about the State's Child Health and Disability Prevention (CHDP) program, which is the State's formal process for meeting the requirements of 1902(a)(43).

6. 1915(b)(3) Services.

___ **This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.**

7. Self-referrals.

_X_ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Under the waiver program, referrals to the MHP for specialty mental health services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to physical health care providers, schools, county welfare departments, other MHPs, conservators, guardians, family members, and law enforcement agencies. MHPs may not deny an initial assessment to determine whether a beneficiary meets the medical necessity criteria for receiving services from the MHP; however, the MHP may require beneficiaries to request these initial assessments through a formal system at the MHP. MHP informing materials provide beneficiaries with the information needed to obtain services from the MHP.

MHPs are, as stipulated in their contracts, prohibited from requiring prior authorization of emergency services. Each MHP may decide whether or not to require prior authorization of all other SMHS and are obligated to require prior authorization of day treatment intensive and day rehabilitation services if those services will be provided more than five days a week.

Each MHP's informing material contains general information regarding their requirements. MHPs provide additional information to beneficiaries on request.

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.**

a. ___ Availability Standards. **The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Hospitals (please describe):

6.___ Mental Health (please describe):

7.___ Pharmacies (please describe):

8.___ Substance Abuse Treatment Providers (please describe):

9.___ Other providers (please describe):

b. ___ Appointment Scheduling **means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Urgent care (please describe):

8.___ Other providers (please describe):

c. ___ In-Office Waiting Times: **The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.**

1.___ PCPs (please describe):

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers (please describe):

d. ___ Other Access Standards **(please describe)**

3. Details for 1915(b)(4) FFS selective contracting programs: **Please describe how the State assures timely access to the services covered under the selective contracting program.**

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

_X__ **The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

_X__ **The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.**

a.___ The State has set enrollment limits **for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.**

b.___ The State ensures that there are adequate number of PCCM PCPs with open panels**. Please describe the State's standard.**

c.___ The State ensures that there is an adequate number **of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.**

d.___ The State compares numbers of providers **before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.**

Providers	**# Before Waiver**	**# In Current Waiver**	**# Expected in Renewal**
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1			
2.			
3.			
4.			

***Please note any limitations to the data in the chart above here:**

e.___ The State ensures adequate geographic distribution **of PCCMs. Please describe the State's standard.**

f.___ PCP: Enrollee Ratio. **The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.**

Area(City/County/Region)	*PCCM-to-Enrollee Ratio*
Statewide Average: (e.g. 1:500 and 1:1,000)	

g. ___ Other capacity standards **(please describe):**

3. Details for 1915(b)(4) FFS selective contracting programs: **Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.**

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

_X__ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. _X_ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

Under the SMHS waiver program, there is no difference in the provision of services for special needs populations and any other covered population. All beneficiaries must meet the medical necessity criteria for specialty mental health services. MHPs are required to ensure that all beneficiaries who meet the medical necessity criteria have an assessment and a treatment plan that meet specific standards included in the MHP Contract (Exhibit A, Attachment 1, Item 11).

The waiver program is limited to the coverage of specialty mental health services provided by specialists.

b. _X_ Identification. **The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.**

For the purposes of the SMHS waiver program, persons with special health care needs are adults who have a serious mental disorder and children with a serious emotional disturbance. These beneficiaries are identified through the assessment process by the MHP as meeting the SMHS medical necessity criteria.

c. ___ Assessment. **Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.**

d. ___ Treatment Plans. **For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:**

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.__ In accord with any applicable State quality assurance and utilization review standards.

e. ___ Direct access to specialists. **If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.**

3. Details for PCCM program. **The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.**

a. ___ Each enrollee selects or is assigned to a primary care provider **appropriate to the enrollee's needs.**

b. ___ Each enrollee selects or is assigned to a designated health care practitioner **who is primarily responsible for coordinating the enrollee's overall health care.**

c. ___ Each enrollee is receives health education/promotion **information. Please explain.**

d. ___ Each provider maintains, for Medicaid enrollees, health records **that meet the requirements established by the State, taking into account professional standards.**

e. ___ There is appropriate and confidential exchange of information **among providers.**

f. ___ Enrollees receive information about specific health conditions that require follow-up **and, if appropriate, are given training in self-care.**

g. ___ Primary care case managers address barriers **that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.**

h. ___ Additional case management **is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).**

i. ___ Referrals: **Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.**

4. Details for 1915(b)(4) only programs: **If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.**

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

_X__ **The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

_X__ **The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.**

_X__ **Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on August 19, 2004.**

_X__ **The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):**

Beginning in FY 2004-2005, a contract with APS Healthcare Midwest for the provision of EQRO activities has been in effect. . Most recently, a contract (Contract Number 09-79002-002) was entered into for the period covering FY 2009/10 through FY 2011-2012 with an option to extend the contract for two additional one year extension periods covering FY 2012-2013 and FY

2013-2014. The State exercised the option of extending the contract covering FY 2012-2013 and the process to exercise that extension has been completed (DHCS# 12-89103). The State is in the process of extending the contract to cover FY 2013-2014. During waiver period 8, the State will conduct a procurement process to assure an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E.(see attachment 5 for the contract work plan.)

Copies of the EQR schedules can be found on the APS web site at: http://caeqro.com/webx?293@780.zhxhaibQmK9.1@.ee845a5 and http://caeqro.com/webx?293@780.zhxhaibQmK9.1@.ee8465f (see attachment 6).

The table below summarizes the State's EQR activities

Program	Name of Organization	Activities To be Conducted FY 2013/2018		
		EQR Study	Mandatory Activities	Optional Activities
	APS Healthcare Midwest	The results of the Performance Measure for 2010/11 are specified in results of monitoring activities for EQRO section -11 page 126 below. The Performance Measure for FY 2011/12 includes analyses of claims data including the following data elements: Gender Race/Ethnicity Service Activity	Validation that the MHP meets federal data integrity requirements Validation of performance measures Validation of PIPs Validation that the MHP meets quality requirements by conducting focus groups to obtain client and family member perspective and conducting interviews with providers and other stakeholders	Participation in statewide QIC meetings and the annual meeting of QI Coordinators Review of the Cultural Competence Plan and/or Update Focus Groups with beneficiaries Consultation with State and MHP information technology personnel on issues that impact State and MHP

Program	Name of Organization	Activities To be Conducted FY 2013/2018		
		EQR Study	Mandatory Activities	Optional Activities
		Eligibility Category (Aid group) Age Groups by Gender Performance Improvement Projects (PIPs): Two studies, one clinical and one non-clinical, are selected by each MHP and reviewed by the EQR in every MHP.	Review of the procedures the MHP has in place for collecting and integrating mental health service, financial, eligibility and service provider information covering service related data, from internal and external sources Participation of a diverse group of consumers and family members as part of the on-site review Validation of consumer satisfaction surveys Recommendations based on observed strengths and weaknesses of the MHP's Quality Management Program Technical assistance to each MHP Development of a statewide	Information Systems and EQR activities

Program	Name of Organization	Activities To be Conducted FY 2013/2018		
		EQR Study	Mandatory Activities	Optional Activities
			summary report after FY 2011/2012 and FY 2012/2103 is completed. **Participation in statewide meetings as required to provide information on EQRO activities** **Recruit and train a diverse group of consumers and family members from around the state who shall participate as part of each on-site review team**	

2. Assurances For PAHP program.

___ **The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.**

___ **The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.**

___ **The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office**

for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. Details for PCCM program. **The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.**

a. ___ The State has developed a set of overall quality improvement guidelines **for its PCCM program. Please attach.**

b. ___ State Intervention: **If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.**

1.___ Provide education and informal mailings to beneficiaries and PCCMs;

2.___ Initiate telephone and/or mail inquiries and follow-up;

3.___ Request PCCM's response to identified problems;

4.___ Refer to program staff for further investigation;

5.___ Send warning letters to PCCMs;

6.___ Refer to State's medical staff for investigation;

7.___ Institute corrective action plans and follow-up;

8.___ Change an enrollee's PCCM;

9.___ Institute a restriction on the types of enrollees;

10.___ Further limit the number of assignments;

11.___ Ban new assignments;

12.___ Transfer some or all assignments to different PCCMs;

13.___ Suspend or terminate PCCM agreement;

14.___ Suspend or terminate as Medicaid providers; and

15.___ Other (explain):

c. ___ Selection and Retention of Providers: **This section provides the State the opportunity to describe any requirements, policies or procedures it has in**

place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

___ **The utilization management system.**
___ **The complaint and appeals system.**
___ Enrollee surveys.
___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. __ Other (please describe).

d. ___ Other quality standards **(please describe):**

4. Details for 1915(b)(4) only programs: **Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:**

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing **includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).**

1. Assurances

_X__ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

The Medi-Cal SMHS Consolidation waiver program provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single MHP operating in the county of the beneficiary. Since there is no enrollment process or choice of plan, marketing by the MHP or the State is not necessary. Accordingly, the remainder of Part IV, Section A has not been completed.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1.___ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. **Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.**

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

- **i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.**
- **ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.**
- **iii.__ Other (please explain):**

B. Information to Potential Enrollees and Enrollees

1. Assurances.

_X__ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages

_X__ Potential enrollee and enrollee materials will be translated into the prevalent non-English languages **listed below (If the State does not require written materials to be translated, please explain):**

The State defines prevalent non-English languages as: (check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.

3. X Other (please explain): Title 9, CCR, Section 1810.410(a) (3) describes the process for determining "prevalent non-English languages" (referred to in the specialty mental health program as "threshold languages") which are defined as a language identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the

beneficiary population, whichever is lower, in an identified geographic area. . The most current information notice can be found at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice11-07.pdf (see attachment 7).

_X__ Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

- **All MHPs must have a toll-free telephone number that is available 24 hours a day, seven days a week to provide information about SMHS in all languages spoken by beneficiaries of that county . Additionally, MHPs must provide oral translation services at key points of contact to assist beneficiaries to access and maintain services.**." **This may be accomplished through translation or "language line" services accessed through a remote telephone services provider. The MHP's process for meeting these requirements must be included in the MHP's Cultural Competence Plan. MHPs are required to comply with their Cultural Competence Plans by Title 9, CCR Section 1810.410. The requirements of the Cultural Competence Plan are detailed in DMH Information Notice No. 02-03 which can be found at http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice02-03.pdf (see attachment 8).**
  CCP plan requirements were updated in 2010 and can be found at http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf and http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf. (see attachments 9 and 10)

_X__ The State will have a mechanism **in place to help enrollees and potential enrollees understand the managed care program. Please describe.**
The State continues to assist enrollees to understand the managed care program through compliance with the requirements of Title 42, CFR, Section 438.10 to the extent applicable to the program. All Medi-Cal beneficiaries receive an annual notice that provides basic information about the program, the toll-free telephone number of their MHP and the other information required by Section 438.10(f)(2). New Medi-Cal beneficiaries will receive similar basic information about the program at the time they apply for Medi-Cal or at the time their eligibility is determined and upon request.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify) _____

_X__ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State. (The State is responsible for the annual notice required by Title 42, CFR ,Section 438.10(f) (2) and a related notice to new beneficiaries.)

(ii) ___ State contractor (please specify):_____

(ii) X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider. (MHPs are responsible for providing information to enrollees upon request and when enrollees first access service but they are not required to provide information contained in notices provided by the State.)

C. Enrollment and Disenrollment

1. Assurances.

_X__ The State assures CMS that it complies with section 1932(a) (4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

_X__ The State seeks a waiver of section 1902(a) (4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

As mentioned previously (see pages 28 and 29), waivers of the following sections of Title 42, CFR, have been requested and granted for the Medi-Cal SMHS Consolidation waiver program in all previous waiver renewals. The State requests that these waivers again be granted as circumstances relevant to enrollment and disenrollment remain unchanged.

- **Section 438.56 in its entirety along with waivers of related references to disenrollment in other regulations.**
- **Section 438.52 for enrollment of beneficiaries in a single MHP in each county.**

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. (Note: This section is not applicable given the nature of the waivers requested. CMS Regional Office has reviewed and approved the MHP contracts for compliance with applicable provisions of section 1932(a)(4) and Title 42, CFR, Chapter IV, Subchapter C, Part 438. Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details. **Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.**

a. Outreach.

____ **The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:**

b. Administration of Enrollment Process.

_X_ **State staff conducts the enrollment process.**

___ **The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.**

___ **The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.**

Broker name: _____

Please list the functions that the contractor will perform:
___ choice counseling
___ enrollment
___ other (please describe):

___ **State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.**

c. Enrollment. **The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.**

___ **This is a new program. Please describe the implementation schedule (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):**

___ **This is an existing program that will be expanded during the renewal period. Please describe the implementation schedule (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):**

___ **If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.**

i. ___ Potential enrollees will have____days/month(s) to choose a plan.

ii. ___ **Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.**

_X_ **The State** automatically enrolls **beneficiaries**

___ **on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)**

_X_ **on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)**

___ **on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____**

___ **The State provides** guaranteed eligibility **of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.**

___ **The State allows otherwise mandated beneficiaries to request** exemption **from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:**

___ **The State** automatically re-enrolls **a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.**

d. Disenrollment:

___ **The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.**

i.___ Enrollee submits request to State.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

_X__ **The State** does not permit disenrollment **from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.**

___ **The State has a** lock-in **period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).**
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

___ **The State** does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.**

___ **The State permits** MCOs/PIHPs/PAHPs and PCCMs to request disenrollment **of enrollees. Please check items below that apply:**

___ **MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:**

___ **The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.**

___ **If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.**

___ **The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.**

D. Enrollee rights.

1. Assurances.

_X__ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

__X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. Assurances for All Programs. **States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:**

a. **informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,**

b. **ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and**

c. **other requirements for fair hearings found in 42 CFR 431, Subpart E.**

_X__ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. Assurances For MCO or PIHP programs. **MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.**

_X__ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

3. Details for MCO or PIHP programs.

a. Direct access to fair hearing.

_X__ The State requires **enrollees to** exhaust **the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.**

___ **The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.**

b. Timeframes

_X__ **The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an** appeal **is 90 days (between 20 and 90). (NOTE: This time frame only applies if a Notice of Action was required.)**

_---_ **The State's timeframe within which an enrollee must file a grievance is days.**

c. Special Needs

___ **The State has special processes in place for persons with special needs. Please describe.**

4. Optional grievance systems for PCCM and PAHP programs. **States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.**

___ **The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):**

___ **The grievance procedures is operated by:**

- ___ **the State**
- ___ **the State's contractor. Please identify: _____**
- ___ **the PCCM**
- ___ **the PAHP.**

___ **Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)**

___ **Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.**

___ **Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)**

___ **Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)**

___ **Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____**

___ **Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.**

___ **Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.**

___ **Other (please explain):**

F. Program Integrity

1. Assurances.

_X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X_ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

Employs or contracts directly or indirectly with an individual or entity that is precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

_X__ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

_X_ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. Note: Amendments to MHP contracts relevant to these provisions will be submitted to CMS for approval.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	**(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)**
Access	**(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)**
Quality	**(Coverage and Authorization, Provider Selection, Quality of Care)**

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

<u>MCO and PIHP programs</u>. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

<u>PAHP programs</u>. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs,

including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Part I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

MCO, PIHP, and PAHP **programs -- there must be at least one checkmark in each column.**

PCCM and FFS selective contracting **programs – there must be at least one checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."**

If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.**

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data							X					X
Data Analysis (non-claims)						X	X					X
Enrollee Hotlines												
Focused Studies												
Geographic mapping												
Measure any Disparities by Racial or Ethnic Groups					X		X				X	X
Network Adequacy Assurance by				X			X	X		X	X	X

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Plan												
Ombudsman							X		X			X
On-Site Review				X	X	X	X	X	X	X	X	X
Performance Improvement Projects					X	X	X	X	X	X	X	X
Performance Measures						X	X		X		X	X
Periodic Comparison of # of Providers							X	X			X	
Profile Utilization by Provider Caseload												
Provider Self-Report Data												
Test 24/7 PCP Availability												
Utilization Review							X			X		X
Other:												
External Quality					X	X	X	X	X	X	X	X

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Reviews												
Cultural Competence Plans					X	X	X	X	X		X	X
Advisory Groups					X	X	X	X	X	X	X	X
Provider Appeals										X		
County Support				X	X	X	X	X	X	X	X	X

<u>Note: For waiver renewal period 8, the Monitoring Activity *Implementation Plan* has been integrated into the Monitoring Activity *Performance Measures* and the Monitoring Activity *Provider On Site Review* has been integrated into the Monitoring Activity *Onsite Reviews*</u>

Part II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- **Applicable programs (if this waiver authorizes more than one type of managed care program)**
- **Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)**
- **Detailed description of activity**
- **Frequency of use**
- **How it yields information about the area(s) being monitored**

a. ____ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. __X__ Consumer Self-Report data

___ CAHPS (please identify which one(s))
_X_ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

Strategy: Consumer Perception Survey

Personnel responsible: **State staff**

Detailed description of activity: **The consumer perception surveys obtain descriptive information about each consumer completing a survey. The surveys include questions about consumer satisfaction with services as well as questions about whether the services consumers received improved their ability to function in several domains.**

During waiver period 8, a convenience sampling methodology will be used similar to that used in waiver period 7.

Frequency of Use: **Annual**

How it yields information about the area(s) being monitored: **The consumer perception surveys are expected to yield information about clients' perceptions of access to care as well as quality and outcomes of care.**

Strategy: Onsite Triennial Review of MHP Beneficiary Satisfaction Policies/Processes

Personnel responsible: **MHPs develop and administer local policies and processes; State staff monitors for compliance during the triennial onsite review.**

Detailed description of activity: **All MHP's are required to have mechanism(s) or activity(ies) in place whereby the MHP can regularly gather and measure beneficiary satisfaction. Such mechanisms include but are not limited to surveys, and client focus groups. MHPs are required to have baseline statistics with goals for each year.**

During the triennial onsite reviews, state staff review the strategies used by the MHP related to beneficiary satisfaction including but not limited to beneficiary satisfaction surveys or focus groups. Such strategies may vary from county to county. State staff verify that the MHP has a strategy(ies) in place and reviews the strategy(ies) with MHP staff. Further, the MHPs provide documentation of the strategy(ies) used and examples of actions taken by the MHP in response to issues which surface during or as a result of beneficiary satisfaction strategies (i.e. reports of focus group discussions or reviews of beneficiary satisfaction survey findings). Deficiencies in this area are noted in the Plan of Corrections (POCs).

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:

> **4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?**
>
> > **4c. Monitoring beneficiary satisfaction as evidenced by:**
> > **1) A mechanism or activity is in place that regularly gathers and measures beneficiary satisfaction.**

***Frequency of Use*: Reviews of MHPs occur triennially**

***How it yields information about the area(s) being monitored*: The triennial review process provides the State with information on whether MHPs are complying with the responsibility to conduct beneficiary satisfaction activities. State staff also ask for examples of how the MHP uses this data to improve services and processes.**

Strategy Assess feasibility of collecting and reviewing results of MHP beneficiary satisfaction strategies

***Personnel responsible*: State staff**

***Detailed description of activity*: During waiver period 8, state staff will evaluate the feasibility of collecting and reviewing the results of strategies used by the MHPs such as beneficiary satisfaction surveys as an additional method to monitor beneficiary satisfaction and to identify problems and concerns that beneficiaries have regarding access to and quality of care. Given the fact that the surveys and other mechanisms are tailor made by each MHP to suit local needs, it is unclear whether any data could actually be aggregated and analyzed. Determining this will be as component of the effort.**

***Frequency of Use*: Determining the optimal timing for collection and review of information/data will be an element of exploring the feasibility of such a project.**

***How it yields information about the area(s) being monitored*: Review of actual data and information may provide a snapshot of particular issues and problems at both a local and state level possibly leading to a more focused follow-up.**

d. _X_ Data Analysis (non-claims)

- **___ Denials of referral requests**
- **___ Disenrollment requests by enrollee**
  - **___ From plan**
  - **___ From PCP within plan**
- **_X_ Grievances and appeals data**
- **___ PCP termination rates and reasons**
- **_X_ Other (please describe) Fair Hearing Data**

Strategy: Grievance and Appeals: Review and Analysis of MHP Annual Reports

***Personnel responsible*: State staff**

Detailed description of strategy: **DHCS requires MHPs to submit annual reports that summarize the numbers of grievances, appeals and state fair hearings by the general category of the complaint (e.g., access, denial of services, change of provider, quality of care, confidentiality or other). The reports are submitted to the County Support Unit in the Mental Health Services Division.**

During waiver period 8, the grievance and appeals data will be used to identify potential trends and/or issues that should be addressed with the individual MHPs and/or that indicate statewide trends that may require technical assistance or policy clarification. Staff in the County Support unit will monitor the submission of these reports and follow-up as necessary with individual MHPs. Staff will also identify potential statewide trends which may need to be addressed more broadly. Additionally, staff in the County Support unit will share significant issues with Program Oversight and Compliance staff prior to onsite reviews.

During the waiver period 8, staff in the County Support unit will develop and provide a standardized reporting format for MHPs to use for their annual report.

Frequency of use: **Annual**

How it yields information about the area(s) being monitored: **The grievance and appeal report from the MHPs provides information on the issues of concern affecting the beneficiaries being served by each MHP, particularly in the area of access to and quality of care.**

Strategy: Onsite Triennial Review: MHP Grievance and Appeals Policies/Procedures

Personnel responsible: **MHPs develop local policies and procedures; State staff review and monitor for compliance**

Detailed description of activity: **All MHPs are required to have strategies in place to evaluate beneficiary grievances, appeals and fair hearings on an annual basis. During the triennial onsite reviews, state staff review documentation of these strategies and evidence that the annual evaluation has occurred. Staff also ask the MHP to provide 1-2 examples of grievances or appeals from receipt through resolution. Deficiencies in this area are noted in the POCs.**

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) Section I, (see attachment 11) are the following:

4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities in the following work plan areas?

4c. Monitoring beneficiary satisfaction as evidenced by:

2) Annual evaluation of beneficiary grievances, appeals, and fair hearings.

Frequency of Use: **Reviews of MHPs occur triennially.**

How it yields information about the area(s) being monitored:
The triennial review process provides the State with information regarding whether MHPs are maintaining grievance, appeals and fair hearing data and evaluating it on an annual basis.

Strategy: Fair Hearing Data

Personnel responsible: **State staff and MHPs**

Detailed description of activity: **State staff provides information to MHPs regarding the status and outcome of state fair hearings for Medi-Cal beneficiaries by providing informational notices, background information, and scheduling information to the MHP. Additionally, the State maintains a database to track the status and disposition of state fair hearings.**

The MHP works directly with the beneficiary, writes the Statement of Position (SOP), and attends the State Fair hearings so that the MHP may represent its position in the hearing process.

The CDSS State Hearings Division notifies appropriate State staff when a beneficiary files a request for a state fair hearing, tracks the status of the fair hearings request, and receives the final results of fair hearings. Administrative Law Judges may consult with State staff concerning proposed decisions prior to issuing final decisions, and rehearing requests.

Frequency of use: **Annual and as needed. The percentage of state fair hearings involving mental health issues is less than 1 percent of the total number of state fair hearings conducted by CDSS.**

How it yields information about the area(s) being monitored:
The review of fair hearing data provides State staff with the ability to provide technical assistance to MHPs on specific fair hearing issues.

e.___ Enrollee Hotlines operated by State

f. ___ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not

require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

g. __ Geographic mapping of provider network

h. X Measurement of any disparities by racial or ethnic groups

Strategy: Review/Analysis of data

***Personnel responsible:* State staff**

***Detailed description of activity:* Data from a variety of sources is reviewed and analyzed for indicators of potential disparities in beneficiaries' access to SMHS. Data is also analyzed in the context of race/ethnicity by gender, age, diagnosis and other factors when such information is available.**

Sources include:

- **Statewide Cultural/Ethnic Population Data obtained from California's Department of Finance**
- **Paid Claims Data broken out by MHP, cost of service, demographic information, and dates of services.**
- **Client and Service Information System (CSI) contains geographic data elements (county, city, MHP), primary and preferred language, ethnicity, race, and gender.**

***Frequency of use:* As needed.**

***How it yields information about the area(s) being monitored*: Review and analysis of data as described above assists the State to determine potential disparities.**

Strategy: Onsite Triennial Review: MHP's Policies/Procedures Regarding Access to Culturally/Linguistically Appropriate Services

***Personnel responsible:* State staff and MHPs.**

***Detailed description of activity:* MHPs are required in their CCP to address and update strategies and efforts for reducing disparities in access to SMHS and quality and outcome of these services in the context of racial, ethnic, cultural, and linguistic characteristics. Further, all MHPs are required to have mechanism(s) or activity(ies) in place whereby the MHP can assess the availability of appropriate cultural/linguistic services within the service delivery capacity of the MHP. Such mechanism(s) include but are not limited to:**

- **A list of non-English language speaking providers in the beneficiary's service areas by category;**

- **Culture-specific providers and services in the range of programs available;**
- **Beneficiary booklet and provider list in the MHPs identified threshold languages;**
- **Outreach to under-served target populations informing them of the availability of cultural/linguistic services and programs;**
- **A statewide toll-free telephone number, 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county that will provide information to beneficiaries about access, services and the use of beneficiary problem resolution/fair hearings;**
- **Interpreter services;**

During the triennial onsite reviews, state staff reviews information provided by the MHP to ensure that the above mechanisms are in place. Deficiencies in this area are noted in the POCs.

Examples of items specific to this issue in the System Review Protocol, Access Section A, (see attachment 11) are:

> **11. Is there evidence that Limited English Proficient (LEP) individuals are informed of the following in a languages they understand: a) LEP individuals have a right to free language assistance services; b) LEP individuals are informed how to access free language assistance services; and c) Is there documented evidence to show that the MHP offered interpreter services?**
>
> **13. Has the MHP developed a process to provide culturally competent services as evidenced by: a) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP, to provider interpreter or other support services to beneficiaries; b) Implementation of training programs to improve the cultural competence skills of staff and contract providers; and c) A process that ensures the interpreters are trained and monitored for language competence.**

Examples of items specific to this issue in the System Review Protocol, Target Populations Section E (see attachment 11) are

> **1a. To the extent resources are available, are services encouraged in every geographic area and are the services to the target populations planned and delivered so as to ensure access by members of the target populations, including all ethnic groups in the state?**
>
> **1b. To the extent resources are available, is the county organized to provide an array of treatment options in every geographic area to the target population categories as described in W&I section 5600.3, including all ethnic groups?**

Frequency of Use: **Reviews of MHPs occur triennially.**

How it yields information about the area(s) being monitored: **The triennial review process provides the State with information as to whether MHPs are complying with their responsibility to provide mechanism(s) about culturally and linguistically appropriate services as a core component of access and quality of care.**

i. X Network adequacy assurance submitted by plan [Required **for CO/PIHP/PAHP]**

Strategy: MHP Contract

Personnel responsible: **State staff and MHPs**

Detailed description of activity: **The MHP contract (Exhibit A1, Items 2C and D) requires MHPs to offer an appropriate range of specialty mental health services that is adequate for the anticipated number of beneficiaries for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area. In addition, MHPs are required to report to the Department whenever there is a change in their operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries or a reduction of an average of 25 percent or more in outpatient provider rates. MHPs must also provide details regarding the change and plans to maintain adequate services and providers available to beneficiaries.**

Frequency of use: **When there is a significant change in an MHP's network.**

How it yields information about the area(s) being monitored: **Assurance from the MHPs that their networks are adequate to meet the needs of the beneficiaries being served provides the State with more current information on the MHPs' networks than might be obtained through on-site reviews or other monitoring activities.**

Strategy: Onsite Triennial Review: MHP's Policies/Procedures Regarding Numbers and Types of Providers

Personnel responsible: **MHPs develop local policies/procedures; State staff review and monitor for compliance**

Detailed description of activity **Each MHP is required to have a Quality Improvement Work Plan that includes its plan to monitor its service delivery capacity as evidenced by a description of the current number, types, and**

geographic distribution of mental health services within the MHP's delivery system. Further, the plan must include goals established for the number, type, and geographic distribution of mental health services. During the triennial onsite reviews, state staff review the QI Work Plan and Work Plan Evaluation to verify that goals have been established regarding the number, type and geographic distribution of mental health services within the MHP's delivery system. Staff also review the MHP provider list. Often the MHP will provide a map displaying geographic distribute of services. Deficiencies in this area are noted in the POCs.

Items specific to this issue in the System Review Protocol, Quality Improvement (QI) section (see attachment 11) are the following:

> **4. Does the QI work plan include goals and monitoring activities and is the MHP conducting activities to meet the following work plan areas?**
>
> > **4a Monitoring the service delivery capacity of the MHP as evidenced by:**
> >
> > **1) A description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system.**
> > **2) Goals are set for the number, type, and geographic distribution of mental health services.**

***Frequency of Use*: Reviews of MHPs occur triennially.**

***How it yields information about the area(s) being monitored*: The triennial review process provides the State with information as to whether MHPs are complying with their responsibility to monitor their service delivery capacity.**

j. X Ombudsman

***Personnel responsible:* State staff and MHPs**

***Detailed description of activity:* The purpose of the Ombudsman Office is to be a bridge between the mental health system and eligible beneficiaries receiving Medi-Cal specialty mental health services, by providing information and assistance to help people navigate the system.**
In addition to assistance available through an MHP, it is important for the State to assist beneficiaries for three reasons:

- **If the beneficiary believes there is the potential for conflict with their MHPs, he/she may feel uncomfortable or fearful about approaching the MHP directly.**
- **The more assistance and resources are accessible to the beneficiary, the more likely it is that they will seek such assistance.**
- **Involvement in beneficiary protections is an important part of state oversight of the waiver program.**

The Ombudsman Office operates a toll-free telephone number. The phone line has staff available Monday through Friday during normal business hours from 8 a.m. to 5 p.m. During periods when staff persons are unavailable, callers can access a confidential voicemail 24 hours a day. The voicemail directs callers to 911 if there is an emergency in both English and Spanish and provides instruction in how to contact their local county mental health departments. Staff follow-up in response to voice mail each day within a prudent and reasonable timeframe based on the nature and complexity of the calls. The Ombudsman office also has a dedicated email address to provide an opportunity for written communication.

The office provides information and presents options to beneficiaries to access SMHS. B~~b~~eneficiaries have an opportunity to voice their concerns, brainstorm what steps they might take to resolve issues in regards to access and gain knowledge of how they might advocate for themselves. The Ombudsman office also assists callers by interfacing with the local Patient's Rights advocate or the assigned MHP problem resolution contact to resolve issues s about access, quality of care, grievance, appeals, and state fair hearings or other issues of concern to the callers.

With most complex cases, the Ombudsman Office will link the beneficiary with an MHP problem resolution contact by scheduling a telephone conference to identify a resolution(s) satisfactory to the beneficiary. The office also serves as an avenue for all Medi-Cal dually-insured beneficiaries, and persons without insurance in providing information and assistance on other issues of concern; for example, assisting beneficiaries to connect with appropriate local resources and/or agencies for resolution.

In cases when the issue may be one of contract compliance by a MHP, the Ombudsman Office will also make a referral to state staff assigned to work with individual MHPs. State staff from other units may work with the Ombudsman Office prior to an audit or review of an MHP to focus attention on potential issues at a particular MHP.

Frequency of use: **Beneficiaries are able to contact the office 24 hours a day 7 days a week by telephone, voicemail, and email. Staff is available between normal business hours of 8 a.m. to 5 p.m. (Monday – Friday) excluding holidays.**

How it yields information about the area(s) being monitored: **The Ombudsman Office utilizes a database for tracking purposes. This database is used to record and produce reports on the numbers of calls, type of calls, language of the caller, caller's county, and subject area of calls. Although the number and type of calls are not used as direct indicators of system performance, this information can be used to identify potential problems providing an**

opportunity for the Ombudsman office to research and prepare resources and options for beneficiaries.
The Ombudsman office works to keep current with changes in governmental policies and procedures that may directly affect beneficiaries served at the local level. This is done by following governmental releases and/or media releases and participating on committees and in workgroups.

k. **X** **On-site review**

There are four components to the State's on site review activities:

1) Triennial Systems Reviews
2) Triennial Chart Reviews- Non-Hospital Services (Outpatient) Adult and Children/Youth
3) SD/MC Hospital Inpatient Reviews
4) Provider Certification On-Site Reviews

Results for each component are described below

1. Strategy: Triennial System Reviews of the MHP

Detailed description of activity: **The triennial on-site system reviews of the MHPs are conducted to determine the MHP's compliance with state and federal regulations, provisions of the approved 1915(b) waiver and DHCS/MHP contractual requirements. The compliance review protocol for FY 2012-2013 includes the following system review sections: 1) Access; 2) Authorization; 3) Beneficiary Protection; 4) Funding, Reporting and Contracting Requirements; 5) Target Populations; 6) Interface with Physical Health Care; 6)Provider Relations; 7) Program Integrity; and 8) Quality Improvement (see attachments 11 & 12). The compliance protocol includes items regarding the MHP's Cultural Competency Plans, Quality Improvement Plans, Compliance Plans, the MHP's policies and procedures and the MHP's application of the policies and procedures in practice.**

The MHP's receive a final report summarizing the findings of the compliance review and are required to submit a Plan of Correction (POC) for each of the protocol items found out of compliance within 60 days of receipt of the final report.

The POC must include the MHP's proposed corrective action and documentation of the implementation of the corrective action. DHCS County Support Unit receives a copy of the final report and the MHP's POC and provides technical assistance to the MHPs as needed.

The MHP may appeal the review findings in writing within 15 working days of the receipt of the final report to the DHCS appeals officer.

The protocol is reviewed annually and revised as necessary. The Compliance Advisory Committee (CAC), in accordance with the Welfare and Institutions

Code, Section 5614, reviews the compliance protocol and provides consultation and recommendations to the Department. The CAC is comprised of representative stakeholders including consumers, family members advocates, mental health departments, community based providers and mental health boards.

***Personnel responsible*: State staff**

***Frequency of use:* Each MHP is reviewed triennially**

***How it yields information about the area(s) being monitored:* The on-site system reviews yield information about each MHP's compliance with regulatory and contractual requirements of the waiver, including access, authorization, beneficiary protection, funding, reporting and contracting requirements, target populations and array of services, interface with physical health care, provider relations, program integrity and quality improvement.**

2. Strategy: Triennial Chart Reviews- Non-Hospital Services (Outpatient) Adult and Children/Youth

-***Detailed description of activity:* The triennial non-hospital outpatient chart reviews are conducted to monitor and ensure compliance with state and federal regulations and statutes and DHCS/MHP contractual requirements. The review team is composed of licensed mental health clinicians and includes both state staff and contractors. The State provides oversight to ensure that the Medi-Cal claims submitted by the MHP's for specialty mental health services (SMHS) met medical necessity criteria for reimbursement and that the documentation in the medical records provided contain the required evidence of medical necessity. The current protocol being used can be found in the ANNUAL REVIEW PROTOCOL FOR CONSOLIDATED SPECIALTY MENTAL HEALTH SERVICES AND OTHER FUNDED SERVICES (see attachment 11).**

The chart sample for the reviews is provided by DHCS staff using established sampling methodology. The sample is drawn from the most recent 90 day period for which paid claims data is available. The chart sample consists of 10 beneficiaries or 20 beneficiaries depending on the size of the county population and consists of one half adult beneficiaries and one half children/youth.

. The team reviews the charts to determine whether the documentation supports the medical necessity criteria for non-hospital (outpatient) services. Chart documentation reviewed by the team includes the following:

- **Medical Necessity**
- **Assessment**

- **Client Plan**
- **Progress Notes**
- **Medication consents**
- **Medi-Cal and other insurance coverage**
- **Legal status, conservatorship and 5150 documentation and other legal documents**
- **Cultural and linguistic access**
- **Other Chart Documentation**

Disallowances are determined in accordance with MHSD Information Notice No. 12-05 "Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services for Fiscal Year 2012-2013" Enclosure 4 Reasons for Recoupment (see attachment 13) Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings.

The MHPs receive a final report with a summary of the findings of the non-hospital outpatient chart review and are required to submit a Plan of Correction (POC) for each of the non-hospital protocol items found out of compliance within 60 days of receipt of the final report. The POC must describe the MHP's corrective action and provide documentation of the implementation of the corrective action. DHCS County Support Unit receives a copy of the final report and the MHP's POC and provides technical assistance to the MHPs as needed. The MHP may appeal the review findings within 15 working days after receipt of the final report to the DHCS appeals officer.

Personnel responsible: **State staff**

Frequency of occurrence of reviews: **The non hospital (outpatient) chart reviews are conducted on a triennial basis. Eighteen to twenty MHPs are reviewed each fiscal year and all 58 MHPs are reviewed during the three year cycle.**
How it yields information about the areas being monitored: **The non-hospital (outpatient) chart reviews provide information on the degree of compliance to which SMHS provided by a MHP and their contracted providers meet medical necessity criteria for non-hospital (outpatient) services. Chart reviews also assist the State in determining if the MHP and their contracted providers are billing and claiming appropriately, and following the MHP's own chart documentation standards. This information enables the State to recoup FFP funds for those non-hospital (outpatient) SMHS which do not meet appropriate regulatory requirements.**

3. SD/MC Hospital Inpatient Reviews

Personnel responsible: **State staff**

Detailed description of activity: **A review team consisting of state staff and licensed mental health practitioners under contract to the State including, at a minimum, a physician and one or more licensed mental health professionals, conducts triennial reviews of SD/MC acute psychiatric inpatient hospitals. The principal focus of these reviews is to determine the following: (1) Whether the hospital's Utilization Review Plan meets requirements outlined in Title 42 of the Code of Federal Regulations Section 456.201-456.245: ; (2) Whether Medical Care Evaluation Studies have been performed as required by Title 42 of the Code of Federal Regulations Section 456.242-243 and whether they have been conducted in a methodologically acceptable fashion; (3) Whether the Plan of Care for each beneficiary meets the standards set forth in Title 42 of the Code of Federal Regulations; (4) Whether documentation for reimbursement of acute hospital days meets the requirements set forth in Section 1820.205 of Title 9 of the California Code of Regulations; (5) Whether documentation for reimbursement of administrative days meets the requirements described in Section 1820.220 of Title 9 of the California Code of Regulations; (6) Whether the hospital's utilization review function is effectively identifying those days for which documentation does not meet medical necessity criteria for admission or continued stay services, or regulatory requirements for administrative day services; and (7) Whether the quality of treatment provided to all beneficiaries meets acceptable community standards of care. The current protocol for these reviews, Sections K and L of the Compliance Protocol for Consolidated SMHS, is included in MHSD Information Notice No. 12-05, which can be found on the DHCS website at http://www.dhcs.ca.gov/formsandpubs/MHCCY/Enclosure1-FINAL_PROTOCOL_FY2012-13.pdf (see attachment 11)**

A sample of 60 admissions is drawn randomly from the universe of all hospital admissions during the most recent 90-day period for which claims appear to be complete. If there are fewer than 60 admissions in the most recent 90-day period for which claims appear to be complete, the audit will take as its subject all of the admissions for which claims were paid during that 90 day period.

The review team reviews the charts to determine whether the documentation supports the medical necessity criteria for acute psychiatric inpatient hospital services, as well as the requirements for administrative day services when applicable. Chart documentation reviewed by the team includes the following:

- **Physicians' admitting, treatment and discharge orders**
- **Physicians' admission summary**
- **History and physical examination**
- **Physicians', nurses' and social workers' progress notes**

- **Physicians' discharge summary**

In addition, the team reviews the medical records to determine the following:

- **Whether there is a written plan of care which includes the following elements:**
  - **Diagnoses, symptoms, behaviors, complaints or complications which indicate the need for admission to an acute psychiatric inpatient hospital**
  - **A description of the functional level of the beneficiary**
  - **Treatment objectives which are behaviorally specific and/or behaviorally quantifiable**
  - **A description of proposed interventions including duration**
  - **Orders for:**
    - **Medications**
    - **Treatments**
    - **Restorative and rehabilitative services**
    - **Activities**
    - **Therapies**
    - **Social Services**
    - **Diet**
    - **Special procedures recommended for the health and safety of the beneficiary**
  - **Plans for continuing care**
  - **Plans for discharge**
  - **Documentation of the beneficiary's degree of participation in and agreement with the plan**
  - **Documentation of the physician's establishment of the plan**

- **Whether documentation reflects staff efforts to screen, refer and coordinate with other necessary services, including, but not limited to:**
  - **Substance abuse treatment**
  - **Educational services**
  - **Health services**
  - **Housing services**
  - **Vocational rehabilitation services**
  - **Regional Center services**

***Frequency of occurrence of reviews*: Every third year. If significantly elevated rates of disallowance or quality of care concerns are detected, reviews may be scheduled more frequently, or may focus on particular areas of concern.**

***How it yields information about the area(s) being monitored*: The SD/MC hospital inpatient reviews provide information on the degree to which beneficiaries' medical records meet medical necessity criteria for admission and continued stay services and, where appropriate, requirements for**

administrative day services. This information enables the State to recoup FFP funds for those hospital days which do not meet appropriate regulatory requirements.

4. Provider Certification On-Site Reviews

***Personnel responsible:*–MHPs and State staff**

Detailed description of activity: **Per DMH Letter 10-04, (see attachment 15) the certification and re-certification of county owned/or operated organizational providers is the joint responsibility of the State and MHPs. The certification and re-certification of organizational providers contracting with the MHPs is the responsibility of the MHPs with the State approving and processing the required documentation.**

The Department is responsible for an onsite certification review of County owned and operated sites that request new Medi-Cal certification or re-certification when the following services are provided or activated or when there is a change of address/location:

- **Crisis Stabilization Units,**
- **Juvenile detention facilities,**
- **Day treatment intensive (full and half day programs),**
- **Day treatment rehabilitative providers (full and half day programs),**
- **When there is an addition of medication mode of services to existing certifications**

The State conducts Medi-Cal provider site certification and recertifications in accordance with Title 9 and DHCS/MHP contractual requirement. The "Provider Site Re/Certification Protocol" is the standardized review tool utilized for the provider site certification and recertification process (see attachment 15).

Frequency of occurrence of reviews: **Certification and recertification of county owned and operated provider sites are conducted as required.**

How it yields information about the area(s) being monitored: **The certification and recertification of county owned and operated provider sites ensure that the specialty mental health services are being certified and the facility itself meets all regulatory and contractual requirements**

l.. X Performance Improvement Projects [Required for MCO/PIHP]

X Clinical

X Non-clinical

Personnel responsible: **MHPs**

Detailed description of activity: **Since 1997, MHPs have been required by Title 9, CCR, Section 1810.440 and CFR Title 42 438.240(b)(1) to have a QI Program that meets specific minimum standards. The MHP contract, Exhibit A Attachment 1, Item 23 specifies the standards for the MHP's quality management and quality improvement programs which includes conducting at least two Performance Improvement Projects (PIPs), one clinical and one non-clinical that meet the validation standards applied by the EQRO contractor. The validation standards are:**

- **Monitoring the service delivery capacity of the MHP**
- **Monitoring the accessibility of services**
- **Monitoring beneficiary satisfaction**
- **Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices.**
- **Monitoring continuity and coordination of care with physical health care providers and other human services agencies**

During the eighth waiver period the EQRO will be collecting information regarding the two required PIPs and reporting findings in their annual reports. Data gathered from the PIPs will be available during the eighth waiver period to assist MHPs to continue to make program enhancements to improve the coordination, quality, effectiveness, and/or efficiency of service delivery to children who are receiving EPSDT services.

Frequency of use: **Ongoing; Each MHP is required to have an annual planning process for active clinical and non clinical PIPs.**

How it yields information about the area(s) being monitored: **PIPs and other quality improvement activities, depending on the specific issues selected for study, can provide the MHPs with information on access, quality of care, continuity/coordination of care, the grievance system, beneficiary informing, and provider selection and capacity. Two of the PIPs, one clinical and one non-clinical are reviewed by the EQRO (for more information regarding the EQRO see section s1 page 103) and a report is completed after each review. These reports provide concrete information on the validity of MHP PIPs.**

m.. X **Performance measures** [Required for MCO/PIHP]

- X **Process**
- _ **Health status/outcomes**
- X **Access/availability of care**
- X **Use of services/utilization**
- _ **Health plan stability/financial/cost of care**
- _ **Health plan/provider characteristics**
- X **Beneficiary characteristics**

Strategy: Measurements of indicators of mental health system performance on an ongoing and periodic basis.

Personnel responsible: **State staff**

Detailed description of Activity:

- **Paid Claims Data**
  - **Mean Monthly Specialty Mental Health (MH) Client Counts by Fiscal Year Quarter**
  - **Mean Monthly Population Served by Age and Race**
  - **Total Cost of Services/Medi-Cal Expenditures**
  - **Costs of Services/Medi-Cal Expenditures by Race**
  - **Types of Services by cost**
  - **Penetration Rate**

- **Consumer Perception Survey**

  Information on the consumer perception survey can be found in section c pages 81-83 and section 1 on page 111.
  - **Perception of Access to Services**
  - **Perception of Quality and Appropriateness of Services**
  - **Perception of Outcomes**
  - **Perception of Participation in Treatment Planning/Family Member Participation in Treatment Planning**
  - **General Satisfaction with Services**
  - **Perception of Changes in Functioning**
  - **Perception of Changes in Social Connectedness**
  - **Perception of Cultural Sensitivity of Staff**

Frequency of use: **Information is gathered and reports created on an as needed basis.**

How it yields information about the area(s) being monitored: **Results provide information about access, cost and the overall functioning of the mental health system**.

Strategy: Implementation Plans

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **The State requires MHP applicants to submit implementation plans that provide assurance that the entity has the capacity to be a successful MHP. Implementation plan requirements are described in Title 9, CCR, Sections 1810.305 and 1810.310 and in DMH Information Notice No. 97-06 which can be found at http://www.dmh.ca.gov/DMHdocs/docs/notices97/97-06not.pdf (see attachment14) The implementation plan process assists in monitoring the**

waiver program by ensuring that each MHP has the basic systems in place prior to the enrollment of beneficiaries with the MHP.

The implementation plan process also requires MHPs to submit changes to their implementation plan to the State for review and approval (see CCR Title 9 section 1810.310 (c)).

Frequency of use: **Once per MHP for the initial plan with ongoing updates**

How it yields information about the area(s) being monitored: **The Implementation Plan approval process for new MHPs provides basic information on an applicant's operational plans for serving as an MHP. The Implementation Plan for operational MHPs provides the State with a basic description of the MHP's systems for providing services to Medi-Cal beneficiaries. The approval process for changes to the operational MHP's Implementation Plans ensures that the State descriptions are current and provides immediate information to state staff regarding changes made or planned by the MHP.**

Strategy: Onsite Triennial Review: MHP's Quality Improvement (QI) Program

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **Each MHP is required (in accordance with the MHP/DHCS contract (Exhibit A, Attachment 1, Section 23), CCR, title 9, Section 1810.440 and CFR Title 42 Section 438.204, 240 and 358) to have a QI program, the purpose of which is to review the quality of specialty mental health services provided to beneficiaries by the MHP. The QI Program must have active participation by the MHP's practitioners and providers, as well as beneficiaries and family members.**

Activities specific to monitoring access, continuity of care and quality include but are not limited to:

- **Collecting and analyzing data to measure the goals, or prioritized areas of improvement that have been identified;**
- **Identifying opportunities for improvement and deciding which opportunities to pursue;**
- **Identifying relevant internal or external committees to ensure appropriate exchange of information with the QI Committee;**
- **Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;**
- **Designing and implementing interventions to improve performance;**
- **Measuring effectiveness of the interventions;**

- **Incorporating successful interventions into the MHP's operations as appropriate; and**
- **Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by CCR, title 9, section 1810.440(a)(5).**

During the triennial System Reviews, state staff review the QI work plan for evidence of QI activities that the MHP has engaged in including recommending policy changes, evaluation of QI activities, instituting needed actions, and ensuring follow-up of QI processes and previously identified issues. The MHP is also asked to show how they evaluate the effectiveness of the QI program and how QI activities have contributed to improvement in clinical care and beneficiary services. Staff verify that the MHP has identified goals and evidence of how they are monitoring the service delivery capacity of the MHP, the accessibility of services, beneficiary satisfaction, and the annual review of grievances/appeals/fair hearings and beneficiary requests to change the person providing services. The MHP is also asked how they monitor their delivery system in terms of relevant clinical issues, safety and effectiveness of medication practices, and what interventions are implemented when potential poor care issues are identified.

Specific protocol items related to this issue can be found in the System Review Protocol Section I, Quality Improvement (QI) section (see attachment 11).

Frequency of use: **The MHP's are required to review the QI Work Plan and revise as appropriate on an annual basis. During the triennial System Review state staff review both the QI Work Plan itself and evidence that activities identified in the Work Plan were implemented.**

How it yields information about the area(s) being monitored: **The review of the QI Work Plan itself and of the monitoring activities incorporated in the Work Plan provides information to both state and local staff in the following areas:**

- **Service delivery capacity as evidenced by a description of the current number, types, and geographic distribution of mental health services within the MHP's delivery system and set goals for the number, type, and geographic distribution of mental health services;**
- **Timeliness of routine mental health appointments;**
- **Timeliness of services for urgent conditions;**
- **Access to after-hours care;**
- **Responsiveness of the 24/7 toll-free number;**
- **Beneficiary satisfaction;**
- **Beneficiary grievances, appeals, and fair hearings;**
- **Requests for changing persons providing services;**

- **Relevant clinical issues, including the safety and effectiveness of medication practices;**
- **Interventions when occurrences of potential poor care are identified;**
- **Identification and evaluation of barriers to improvement related to clinical practice and/or administrative aspects of the delivery system by providers, beneficiaries, and family members; and**
- **Provider appeals**

n. Periodic comparison of number and types of Medicaid providers before and after waiver.

Personnel responsible: **State staff**

Detailed description of activity:
Inpatient Providers
MHPs are required to provide the State with a listing of their contract hospitals on October 1st of each year. The State also establishes the annual per diem rates for those hospitals that enroll in the Medi-Cal program to provide emergency psychiatric inpatient hospital services, but do not contract with any MHP. The State uses this information to monitor changes in the number of hospitals participating in the program since the beginning of the waiver program in 1995 and from year-to-year. The year-to-year changes are more significant than the changes since the beginning of the waiver program, because of the length of time the waiver has been in operation.

Non Hospital Providers
The Medi-Cal SMHS Consolidation waiver enabled MHPs to expand the range of practitioner types in their individual provider networks to include MFTs, LCSWs and RNs. This allows for greater ability to increase the number of available network practitioner providers.

However, although the State has rough approximations of the numbers and types of other specialty mental health providers before and after the waiver based on the SMHS waiver provider file, the number and types of mental health clinics and mental health professionals before and after the waiver have not been monitored because the differences in the delivery system before and after the waiver does not allow an accurate count. The capacity of organizational providers is not known from State data. Further, MHPs were only required to obtain one provider number for each practitioner type in their FFS/MC network, so there has not been current information available on the number of practitioner/providers statewide who contracted with MHPs.

In waiver period 8, the State will explore the feasibility of developing a data base, utilizing the National Provider Identifier, of the total number of individual providers under contract with MHPs and the total number of those providers who actually deliver SMHS services. FY 2008/2009 will be used as the base year since that was the first full fiscal year that providers under contract to the MHPS were required to utilize a NPI. If the development of such a data base proves feasible, a comparison will be done for each year since the baseline year comparing numbers and types of providers.

Frequency of use: **Information on contract hospitals is gathered annually. It is not known at this time how frequently data on individual providers may be available.**

How it yields information about the area(s) being monitored: **Monitoring the number of hospitals contracting with the MHPs provides information about access and provider selection. If a data base of providers can be developed information will be available as to the actual numbers and types of individual providers for each MHP as well as statewide allowing the State to identify trends potentially relevant to network adequacy.**

o.. ___ Profile utilization by provider caseload (looking for outliers)

p. ___ Provider Self-report data

___ Survey of providers

___ Focus groups

q.. ___ Test 24 hours/7 days a week PCP availability

r.. X Utilization review (e.g. ER, non-authorized specialist requests)

Strategy: MHP Utilization Management Program (UMP): Payment Authorization System

Personnel responsible: **MHPs/State staff**

Detailed description of activity: **MHPs are required ~~to~~ have a UMP which addresses ~~to~~ consistent application of medical necessity in their payment authorization systems. The UM Pin each MHP assists in monitoring the waiver program by ensuring that each MHP has systems in place to ensure beneficiaries have appropriate access to specialty mental health services as required by Title 9, CCR, Section 1810.440 and the MHP contract, Exhibit A, Attachment 1, Item 24.**

MHPs are required to establish MHP payment authorization systems consistent with Title 9, CCR, Section 1810.350, 1820.215, 1820.220, 1820.225

and 1820.230 for psychiatric inpatient hospital services and Section 1830.215 for all other services.

MHPs may determine whether or not to require prior authorization of services, with a few exceptions. MHPs may not require prior authorization of emergency services. However, as specified in the MHP contract Exhibit A, Attachment 1 item 8, MHPs must require prior authorization of day treatment intensive services, and day rehabilitation if those services will be provided more than five days a week. Additionally, MHPs must complete TARs for FFS/MC hospitals to allow payment by the Medi-Cal fiscal intermediary. In most cases the TARs are completed after the beneficiary is discharged.

During the triennial onsite reviews, state staff review the MHP's Utilization Management Program to assess whether MHPs provide beneficiaries access to specialty mental health services in the context of their established authorization criteria.

Frequency of use: **Annual evaluation by the MHP; Triennial review by state staff**

How it yields information about the area(s) being monitored: **The triennial review process provides the State with information as to whether the MHP UMP addresses access to services in the context of the MHP's authorization systems.**

s. X Other: (please describe)

1. **External Quality Reviews (EQRs)**

Personnel responsible: **State staff and EQRO contractor**

Detailed description of activity:
EQR activities are conducted with a focus on three overarching principles which have been agreed upon by the EQRO, the State and the MHPs as being core to the EQRO:

- **Cultural competence**
- **Consumer/family empowerment and involvement**
- **Wellness and recovery**

The three primary activities in which the EQRO contractor engages during reviews of MHPs in order to meet the requirements for EQR are:

- **PIP: Reviewing the validity of two MHP PIPs.**
- **Information Systems Capability Assessment (ISCA): Utilizing a California-specific ISCA protocol to review the integrity of the MHP's' information systems and the completeness and accuracy of the data produced by those systems.**

- **Technical Assistance and Training: Providing technical assistance and training as part of the site review and as well as post review.**

The review of each MHP is customized each year according to the findings of the previous year's reviews on statewide issues as well as the issues and recommendations made by the EQRO to that MHP in the context of their previous review. It includes an evaluative process of the overall service delivery system as it relates to business practices and strategic planning and development.

Representatives from the following MHP units are requested to participate in the review:

- **Executive leadership**
- **Information systems**
- **Finance, Data, and Operations**
- **Quality improvement**
- **Key direct clinical service staff and clinical supervisors**
- **Organizational contract providers**

The list of planned participants is discussed in detail with the lead reviewer prior to the site review in order to ensure that the appropriate staff members are included in each component of the review. The role of contract providers throughout the review is determined by consultative discussion between the lead reviewer and the MHP contact for the review.

Prior to the actual review, the following information is submitted by the MHP. The EQRO then considers the information during the review:

- **Detailed descriptions of two PIPs. The PIP Outline is sent to each MHP to aid them in determining areas to include in the descriptions. The MHP is asked to include other pertinent information as well that indicates the overall findings and changes in processes in response to the PIP findings.**
- **The current QI Work Plan, QI Work Plan Evaluation, Quality Improvement Committee (QIC) meeting minutes from the last year.**
- **A list of current cultural competence goals and cultural competence committee meeting minutes from the last year.**
- **A list of surveys of beneficiaries conducted within the last year.**
- **A current, detailed MHP organizational chart.**
- **A list of current MHP strategic initiatives.**
- **Timeliness Self-Assessment**
- **Response to the Prior Year Recommendations**
- **An updated ISCA**

Additional information on EQRO related monitoring activity can be found in section III.1 pages 53-56.

Frequency of use: **Annual**

How it yields information about the area(s) being monitored: **The EQRO completes a report on each MHP after the review. These reports provide concrete information on the validity of MHP PIPs, the State/MHP performance measurements and MHP information system capability including recommendations tailored to each MHP's situation.**

The EQRO also provides a written statewide annual report incorporating the findings of the performance measures validation activities, PIP validation activities, ISCA and input from clients and family members. This report:

- **Includes a detailed technical review that describes the manner in which data from all activities were aggregated and analyzed.**
- **Includes various analyses of Medi-Cal approved claims**
- **Addresses the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data;**
- **Outlines MHP performance in the four areas of Quality, Access, Timeliness and Outcomes.**
- **Includes an assessment of MHP's strengths and weaknesses with respect to the quality, timeliness and access to specialty mental health services furnished to the Medi-Cal beneficiaries by MHP's, including strengths and weaknesses on these issues from a cultural competency perspective.**
- **Includes recommendations representing the combined perspectives from the clinical/program lead, information systems reviewer, and consumer/family member consultant.**
- **Includes comparison to relevant national quality standards for Medicaid programs or comparable commercial products.**
- **Includes a public presentation of the report done via an electronic web based presentation or whatever means is agreed upon in writing by the contractor and the State.**

2. **Cultural Competence Plans**

Personnel responsible: **MHPs and State staff**

Detailed description of activity: **Title 9, CCR, Section 1810.410 requires each MHP have and comply with a Cultural Competence Plan (CCP) approved by the State and submit a CCP annually to the State. The 2010 CCP requirements are included in DMH Information Notices Nos 10-02 and 10-17 which can be found on the DHCS website at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-2.pdf (see attachment 9) and http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-17.pdf (see attachment 10**

DHCS is developing a plan to move forward with review of the CCPRs during waiver period 8. This plan includes collaboration with the newly established Office of Health Equity (OHE) located at the California Department of Public Health (DPH) to provide guidance on reducing mental health disparities to vulnerable communities. This collaboration will be strengthened through an interagency agreement between the two departments which will outline the process by which the departments will jointly work together to achieve the highest level of mental health for culturally, ethnically, linguistically, and geographically isolated communities. The collaboration will entail sharing resources to allow for appropriate CCPR developments and updates with monitoring through the triennial compliance reviews. In addition, the department will enlist input from subject matter experts and interested stakeholders to develop a robust CCPR process. Finally, DHCS is in the process of hiring additional staff to work on reviews of cultural competence plans and other related tasks.

Frequency of use: **As determined by the State**

How it yields information about the area(s) being monitored: **The county CCPs provide the State with baseline race and ethnicity data by county and enable MHPs to identify issues around disparities within their system.**

The CCP update approval process provides information on the MHP's progress in improving cultural competence and provides an opportunity for immediate feedback to the MHPs on problem areas.

3. Advisory Groups

a) Compliance Advisory Committee (CAC)

Personnel responsible: **State staff**

Detailed Description of Activity: **As specified in W&I Code, Section 5614, the State shall have representatives from relevant stakeholders including, but not limited to local mental health departments, local mental health boards and commissions, private and community based providers, consumers, family members and advocates.**

The CAC plays a very significant role in the establishment of the annual Compliance Review Protocol tool which includes the following elements:

- **Access**
- **Authorization**
- **Beneficiary protection**
- **Funding, reporting and contracting requirements**
- **Target populations and array of services**
- **Interface with physical health care**

- **Provider relations**
- **Program Integrity**
- **Quality improvement**
- **Chart review—non-hospital services**
- **Chart review—sd/mc hospital services**
- **Utilization review—sd/mc hospital services**
- **Therapeutic behavioral services**

Annual meetings are held with CAC members and state staff to review drafts of the annual Compliance Review Protocol for specialty mental health services. The CAC recommendations are taken under consideration and incorporated into the protocol as deemed appropriate. The collaborative ongoing partnership between CAC and the State has ensured that local mental health departments meet statutory and regulatory requirements for the provision of publicly funded community health services.

The State will continue with the plan and practice of consultation and collaboration with the CAC in FY 2013-2018 regarding the Compliance Review Protocol.

b) California Mental Health Planning Council (CMHPC)

Personnel responsible: **State staff and CMHPC**

Detailed Description of Activity: **The CMHPC is mandated by federal and state law to advocate for children with serious emotional disturbances and adults and older adults with serious mental illnesses. It also provides oversight and accountability for the public mental health system as a whole and has a pivotal role in obtaining federal Community Mental Health Services Block Grant funding for California. It has been and continues to be an invaluable instrument for public involvement in mental health planning and program development.**

In addition to the above, the CMHPC has a legislative mandate to establish performance outcome measures for system accountability. In this role, it has been instrumental in establishing Local Boards and Commissions as critical partners in local public mental health system oversight through the use and interpretation of performance indicators data.

4. Provider Appeals

***Personnel responsible*:** **MHPs and State staff**

Strategy: Inpatient Service Treatment Authorization Requests (TAR) State Appeals: FFS Hospitals

Detailed description of activity: **MHPs are required to have a provider problem resolution process pursuant to CCR, Title 9, Section 1850.305.**

When the appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, the providers may appeal to the State if the MHP denies the appeal in whole or in part. Appeals to the State are generally referred to as "State/second-level TAR appeals." A review fee is assessed for each State/second-level TAR appeal filed. The fee is charged to the MHP if the State reverses the MHP's initial denial or to the provider if the State upholds the MHP's initial denial. If there is a split decision the fee is prorated. The FFP share (50 percent of collected TAR appeal review fees are reflected on DHCS Administrative Costs invoices. DHCS' MHSD codes any TAR appeal review fee adjustments as line 7 for increasing costs and line 10B for decreasing costs. As with any other overpayments, the State has one (1) year from the discovery of any overpayment to refund the federal share of these fees.

Frequency of use: **Providers determine the frequency of appeals filed. Providers filed an average of ten State second level TAR appeals each month in the period from July 2010, to December 31, 2012. This was a decrease from the period from July 1, 2009 through June 30, 2010 when an average of 22 State second level TAR appeals were filed per month.**

How it yields information about the area(s) being monitored: **The second-level TAR appeal process provides the State with information about the effectiveness of the MHP's post-service authorization system for psychiatric inpatient hospital services.**

Strategy: Appeals re EPSDT Services

Detailed description of activity: **In accordance with CCR Title 9 sections 1810.203.5 and 1850.350, the State has established a progressive appeals process that includes a two-level (informal and formal) appeal process through which MHPs and other legal entity providers may appeal claims that were disallowed for services delivered to EPSDT beneficiaries pursuant to the State's review of the MHP or other provider's client records. DHCS is currently promulgating regulations which will govern the formal appeals process and anticipates having them in place during the 8th waiver period.**

Frequency of use: **During the next five fiscal years (July 1, 2013-June 30, 2018), it is anticipated that four formal appeals will be processed.**

How it yields information about the area(s) being monitored: **The EPSDT appeals process provides the State with information regarding specific chart documentation concerns of providers delivering EPSDT services.**

5. **County Support Unit**

Personnel responsible: **State staff**

Detailed description of activity: **County Support staff function as the central point of contact for the MHP, by providing technical assistance to the MHP and when necessary referring the MHP to other resources within or outside DHCS.**

Staff provides assistance via phone, e-mail and onsite visits as necessary. Technical assistance may involve clarifying information contained in policy documents, statutes and/or regulations, review of key documents and participation in regional Quality Improvement Committees. Examples of the areas in which the assigned staff will provide technical assistance include beneficiary protection, Medi-Cal billing, implementation plan revisions, quality improvement work plans

During the waiver period, County Support staff will participate when possible in the exit conferences for the triennial reviews conducted by the DHCS Program Oversight and Compliance Branch. County Support staff will offer assistance to MHPs in implementing plans of correction required by the review and contact the MHPs as needed to monitor the status of the plans of correction following the review.

County Support staff will review the draft and final EQRO reports for assigned MHPs. Staff will contact the MHPs as needed to monitor the status of implementing EQRO recommendations and the MHP's Performance Improvement Projects.

Frequency of use: **Daily and ongoing**

How it yields information about the area(s) being monitored: **The assignment of County Support staff to each MHP provides the MHPs with a single point of contact with whom to raise issues of concern and obtain technical assistance, and provides the State with an individual who knows specifics about the operation of particular MHPs. The direct, personalized relationship between State staff and MHPs allows the State to monitor the MHPs activities, be aware of MHP concerns and offer assistance.**

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ **This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.**

_X_ **This is a renewal request.**

- __ **This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.**
- X **The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.**

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- Confirm **it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.**
- Summarize the results **or findings of each activity. CMS may request detailed results as appropriate.**
- Identify problems **found, if any.**
- Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.**
- Describe system-level program changes**, if any, made as a result of monitoring findings.**

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ **Yes**

___ **No. Please explain:**
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

1. ***Monitoring Activity*: Consumer Self Report Data**

***Strategy*: Consumer Perception Survey (CPS)**

Confirmation it was conducted as described:
__ X Yes
__ No. Please explain

Summary of results: **During waiver period seven, the CPS was conducted using the convenience sampling method. The plan had been to conduct the surveys using a random sampling technique similar to that used during the pilot study done in FY 2009-10. However, the final evaluation of the pilot study revealed that the random sampling method used did not produce a sample much more representative than the convenience sample methodology.**

During a one week survey period, surveys were provided by counties to consumers and parent/guardians of child consumers who received services from in county-operated and contract providers. Please note that since the surveys were originally developed and used in compliance with Substance Abuse and Mental Health Services Administration (SAMHSA) requirements, the surveys were provided to all consumers who received services at the county level not just to consumers and parents/guardians of child consumers who received SMHS. The surveys obtained descriptive information from each consumer and included questions about consumer satisfaction with services and questions about whether the services consumers received improved their ability to function across several domains.
Four types of forms were used during the survey period: Adult (for ages 18-59), Older Adult (for age 60+), Youth Services Survey (YSS) (for ages 13-17 and transition-age youth who still receive services in the child system), and Youth Services Survey for Families (YSS-F) (for parents/caregivers of youth under age 18). The forms were available in seven languages (English, Spanish, Chinese, Russian, Vietnamese, Tagalog, and Hmong).
The data was analyzed to adhere to the SAMHSA Scoring Protocols for the CPS. California's Adult and Older Adult Survey items were scored together to yield federal MHSIP results; and California's Youth and Caregiver Surveys were scored together to yield federal YSS/YSS-F results. Below are the results of the convenience sampling process.

Percentage of Positive Responses
Adults and Older Adults Receiving Services in FY 2011-12

Domain	Adult/Older Adult % Positive
Access	85%
Quality and Appropriateness	88%
Outcomes	70%
Participation In Treatment Planning	78%
General Satisfaction with Services	90%
Functioning	67%
Social Connectedness	70%

Total Number of Responses (N)
Adults and Older Adults Receiving Services in FY 2011-12

Domain	Adult/Older Adult Responses
Access	14,797
Quality and Appropriateness	14,518
Outcomes	13,972
Participation In Treatment Planning	13,906
General Satisfaction with Services	14,961
Functioning	14,072
Social Connectedness	13,773

Percentage of Positive Responses
Youth Receiving Services in SFY 2011-12

Domain	Youth % Positive
Access	85%
General Satisfaction	87%
Outcomes	68%
Family Member Participation in Treatment Planning	85%
Cultural Sensitivity of Staff	94%
Functioning	72%
Social Connectedness	86%

Total Number of Responses (N)
Youth Receiving Services in FY 2011-12

Domain	Youth Responses
Access	14,000
General Satisfaction	14,247
Outcomes	13,816
Family Member Participation in Treatment Planning	13,985
Cultural Sensitivity of Staff	13,274
Functioning	13,895
Social Connectedness	13,928

***Problems identified*: None.**

***Corrective action (plan/provider level)* N/A**

Program change (system-wide level): **None**

2. *Monitoring Activity*: **Data Analysis (non-claims)**

Fair Hearing Data

Confirmation it was conducted as described:

_X_ Yes
__ No. Please explain:

Summary of results: **In FY 2010-2011, 69 State Fair Hearings concerning Mental Health issues were reported.**

In FY 2011-2012, 56 State Fair Hearings concerning Mental Health issues were reported.

In FY 2012-13, 24 State Fair Hearings concerning Mental Health have been reported through 12/12.

The summary results from the fair hearing database are provided below

	FY 10/11	FY 11/12	FY 12/13 (to 12/12)
Number of Hearings Filed	69	56	24
Case Granted	7	1	1
Case Dismissed:	17	4	1
Case Denied	8	7	6
Withdrawals	50	37	8
Non-appearances	9	7	3

The data illustrated in the table above is collected by the California Department of Social Services, State Hearing Division. The total number of filings does not represent the total activity in a given period because a request for a fair hearing can be filed in one month and be heard, postponed, withdrawn or adjudicated in the following month(s).

The results indicate that many fair hearing requests are withdrawn or dismissed for non-appearance of the beneficiary. According to CDSS this is not an atypical pattern.

During waiver period 7, State staff were not contacted by the MHPs for technical assistance.

Problems identified: **None**

Corrective action (plan/provider level): **NA.**

Program change (system-wide level): **NA**

3. *Monitoring Activity*: **Measurement of any disparities by racial or ethnic groups**

Confirmation it was conducted as described:

_X_ Yes

___ **No. Please explain**

Summary of results: **During waiver period 7, the Office of Multicultural Services (OMS) continued to work with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial, ethnic and cultural communities. As of July 1, 2012, The Office of Multicultural Services, formerly at DMH, transferred to the Office of Health Equity at the DPH. They will continue to track this data under the purview of DPH.**

The following table shows the distribution of clients served in the State during CY 2011. The client population reflects the diversity of the State population although not all groups are represented proportionally to the State population.

Race/Ethnicity/Culture	**Total**	**0-5**	**6-17**	**18-59**	**60+**
Total	447,585	25,608	164,499	218,874	38,604
White	155,835	6,344	43,415	88,558	17,518
Hispanic	158,486	13,904	83,904	54,613	6,065
Asian/Pacific Islander	29,822	597	4,294	18,626	6,305
Black	75,231	3,799	25,101	41,362	4,969
American Indian	3,730	149	1,214	2,102	265
Multi Race	24,481	815	6,571	13,613	3,482

Figures based on APS HealthCare claims data: websitewww.caeqro.com:

In comparison, the following table shows the distribution of the total state populations in 2011.

TOTAL STATE POPULATION 2011
BY RACE AND AGE GROUP

RACE/ETHNICITY	Total	AGE GROUP		
		0-17	18-64	65+
Total	37,560,774	9,105,044	24,107,257	4,348,473
White	14,577,131	2,407,796	9,531,036	2,638,299
Hispanic	14,493,180	4,751,089	8,939,227	802,864
Asian/Pacific Islander	5,275,655	1,036,263	3,618,375	621,017
Black	2,142,188	508,691	1,408,038	225,459
American Indian	155,574	39,356	100,326	15,892
Multi Race	917,046	361,848	510,255	44,942

Based on Department of Finance figures accessed at website:http://epicenter.cdph.gov

Performance Measures
Review of performance measures data includes analyzing indicators by race/ethnicity to determine potential disparities. Information on recent performance measures data on the use of specialty mental health services by race/ethnicity can be found on section 8 page 121. For more specifics see "Summary of Department of Mental Health Specialty Mental Health Services by Race/Ethnicity" (attachment 17).

Cultural Competence Plans
Due to the suspension of all activity related to review of the CCPs in the context of transitioning activities formerly under DMH's purview to other state departments, the CCP could not be used as a source of information for this monitoring activity during waiver period 7.

Problems identified: **None**

Corrective action (plan/provider level: **NA**

Program change (system-wide level): **NA**

4 ***Monitoring Activity*:** **Network adequacy assurance submitted by plan**

Confirmation it was conducted as described:

_X__ Yes
No. Please explain:

Summary of results: **In accordance with their contract (Exhibit A, Attachment 1, Item 2), MHPs are required to report to the Department when a significant change occurs in the MHPs operation that could impact network adequacy. Significant change is defined as a change in the MHP's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries or a reduction of an average of 25 percent or more in outpatient provider rates. No MHP reported any such change in operations during the 7th waiver period i.e. July 1 2011-June 30, 2013.**

Problems identified **None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA**

***5. Monitoring Activity*: Ombudsman**

Confirmation it was conducted as described:
_X Yes
__ No. Please explain:

Summary of results: **Note: Although the Ombudsman Unit continued its primary function to be a bridge between the mental health system and individuals and family members providing information and presenting options to consumers in accessing mental health services, the data base used to record calls and their nature as originally designed has proved to be insufficient as volume increased. Therefore information as to numbers and nature of the calls received during this waiver period are estimates. DHCS is reviewing and may pursue updating the data base during waiver period eight.**

For the period July 2011 through December 2012 it is estimated that the Ombudsman toll free number received approximately 3000 calls. Approximately 1/3 of all the calls were related to Medi-Cal and of those calls approximately half were in the nature of complaints primarily regarding providers and patient's rights advocates.

Other relatively high volume areas were calls requesting information and/or access to non Medi-Cal and/or Medicare related service and calls administration related. In those cases, callers were referred to other units/divisions within the department or to other state agencies.

In about 20 percent of calls, the caller either hung up before the staff could answer the phone or the call was routed to voicemail and the caller left no follow up information. However, since December 2012, the Ombudsman Unit has been relocated and has access to a new phone system which allows for simultaneous bell ring for all Ombudsman staff. Since calls received during business hours will no longer be routed to an answering machine staff estimate that this will result in a significant increase in calls which are connected to a staff member.

***Problems identified*: Due to the number of monthly calls received,** as **well as the types of calls received, the Ombudsman database is not adequate to store all of the information gathered and to accommodate the additional reports requested by management.**

***Corrective action (plan/provider level):* NA**

***Program change (system-wide level):* As mentioned above, DHCS plans to pursue updating the data base in the upcoming waiver period.**

6. ***Monitoring Activity:* Onsite System Reviews**

Confirmation it was conducted as described

X Yes

___ No Please explain:

There were three components to the State's on site review activities during waiver period 7

1 Systems Reviews

2) Non-Hospital Services Outpatient Chart Review/EPSDT Chart Reviews

3) SD/MC Hospital Reviews

Results for each component are described below

1. Systems Review

***Summary of Results*: In FY 2010-2011, there were 18 onsite MHP reviews conducted. In FY 2011-2012, there were 20 onsite MHP reviews conducted. The findings obtained from FY 2010-2011 and FY 2011-2012 Program Oversight and Compliance reviews are summarized below.**

***Problems identified*: For the two FYs reviewed, the two sections of the Protocol with the highest items out of compliance are in Access and the Chart sections. These two areas have been noted in the prior waiver period. Access items include the availability of information regarding SMHS and providers of services; availability of a 24/7 toll free number, maintenance of a written log of initial requests for specialty mental health services, availability of information regarding how a beneficiary might change providers etc. No items stand out as being notable in the chart review.**

FY 2010-2011
In the Access section, 17 out of the 18 MHP's reviewed were out of compliance with 1-5 items.

Of possible 21 chart items, all of the 18 MHPs had between 7-17 items out of compliance in this area.

FYs 2011-2012
In the Access section, 18 out of the 20 MHPs reviewed were out of compliance with 1-14 items out of compliance with questions 9a and 10 being the highest tally of items out of compliance. These items relate to the availability of a toll free telephone number 24/7 with linguistic capability in all languages spoken by beneficiaries in that county.

Of a possible 21 chart items, 6-17 items were out of compliance during FY 2011-2012.

In FY 2012-2013, there are 17 MHPs scheduled for review. There were five MHP reviews completed from October 2012 through December 2012 in this reporting period. Data will be available after the completion of the reviews for FY 2012-2013 ending June 2013.

Corrective action (plan/provider level): **During onsite reviews, DHCS staff provide feedback about critical issues such as the MHP's 24/7 toll free lines and lack of written log documentation. It is recommended that MHPs regularly conduct their own test calls for compliance and provide regular training to their Access teams to reduce and eliminate these problems.**

On a more general level, MHPs are notified of all out of compliance items. MHPs are required to submit a Plan of Correction (POC) for all out of compliance items due within 60 days after receipt of the Final Report. If the MHP wishes to appeal any of the out of compliance items, the MHP may do so by submitting an appeal in writing within 15 working days after receipt of the Final Report. Once the POC is received, the MHP works with Program Oversight and Compliance Branch and DHCS Quality Assurance Section, County Support Unit staff to implement the POC.

During FY 2010-2011, Program Compliance received 18 Plan of Corrections (POCs) from the MHPs. In FY 2011-2012, 16 Plan of Corrections have been received.

Program change (system-wide level): **None**

2: Non-Hospital Services Outpatient Chart Review/Adult and EPSDT Chart Reviews

Summary of results: **Results are reported for July 1, 2010 – December 31, 2012. The chart review team, consisting of licensed mental health clinicians, review the MHP's non-hospital services provided to Medi-Cal beneficiaries both adult and children/youth on a triennial basis. The principal focus of these reviews is to ensure federal and state requirements are being met along with MHP contractual requirements. The State provides oversight to ensure that the SD/MC claims submitted by the MHPs meet medical necessity criteria for reimbursement.**

DHCS Program Compliance and Oversight Branch completed 18 MHP outpatient chart reviews in FY 2010-2011; 20 reviews in FY 2011-2012 and 5 reviews were completed from October-December, 2012. There are 15 remaining reviews scheduled for FY 2012-2013. As of December 12, 2011, the separate EPSDT outpatient chart review based on extrapolation were suspended for FY 2011-2012 and review of charts for EPSDT beneficiaries were integrated into the outpatient chart reviews of non-hospital services. Half of the claim sample is adults and the other half is EPSDT.

Problems identified: **The primary reasons for disallowances is that the chart documentation failed to meet medical necessity.**

Corrective action (plan/provider level): **A written Plan of Correction (POC) for all out of compliance items found in the chart reviews is required from the MHP within 60 days of the receipt of the report of the audit findings. The POC must specify the corrective actions taken to address the items out of compliance. The DHCS County Support Unit reviews the POCs and provides technical assistance and ensures the POCs are implemented. POCs were required for all reviews completed within waiver period 7.**

A disallowance is taken for each claim line for which there is insufficient documentation. Disallowances are only taken on claims for services documented in the review sample. There is no extrapolation of the findings.

Program change (system-wide level): **None**

3. On-site Reviews -SD/MC Hospital Reviews

Summary of results: **Findings from the FY 2010-2011 and FY 2011-2012 reviews of SD/MC psychiatric inpatient hospitals are provided in attachment 16.**

Problems identified: **The principal deficiencies identified during the FY 2010-2011 and FY 2011-2012 reviews were: (1) Documentation which failed to meet medical necessity criteria for continued stay services; and (2) Documentation which failed to meet criteria for administrative day services.**

Corrective action (plan/provider level)**: MHPs are notified of all deficiencies identified during the inpatient review. FFP for all disallowed hospital days is recouped and returned to DHCS. MHPs are also required to submit a Plan of Correction (POC) which addresses all identified deficiencies. These POCs are reviewed by DHCS staff and, when adequate, are approved. If POCs are determined to be deficient, the MHPs are required to revise and resubmit them.**

During FY 2010-2011, seven (7) inpatient reviews were conducted, and all seven of these hospitals were required to submit POCs.

During FY 2011-2012, six (6) inpatient reviews were conducted, and all six of these hospitals were required to submit POCs.

Program change (system-wide level :) **None**

7. ***Monitoring Activity:*** **Performance Improvement Projects**

Confirmation it was conducted as described:

_X_ Yes
___ No Please explain:

Summary of results: **The EQRO reviews two PIPs (one clinical, one non clinical) during their reviews of MHPs. The EQRO also provides DHCS with information regarding the PIPs: including topics, activity level, and status of interventions. Lastly, the EQRO, reports to DHCS on MHP compliance with the PIP requirement. For more information regarding the EQRO process and results see section 11 pages 126-128.**

Problems identified: **N/A**

Corrective action (plan/provider level): **N/A**

Program change (system-wide level): **N/A**

8. ***Monitoring Activity***: **Performance Measures**
Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:
Expenditures and Penetration Rates for Medi-Cal Recipients
As seen in data from the report, "Summary of Department of Health Care Medi-Cal Specialty Mental Health Services by Race/Ethnicity", (see

attachment 17) California served between 200,000 and 220,000 Medi-Cal beneficiaries with specialty mental health services each month between FY 2006/07 to FY 2011/12. More adults received services until the last two quarters of FY 2011/12. Approximately, the same number of children and adults received services in the last two quarters of FY 2011/12.

The Medi-Cal penetration rate decreased slightly from 7.1% to 6.9% between FY 2006/07 to FY 2011-2012. The number of individuals enrolled in Medi-Cal and the number of beneficiaries increased during this six year period. Penetration rates were highest for the White population through FY 2008/09. The penetration rate for the Native American population spiked in FY 2009/10 and remained high through FY 2011/12. The penetration rate for the Hispanic population was lowest through FY 2009/10. The penetration rate for the Asian/Pacific Islander population dropped below the Hispanic population in FY 2010/11 and remained lowest through FY 2011/12. The penetration rate for the Other category showed a similar increase beginning in FY 2010/11 through FY 2011/12, which suggests that the race of Asian/Pacific Islander beneficiaries may have been miscoded as Other during this period of time .

The mean annual beneficiary cost had a gradual and moderate increase between FY 2006/07 and FY 2011/2012 for all races.

Consumer perception of care indicators
The results of the consumer perception indicators are reported above under item 1 Consumer Self Report Results page-111.

***Problems identified*: None.**

***Corrective action:* None.**

***Program change*: None**

9 .*Monitoring Activity*: Periodic comparison of number and types of Medicaid providers before and after waiver

Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:
Summary of results:
Please note: While transferring the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions from DMH to DHCS there have been significant difficulties migrating the data associated with the SMHS program such that staff have been unable to date to access certain data. Therefore some of the data provided in previous

wavier periods is not available and this has been so noted in the following charts and information by NA – not available.

Table 1 Hospitals

FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	9/10	10/11
TOTAL FFS/MC HOSPITALS	204	191	189	184	186	194	194	192	187	185	185	180	170	NA	NA
FFS/MC HOSPITALS PROVIDING SERVICE	121	122	118	113	105	95	99	92	93	92	93	91	83	75	77
FFS/MC CONTRACT HOSPITALS	103	101	101	96	98	82	82	74	75	70	71	69	67	69	70
SD/MC HOSPITALS	29	27	23	23	23	24	24	21	21	23	21	20	20	20	22

As shown in table 1 above, the total number of FFS/MC psychiatric inpatient providers decreased from FY 1996-97 (prior to the first waiver period) through FY 2008-09. Research during prior waiver periods indicated that this is in part due to a number of hospitals statewide who, as a component of their restructuring efforts, closed their psychiatric units. Since data is unavailable at this time for FY 09/10 and FY 10/11 it is not possible to determine if this trend has continued.

The number of FFS/MC hospitals actually providing psychiatric inpatient hospital services to Medi-Cal beneficiaries has continued an overall decrease from FY 1996-97 to FY 2010-11. One hundred and twenty one (121) FFS/MC psychiatric inpatient hospitals provided services in FY 1996-97, while 77 FFS/MC psychiatric inpatient hospitals provided services in FY 10-11. The slight increase in the number of FFS/MC hospitals providing service between FY 2001-2002 and FY 2002-03 can be attributed to the identification of out-of-state non-border hospitals providing inpatient mental health services to Medi-Cal beneficiaries.

In FY 1996/97, 103 FFS/MC hospitals were under contract with MHPs. This number has shown a small increase in FY 09-10 and FY 10-11 from a low of 67 in FY 08-09. There were 70 FFS hospitals under contract to the MHPs in FY 10-11.

As shown below, recent paid claims data shows that, despite the decrease in the number of FFS/MC hospitals under contract and/or providing services, the number of unduplicated clients receiving care in those facilities rose in the years between FY 2006/2007 and FY 2011-2012.

FFS/MC Hospitals Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$154,544,462	20,867
FY 07/08	$149,146,681	20,762
FY 08/09	$156,111,674	22,057
FY 09/10	$163,635,421.	22,794
FY 10/11	$175,815,037.	23,901
FY 11/12	$188,168,445	23,228

The number of Short-Doyle/Medi-Cal (SD/MC) hospitals has also decreased from 29 in 1996-97 to 22 in FY 2009-10. However, the number of SD/MC hospitals has stayed fairly consistent since FY 1998/99 ranging between 20 and 24. Recent paid claims data shows that the number of unduplicated clients has varied only slightly between FY 2006/2007 and FY 2011-12.

SD/MC Psychiatric Inpatient Hospital Services

Fiscal Year	Total Claims	Total Beneficiaries
FY 06/07	$78,461,862	8343
FY 07/08	$71,106,397	7638
FY 08/09	$73,009,647	8320
FY 09/10	$70,535,824	8211
FY 10/11	$68,055,913	8135
FY 11/12	$67,893,065	8200

Table 2
Professional and Rehabilitative Service Providers

FISCAL YEAR:	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
TOTAL SD/MC ORGANIZATIONAL PROVIDERS	1014	1225	1401	1649	1882	2101	2369	2527	2645	2952	3125	3195	3318	3387	3604
SD/MC ORGANIZATIONAL PROVIDERS PROVIDING SERVICE	939	1072	1154	1309	1491	1548	1852	1915	1913	2187	2271	2395	2435	NA	NA
FFS/MC PRACTITIONERS	3314	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	NA

As can be seen in table 2, the total number of SD/MC Organizational providers showed a steady increase from 1,014 in FY 96/97 to 3,604 in FY 10/11. The number of SD/MC organizational providers actually providing services -increased from 939 in FY 1996-97 to 2,435 in FY 2008-09. Numbers are not available at this time for FY 09-10 and FY 10/11. It should be noted that SD/MC organizational providers consist of a varying number of actual practitioners who serve Medi-Cal beneficiaries. Information is not available

at the State as to the actual total number of SD/MC practitioners who are employed by SD/MC organizational providers.

Data on paid claims for FFS/MC psychiatrists and psychologists for FY 1996-97, prior to the first waiver renewal period, revealed that 3,314 psychiatrists and psychologists received Medi-Cal payments during that year. It should be noted that since FY 1996-97 was prior to Medi-Cal Specialty Mental Health Services Consolidation, some of these claims may be for services to beneficiaries who would not have met medical necessity criteria developed for consolidation, so the number may be somewhat inflated.

The Medi-Cal SMHS Consolidation waiver enabled MHPs to expand the range of practitioner types in their individual provider networks to include MFTs, LCSWs and RNs. This allows for greater ability to increase the number of available network practitioner providers and may account for some of the increase seen in the number of organizational providers. State Medi-Cal oversight reviews that were conducted during the past and present waiver periods found that, in general, MHPs had maintained or increased the number of practitioner providers compared to those available to beneficiaries under FFS/MC.

Problems identified: **None**

Corrective action (plan/provider level): **None**

Program change (system-wide level): **None**

10. ***Monitoring Activity***: **Utilization review**

Strategy **MHP Utilization Management Plan**

Confirmation it was conducted as described:

_X_ Yes
__ No Please explain:

Summary of results**: All MHP's Utilization Management Plans reviewed during waiver period 7 contained requirements related to consistent application of medical and service necessity in payment authorization systems.**

Problems identified**: None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA**

11. *Monitoring Activity*: **External Quality Reviews (EQR)**

Confirmation it was conducted as described:

_X_ Yes

__ No Please explain:

Summary of results: **FY 2011-2012**

Note: **Information regarding FY 2012-2013 is not yet available**

FY 2011-2012 EQR activities focused its activities on three monitoring areas:

- **Access**
- **Timeliness**
- **Quality**

PIPs

- **PIPs continue to be an area where MHPs have only partial success. While 70 percent of MHPs had two active PIPs as required, only half of those or 20 percent of all MHPs had PIPs that had active interventions and had measured the impact of those interventions.**
- **32 PIPs reached completion, largely a function of the sunset of the formerly required EPSDT PIP. While PIPs were completed, they did not necessarily conclude successfully with demonstrated improvement in care.**
- **In cases where the MHP had struggled with the same issue over a number of years they were provided technical assistance in selecting a new PIP topic for which the infrastructure needed to support successful setup and follow through was available.**
- **MHPs may contact the department's County Support Unit to initiate meetings with EQRO staff and resolve issues with developing and implementing PIPs.**

Performance Measures

The Performance Measure for Year Eight FY 11-12 focused on psychiatric inpatient follow-up services and readmission (CY10 data). The following results were found.

- **Inpatient services alone accounted for 13 percent of claims dollars, providing inpatient services to 7.5 percent of beneficiaries.**
- **13 percent of all claims dollars were for Inpatient services while 7.5 percent of beneficiaries received Inpatient services**
- **There was an increase in the number of beneficiaries receiving inpatient services, though the average approved claims for inpatient services decreased.**
- **Rehospitalization rates were 8 percent within seven days and 18 percent within thirty days.**

- **For youth 6-17, rehospitalization rates were lowest and outpatient follow-up highest.**

ISCA

The EQRO is responsible for the independent review of the health information systems of each MHP in California. As part of this process, CMS also mandates administration of an ISCA each year at each MHP.

- **New and ongoing implementations of information systems continue to create extensive demands on MHP staff resources. Implementation time is therefore often longer than anticipated.**
- **State changes in Medi-Cal billing processes added additional complications which impacted timely claims, denials, and impeded cash flow.**
- **Electronic Health Records (EHR): The year showed significant advancement in electronic health record implementation. Electronic progress notes have been implemented in 30 MHPs. Assessments are in place in 27 MHPs, and treatment plans in 22 MHPs.**

In addition to those activities described in the monitoring plan for the 7th waiver period focus groups were used to gain valuable information. Beneficiary feedback continues to be an important aspect of the EQRO process.

- **752 individuals participated in 95 focus groups. 39 percent of the participants were Latino and 37 percent of groups conducted included an interpreter.**
- **Spanish-speaking beneficiaries generally reported longer wait times to access services.**
- **Longer wait times were also more common among children seeking services, particularly for psychiatry**

Problems identified: **The overall results of the site review process were presented to the State and MHPs in the individual and statewide reports based on comparative analysis of claims data for CY10. Some key findings include:**

- **Statewide penetration rate dropped slightly due to an increase in beneficiaries and decrease in numbers served.**
- **Females continue to have lower penetration rates and average approved claims. The greatest disparity is in the adult 18-59 age group.**
- **Hispanic penetration rate increased but remains significantly disparate from White penetration rates or overall average penetration rates. However, the claims disparity previously existing for Hispanic beneficiaries no longer exists. Equal dollars are spent for Hispanic and white beneficiaries.**
- **Youth 6-17 continue to have the highest average claims.**
- **High cost beneficiaries (greater than $30,000 in services in the CY) continue to consume a disproportionate amount of services, slightly**

increased over prior years. High cost beneficiaries were more likely to be male and child.

- **Foster care penetration rate continued to increase; however there was a decrease in numbers served and a more significant decrease in the population.**
- **As noted above, Spanish –speaking beneficiaries generally reported longer wait times as did children seeking particularly psychiatric service**

Corrective Action (plan/provider level): **Every MHP is given 5 recommendations of strategies to consider for improvement. Those items are then reviewed during the following year's review. Opportunities and Recommendations for MHP improvement note are:**

- **Increase stakeholder involvement in quality monitoring and improvement processes.**
- **Increase and improve the quality of consumer and family member employment within the MHP.**
- **Increase the use of outcome data, including implementation of evaluation tools.**
- **Increase consumer and family member involvement in system and program planning.**
- **Develop more collaborative processes with primary care.**
- **Evaluate consumer satisfaction with service delivery.**

MHPs implemented activities in response to EQRO recommendations made in the prior year. 87 percent of all recommendations were either fully addressed or partially addressed. Recommendations associated with improving access to underserved populations were most significantly addressed at 94 percent of the time.

Program change (system-wide level) **None**

12. *Monitoring Activity:* **Implementation Plans**

Confirmation it was conducted as described:

_X_ Yes
___ No._Please explain:

Summary of results: **The Implementation Plan is required by state regulation when an MHP begins operation. The State has approved the Implementation Plans for all current MHPs. State regulations require MHPs to submit proposed changes to their Implementation Plans to the State in writing. The State approved Implementation Plan updates received during the waiver period.**

Problems identified: ***None***

Corrective action (plan/provider level): **NA**

Program change (system-wide level): -**NA**

13. *Monitoring Activity*: **Cultural Competence Plans**

Confirmation it was conducted as described:

___ Yes
_X_ No Please explain: See S*ummary of Results* below

Summary of Results **DMH Information Notices Nos. 10-02 and 10-17 Cultural Competence Plan Requirements (CCPR) were issued respectively for mid-size and large counties on January 25, 2010 and for small counties on August 17, 2010 (see attachments 9 and 10). DMH had planned to convene review panels to review and score all the CCPR submissions during Spring and Summer 2011.**

However, due to activities required by Assembly Bill (AB) 102, which transferred the state administration of the Medi-Cal Specialty Mental Health Services Waiver and other applicable functions from DMH to DHCS, DMH-OMS staff were redirected to perform a number of transition activities. Thus, the functions of the CCPR, including training, webinars, review and scoring of plans were postponed until completion of the transfer of cultural competence functions to DHCS and CDPH, including the transfer of the CCPR.. In addition, the majority of counties requested extensions ranging from 1-15 months, often requesting third and fourth extensions. Consequently, the review team had to wait for the cost benefit threshold to be reached (i.e., there had to be a pool of plans large enough to review before the team would convene a four hour Reviewer Training).

DMH established an interim plan and informed counties to implement their submitted CCPR plans, per language incorporated in the MHP contract, (Exhibit E, Item 5) which states, "*Contractor may implement the plan 60 calendar days from submission to the Department if the Department fails to provide a Notice of Approval or Disapproval.*" In addition, submitted CCPRs were monitored during the triennial Compliance Review.

Problems identified: **NA (since the plans could not be reviewed as planned)**

Corrective action (plan/provider level) **NA**

Program change (system-wide level): **DHCS is currently developing an implementation plan to move forward with the CCPRs. For more information please see Section s2 page 105.**

14. *Monitoring Activity*: **Provider Certification On-Site Reviews**

Confirmation it was conducted as described:

__X_ Yes

____ No. Please explain:

Summary of results: **-Results are reported for July 1, 2010 – December 31, 2012. DHCS has conducted 63 provider onsite reviews of county owned and operated providers, and certified or re-certified 385 providers as eligible to bill for the provision of specialty mental health services from July 1, 2010 through December 31, 2012. The number of onsite certification reviews has decreased from the last waiver report period i.e. October 1 2009-June 30 2011 because, in accordance with DMH Letter #10-04 (see attachment 15) effective July 8, 2010 the State was required to certify/recertify only a limited number of county owned and operated sites.**

MHPs monitor and track the recertification for their contracted organizational providers. As specified in the contract between the DMH and MHPs, the MHP/contractor shall comply with CCR, Title 9, Section 1810.435 in the selection of providers and shall review its providers for continued compliance with standards at least once every three years, except as otherwise provided in the contract. (Refer to Exhibit A-Attachment 1 Item 4 Provider Selection and Certification of the Boilerplate MHP Contract).

Problems identified: **There were no problems identified.**
Corrective action (plan/provider level) **Any Plans of Corrections (POCs) issued as a result of an onsite review (see section 6 page 118) are reviewed and out of compliance items must be resolved prior to certifying and/or re-certifying a provider's eligibility to bill Medi-Cal for the provision of specialty mental health services. About 20 percent of the providers needing certification/recertification have POCs with items that need resolution. .**

Program change (system-wide level): **None**

15. *Monitoring Activity*: **Advisory Groups**

Confirmation it was conducted as described:

_X Yes

__ No Please explain:

a. Compliance Advisory Committee (CAC)

Summary of result: **The continuation of the relationship between the State and the CAC ensures that stakeholders have a significant voice in how quality and access are monitored.**

Problems identified: **None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **Changes implemented with significant input from the CAC include revisions to the Compliance Review Protocol, which is used the State to review MHPs on-site for system compliance with program requirements.**

b. Cultural Competence Advisory Group (CCAC)

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of result: **During the 7th waiver period, Cultural Competence Advisory Group meetings continued until June 30, 2012 and were then put on hold pending the transfer of responsibility for the group to CDPH in accordance with legislation which transferred DMH functions to various other state departments, primarily DHCS.**

Effective July 1, 2012, The Office of Multicultural Services (OMS), formerly at the DMH was, transferred to the Office of Health Equity (OHE) at the California Department of Public Health (CDPH). At that time, responsibility for the Advisory Group was also transferred to CDPH.

However, DHCS staff, particularly staff involved with the Cultural Competency Plan continued to have contact with stakeholder groups such as the CCAC and OHE staff thus facilitating stakeholder voice in the conduct of mental health programs.

Problems identified: **None.**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA**

c. California Mental Health Planning Council (CMHPC)

Confirmation it was conducted as described:

_X_ Yes
___ No. Please explain:

Summary of results:

A. **The CMHPC is working closely with the California Association of Local Mental Health Boards and Commissions (CALMHB/C) to monitor access through updating data workbook development and training.**
B. **The CMHPC staff has participated on reviews of County Cultural Competence Plans to ensure compliance with Plan requirements.**
C. **The CMHPC represented the interest of stakeholders in meetings held by the state during the transition from DMH to DHCS.**

D. **As part of our commitment to rehabilitative services the CMHPC actively opposed legislation to continue involuntary outpatient services. The Council takes positions on legislation and advocates for community-based care in lieu of institutional care.**

E. **The CMHPC holds quarterly meetings, open to the public, and encourages robust stakeholder input.**

Problems identified: **None**

Corrective action (plan/provider level) **NA**

Program change (system-wide level): **NA**

16. *Monitoring Activity*: **Provider Appeals Inpatient Services and EPSDT Services**

Confirmation it was conducted as described:

__X_ Yes

____ No. Please explain:

Strategy: Provider Appeals Inpatient Services: FFS Hospitals

Summary of results: **Results are reported for July 1, 2010-December 31, 2012. MHPs are required to have a provider problem resolution process pursuant to CCR, title 9, section 1850.305. When an appeal concerns a dispute about payment for emergency psychiatric inpatient hospital services, and that service has been provided at a FFS Hospital, the providers may appeal to the State if the MHP denies the appeal in whole or in part. Such appeals to the State are generally referred to as "State/second-level TAR appeals".**

Decisions on State second-level TAR appeals were rendered at a rate of 8.5 per month in FY 2009-2010. Decisions were rendered July 1, 2010 through December 31, 2012 on an average of 16 decisions per month. The percentage of TAR appeal decisions upholding the MHP's original denial is above 90 percent.

Problems identified: **DHCS has determined that the high percent of the second-level TAR appeals denied by the State indicates that there is a continuing problem at the provider level with understanding documentation of medical necessity criteria for acute and administrative days.**

Corrective action (plan/provider level): **Feedback via the State/second level TAR appeals process to the providers on medical necessity criteria.**

Program change (system-wide level): **None**

Strategy: Provider Appeals: EPSDT Services

Summary of results: **From July 1, 2011 - -January 2013, 33 informal appeals were filed; however, in 24 of those cases the legal entities chose to drop the appeal and four MHP subcontractors have requested formal appeals. A process to handle formal appeals is in development. As of January 2013, no new requests for either informal or formal appeals have been filed.**

Problems identified **None**

Corrective action (plan/provider level): **NA**

Program change (system-wide level): **NA.**

17. ***Monitoring Activity:*** **County Support Unit (formerly County Technical Assistance Section)**

***Confirmation it was conducted as described*:**

_X_ Yes

___ No. Please explain:

***Summary of results*:** **During the waiver period, the County Support Unit (formerly the County Technical Assistance -Section) has functioned as the central point of contact for the MHPs, provided resources and technical assistance for the administration and provision of community mental health service programs.**

***Problems identified*:** **The County Support Unit contacted MHPs as needed following their Medi-Cal Oversight System Review conducted by the Program Oversight and Compliance Branch to monitor the status of implementing plans of correction and offer technical assistance and resources.**

***Corrective action (plan/provider level*):** **-The County Support Unit collaborated with the Program Oversight and Compliance Branch to conduct a focused review on one county that needed additional assistance to maintain compliance with state requirements. The technical assistance in the form of regularly schedule contacts continued for several months. Additionally County Support staff will assist the county to prepare for and will accompany Program Oversight and Compliance on the upcoming system review in June 2013.**

Program change (system-wide level): **None**

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. In its application and each quarter during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost effective and efficient*. The State must project waiver expenditures for the upcoming waiver period, called Prospective Years (PY) (e.g Prospective Year 1 (P1); Prospective Year 2 (P2); Prospective year 5 (P5) etc.). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective waiver period.

For waivers that include recipients who are eligible for both Medicare and Medicaid benefits (duals) the State may request a waiver period of up to 5 years. Initial waivers and continuation of a waiver beyond its initial approval period requires that the state submit a five-year waiver renewal application and a determination by CMS that, the State's projections demonstrate costs appropriate for the effective and efficient provision of services or for renewals, that while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other Federal requirements, including the submission of mandatory quarterly waiver reports. Each subsequent renewal of the waiver also requires the submission of a renewal application and a CMS determination that the state has continued to meet Federal requirements.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Definitions and Terminology

The following terms will be used throughout this document and are defined below:

For Initial Waivers:

Historical Period:

- BY = Base Year

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

For Renewal Waivers:

Retrospective Waiver Period

- RY = Retrospective Year(s)
- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2 when changing from a two year waiver period
- R3 = Retrospective Year 3
- R4 = Retrospective Year 4
- R5 = Retrospective Year 5 Project forward from end of R5 using experience/trends from RY 1 through R5

Projected Waiver Period

- PY = Prospective Year(s)
- P1 = Prospective Year 1
- P2 = Prospective Year 2
- P3 = Prospective Year 3
- P4 = Prospective Year 4
- P5 = Prospective Year 5

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.

- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: _____

c. Telephone Number:_____

d. E-mail:_____

e. The State is choosing to report waiver expenditures based on ___ date of payment. **(because county mental health plans (MHPs) are also matching agencies incurring certified public expenditures, date of service and date of payment are the same.)**

__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c._X_ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced*

payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. NOT APPLICABLE. **Capitated portion of the waiver only: Type of Capitated Contract**

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b.___ PIHP
c.___ PAHP
d.___ Other (please explain):

The county MHPs under the Medi-Cal specialty mental health services (SMHS) waiver are not paid on a capitated basis. Counties pay with non-federal funds at the time of service. The counties then submit certified public expenditures (CPEs) to the State in order for the State to draw down eligible federal financial participation (FFP) for these services based on the State's adjudication of claims to determine Medi-Cal eligibility. County MHPs receive interim CPE reimbursement of FFP on a fee-for-service (FFS) basis pursuant to approved rates for approved units of service for allowable procedure codes. After the county MHPs are paid FFP on an interim FFS basis, initial cost settlement is completed approximately 15 – 18 months after the close of each state fiscal year (SFY). Final cost reconciliation of county MHP expenses then occurs anywhere from 18 to 36 months after initial cost settlement is completed. Initial cost settlement and final cost reconciliation are also based on county MHP CPEs.

D. NOT APPLICABLE **PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a.___ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

1.___ First Year: $____ per member per month fee
2.___ Second Year: $____ per member per month fee
3.___ Third Year: $____ per member per month fee
4.___ Fourth Year: $____ per member per month fee
5.___ Fifth Year: $____per member per month fee

b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only: NOT APPLICABLE

a.___ Population in the BY data

1.___ BY data is from the same population as to be included in the waiver.

2. __ BY data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time:

_____

d. ___ [Required] Explain any other variance in eligible member months from BY to the final PY _____

e.____ [Required] List the year(s) being used by the State as a BY:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the BY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any BY data is not derived directly from the State's MMIS fee-for-service claims data:
_____

For Renewal Waivers:

a._X_ [Required] Population in the BY and the Retrospective years R1, through the end of the waiver period data is the population under the waiver.

b._X__ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete final RY to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for the final RY of the previous waiver period.*

c.__X_ [Required] Explain the reason for any increase or decrease in member months projections from the BY or over time: **Member months under the waiver equal the full-scope Medi-Cal enrolled population. Actual member months are included in the waiver renewal for all of R1 (which is the four-quarter period July 1, 2011 through June 30, 2012) and the first two quarters of R2 (which is the period July 1, 2012 – December 31, 2012) as reported to CMS in the quarterly "MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORT" (e.g. Member Months Report) for the SMHS waiver through the December 2012 quarter.**

1. **Medi-Cal beneficiaries in the "Disabled" and "Other" Medicaid Eligibility Groups (MEGs) for the six quarters beginning January 1, 2013 through June 30, 2014 are estimated and assumed to change based on the percentages provided by the Department of Health Care Services' (DHCS) Fiscal Forecasting and Data Management Branch (FFDMB) as included in the January 2013 Governor's January Budget for SFY's 2012-13 and 2013-14.**

- **The FFDMB percentage in the Governor's Budget for SFY 2012/13 is used to estimate the March 2013 and June, 2013 quarterly Member Months (last two quarters of Retrospective Year 02.**
- **The FFDMB percentage in the Governor's Budget for SFY 2013/14 is used to estimate the Member Months for P1 (e.g. the period July 1, 2013 through June 30, 2014) and for each of Prospective Years 02 through 5 (e.g. beginning July 1, 2014 through June 30, 2018).**

Medi-Cal caseload estimates provided by DHCS' FFDMB are forecast using the most recent 36 months of actual caseload and running multiple regressions for 18 separate beneficiary aid category groupings. This provides the base caseload estimate. To the base caseload estimate are added any estimated caseload impacts of policy changes that are expected to occur during each SFY.

2. **The California Department of Social Services (CDSS) projected caseload and percentage change included in the January 2013 Governor's Budget for California foster care enrollees is used to estimate the "Foster Care" MEG member months for the: i) two-quarter gap period (e.g. based on the SFY 2012-13 annualized decrease of 7.02 percent contained in the Governor's Budget); and ii) P1 through P5 (e.g. based on the SFY 2013-14 estimated annual decrease of 8.02 percent contained in the Governor's Budget). Foster Care and Child Welfare Services caseload forecasts are provided by CDSS' Estimates Branch. Caseloads are reported by funding source, and forecasts are developed by using the most recent actual caseload data trends and running multiple regressions. This provides the base caseload estimate for determining fiscal and case impacts as a result of policy changes.**

3. **Medi-Cal beneficiaries for the "MCHIP" MEG for the four quarters of calendar year 2013 (e.g. the period January 1, 2013 through December 31, 2013) are assumed to increase by the number of California Children's Health Insurance Program (CHIP) beneficiaries estimated to transition to the Medi-Cal program in these quarters, as also described in the January 2013 Governor's Budget.**

   In addition, the annual inflation percentage increase for the "MCHIP" MEG contained in the Trend Data table for the two-quarter gap period and the first two quarters of P1 (prior to the CHIP transition) is based on the SFY 2011-12 historical rate of change for monthly MCHIP enrollees. For the last two quarters of P1 and each of waiver years P2 through P5, the caseload weighted average of the rates for MCHIP and the CHIP transition were used, based on the historical SFY 2011-12 rate of change for both MCHIP and CHIP monthly enrollees combined.

4. **Amendment #1 projects an additional 575,184 monthly eligibles for the last 6 months of P1 (e.g. January 1, 2014 – June 30, 2014) under the Optional Adult Medicaid Expansion (OAME). This**

equals an increase of 3,451,104 member months in the "OTHER" Medicaid Eligibility Group (MEG) for P1. Amendment #1 projects an additional 757,405 monthly eligibles, or 9,088,860 member months in the "OTHER" MEG for the 12 months of P2. These new beneficiaries are projected to be eligible for Medi-Cal SMHS waiver and Medi-Cal non-SMHS mental health services in accordance with California Senate Bill X1-1, which modified the Medi-Cal program to include Medi-Cal benefits for individuals who meet the eligibility requirements of Section 1902(a)(10)(A)(i)(VIII) of Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(i)(VIII)).

The quarterly member months reports currently report: i) all Medi-Cal enrolled beneficiaries with eligibility during the quarter and; ii) all Medi-Cal enrolled beneficiaries who received "adjusted" eligibility during the quarter for any other months of the waiver term.

d. _X_ [Required] Explain any other variance in eligible member months from the BY through the R year(s) to the final Prospective year: **No other changes were applied.**

e.__X_Required] Specify whether the BY/RY is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: **R1 is SFY 2011-12 (July 1, 2011 through June 30, 2012) and R2 is SFY 2012-13 (e.g. July 1, 2012 to June 30, 2013). Actual data, as reported in the "MEDICAID MANAGEMENT INFORMATION SYSTEM, ELIGIBLE MEMBER/MONTHS REPORTs" (e.g. Member Months Reports) are displayed in this waiver renewal for R1 and the first two quarters of R2 (July 1, 2012 to December 31, 2012). Only this actual data as reported in the Member Months Reports is used in the waiver renewal to calculate the Base Year (BY) PMPM costs. Only member months in the October 2011 through December 2012 Member Months Reports with dates of Medi-Cal eligibility between July 1, 2011 through December 31, 2012 (e.g. who had Medi-Cal eligibility within the R07 term) are included as actual member months in Appendix D1 and elsewhere in the Section D Appendices.**

Medi-Cal eligibility can be established retroactively for beneficiaries based on any of the following factors: i) Social Security Act section 1902 (a) (34); ii) retroactive Medi-Cal eligibility as legally ordered by courts or administrative law judges; and c) retroactive Medi-Cal eligibility based on the determination and approval of federal SSI/SSP eligibility (e.g. Medi-Medi or dual-eligible status) for the beneficiary. For Medi-Cal beneficiaries who obtain retroactive eligibility, retroactive member months are reported in the quarter in which the eligibility first appears in DHCS' Medi-Cal eligibility system for months included in the current waiver term. Also, as discussed above,

only retroactive member months that fall within the current waiver term are included in the Member Months Reports. Thus, any retroactive eligibility for months prior to the current waiver term are not included in the Member Months reports. Member months are reported to CMS quarterly, sixty days after the end of the quarter. For example, for the quarter ended March 31st, the member months are sent to CMS by June 1st of the same calendar year. Once quarterly member months are reported to CMS, they are not changed in subsequent quarters.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers: NOT APPLICABLE

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: **The same services are included in the Actual Waiver Cost and for the upcoming waiver period. Beginning January 1, 2014, Amendment #1 includes in Section D coverage of: i) individual and group mental health and evaluation (psychotherapy); ii) psychological testing; and iii) outpatient services for drug monitoring, by the Medi-Cal Managed Care Plans (MCPs) for all Medi-Cal enrollees age 21 and older. These services are added to the Medi-Cal benefit package and are to be provided by MCPs pursuant to California Senate Bill X1-1. These services were available prior to Amendment #1 and will continue to be available under Amendment #1 to full-scope Medi-Cal enrollees under the age of 21 through either Medi-Cal MCPs or Fee-for-Service Medi-Cal (FFS/MC) Program as an EPSDT benefit.**

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **All State of California Medi-Cal mental health service costs are included in this waiver. Other non-mental health costs of serving Medi-Cal clients are accounted for in other State of California waivers and/or state plan programs.**

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial*

programs will enter only FFS costs in the BY. Renewal waivers will enter all waiver and FFS administrative costs in the RY or BY.

For Initial Waivers: NOT APPLICABLE

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$65,625 or .03 PMPM P2* *$72,166 or .03 PMPM P3* *$79,361 or .03 PMPM P4* *$87,274 or .03 PMPM P5*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The MHP's allocate their administrative costs among the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of three methods. These allocation methods are to apply: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report.

As indicated in the above paragraph, MHP's have three options regarding allocation of their administrative costs among its various programs. The allocation method for either initial or renewal waivers is explained below **including notes regarding the appropriateness of each method to various programs:**

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._X_ Other (Please explain). **For SFY 2011-12 (e.g. R1) the State Department of Mental Health (DMH) directly identified DMH costs associated with administering this Medi-Cal waiver program. Since DMH only operated the Medi-Cal services under this waiver and did not operate/oversee any other Medi-Cal programs, all DMH Medi-Cal costs for R1 are included under this Waiver and there is no need to allocate DMH Medi-Cal costs for R1 between this Waiver and other programs. Additionally, the State Department of Health Care Services (DHCS) incurred some State Medi-Cal administrative costs associated with this waiver for R1. DHCS incurred all state Medi-Cal administrative costs associated with this Waiver in R2, as all DMH Medi-Cal staff responsible for this waiver were transferred to DHCS effective July 1, 2012 (e.g. the beginning of R2). DHCS directly identifies DHCS's costs associated with this waiver. DMH and DHCS costs are based on actual percentages of time spent by State staff on this waiver. Finally, county Mental Health Plans (MHP) Administration costs for: i) county administration; ii) quality assurance and utilization review (QA-UR); and iii) Medi-Cal Administrative Activities (MAA), are also included as part of the State Administrative costs. MHPs allocate costs between the Medi-Cal program, MCHIP program, Healthy Families program, and all other programs using one of the three following methods: 1) the percentage of program beneficiaries in the population served, 2) the percentage of gross costs in each program, or 3) a relative value calculation based upon units and customary charges. The allocation methodology is reviewed upon fiscal audit of the cost report.**

H. Appendix D3 – Actual Waiver Cost

a.___ NOT APPLICABLE The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please

include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for PY on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$65,625 or .03 PMPM P2* *$72,166 or .03 PMPM P3* *$79,361 or .03 PMPM P4* *$87,274 or .03 PMPM P5*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for the RY on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for PY on **Column W in Appendix D5**.

Chart: Renewal Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in

			Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ NOT APPLICABLE The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.___ NOT APPLICABLE Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____NOT APPLICABLE Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. NOT APPLICABLE **Appendix D4 – Initial Waiver – Adjustments in the Projection for DOS within DOP**

Initial Waiver Cost Projection & Adjustments (If this is a Renewal waiver for DOP, skip to J. Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the BY in order to accurately reflect the waiver program in PY. If the State has made an adjustment to its BYBY, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this

section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (PY). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to PY in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: BYs_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-

specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between PY.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during PY that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: BYs_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The BY already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the BY and P1 of the waiver and the trend between

the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from BY data.

2.___ We assure CMS that GME payments are included from the BY data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the BY data was completed, the BY data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.

i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).

ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).

2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.

3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the BY costs should be reduced by the amount to be collected.

Basis and method:

1.___ No adjustment was necessary
2.___ BY costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
   i.___ Post-pay recoveries were estimated and the BY costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
   ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the fee-for-service or capitated base. If the BY costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the BY costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.
2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.
3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting

documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from BY data.
2.___ We assure CMS that DSH payments are excluded from the BY data using an adjustment.
3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the BY costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.
2.___ This adjustment was made:
a. ___Potential Selection bias was measured in the following manner:
b.___The BY costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** BY costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The BY costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the BY data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only: Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM BY Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that

payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Renewal Waiver Cost Projection and Adjustments.
If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The RY data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from RY to the end of the waiver (PY). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. _X_ [Required, if the State's BY or RY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used **varies by time period**. Please document how that trend was calculated: **For R1 (e.g. the waiver year July 1, 2011 to June 30, 2012), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2011, December 2011, March 2012, and June 2012 quarterly CMS-64 Reports for waiver year CA17.R07.01 and dividing those expenditures by actual Member Months as reported in the Member Months Reports summed for the same 4 quarters. For the first two (2) quarters of R2 (e.g. the period July 1, 2012 to December 31, 2012), the cost per member per month by MEG was calculated by summing the State Plan service expenditures for each MEG reported in the September 2012 and December 2012 quarterly CMS-64 Reports for waiver years CA17.R07.01 and CA17.R07.02 and dividing these expenditures by the actual member months per MEG as reported in**

the Member Months Report summed for the same two quarters. The State then included a two quarter gap for the last two quarters of R2 from January 1, 2013 to June 30, 2013. The BY PMPM costs per MEG for R2 are then trended for prospective years utilizing DHCS' forecast methodology for each MEG in order reflect medical service (e.g. cost) inflation under the CA.17 waiver program and to align the PY costs with those included/projected in the SFY 2013-14 Governor's Budget. The DHCS forecast methodology utilizes the federal Centers for Medicare and Medicaid Services (CMS) Home Health Agency Market Basket (HHAMB) Index, prepared by CMS' Office of the Actuary (OACT), computing the annual percentage change in the 4 Quarter Moving Average for each PY.

Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R07 was cost effective for R1 in terms of State Plan Services aggregate costs and PMPM per MEG as well as Total Actual Waiver aggregate costs and PMPM. Despite the fact that R1 was cost effective, the State has determined that the PMPM per MEG for State Plan Services and Total Actual Waiver Costs is significantly underreported for R1. This is because many State Plan service costs for waiver year CA17.R07.01 were not reported in the September 2011, December 2011, March 2012, and June 2012 CMS-64 Reports and thus were not included in Appendix D3 as R1 costs.

Appendix D7 of this waiver renewal demonstrates that waiver renewal CA17.R07 was cost effective for R2 in terms of State Plan Services aggregate costs for all MEGS and for Total Actual Waiver services costs. R2 was also cost effective on a PMPM basis for the Disabled, Foster Care and Other MEGs. The R2 State Plan Services PMPM cost slightly exceeded the State Plan Services cost effectiveness projection for the MCHIP MEG. The projected MCHIP PMPM in waiver renewal CA.17.R07 for P2 was $8.94, but actual PMPM expenditures for this waiver year (e.g. R2) were $9.19. This exceeds the projected PMPM costs by 2.8 percent. The reason MCHIP PMPM slightly exceeds projections is due to the fact that actual Medi-Cal enrollment in MCHIP was significantly below projections in both R1 (8.7 percent fewer member months than projected) and R2 (6.1 percent fewer member months than projected). However, the number of MCHIP beneficiaries actually served by the CA.17 waiver program in R2 [e.g. those with serious emotional disturbances (SEDs) who actually received services from the county MHPs] and average utilization of services by these beneficiaries did not correspondingly drop. This reflects the fact that despite the lower than projected MCHIP enrollment, those MCHIP eligible individuals with the most serious medical conditions such as SED still enrolled and presented

for services, reflecting adverse selection despite lower than projected total enrollment.

The State Plan Services MCHIP PMPM for R2 also clearly reflects a statistical anomaly in that: i) the December 2012 CMS-64 Report contained the largest total dollar volume of CA.17.R07 claims of all six quarters of retrospective data; and ii) the December 2012 CMS-64 Report contained the highest proportion of State Plan Services claims for the retrospective years that were for the MCHIP MEG. To summarize, not only were retrospective year claims highest in the December 2012 quarter (e.g. $948,752,774), but the percentage of these claims that were MCHIP was also the highest of all six retrospective quarters. MCHIP claims reflected 1.16 percent of all December 2012 State Plan services claims. In contracts, MCHIP claims reflected only: i) 0.77 percent of September 2012 claims; ii) 0.94 percent of June 2012 claims; iii) 1.09 percent of March 2012 claims; iv) 1.00 percent of December 2011 claims; and v) 0.00 percent of September 2011 claims. Even if the December 2012 MCHIP claims had been at the proportion of the next highest retrospective year quarter (e.g. 1.09 percent as reflected in the March 2012 quarter), the MCHIP MEG would have been cost effective for State Plan Services in R2. This data clearly shows that the MCHIP State Plan Services PMPM for R2 exceeded cost projections due to a random statistical anomaly.

Actual MCHIP PMPM has never exceeded the estimated R07.02 projection of $8.94 in any previous retrospective year since California first began using the current cost effectiveness test in waiver renewal CA.17.R05. The highest previously reported MCHIP actual PMPM in any RY was $7.28 for waiver year CA.17.R06.02.

Despite the fact that R2 was cost effective, except for the slight variance in the MCHIP MEG, the State believes that the PMPM per MEG for State Plan Services and Total Actual Waiver costs may be somewhat underreported for R2 by between 5 percent to 10 percent. This is because some State Plan service costs incurred for waiver years CA17.R07.01 and CA17.R07.02 which would normally have been reported in the September 2012 and December 2012 CMS-64 Reports may not have been. Specifically:

A. DHCS' automated accounting system for the waiver CA.17 program through which the State pays the county MHPs FFP and generates the costs included in the CMS-64 Reports was taken off-line for 6 weeks from July 15 – August 31, 2012 for transition from the Department of Mental Health (DMH) to DHCS. This significantly reduced the reporting of CA17.R07.01 costs in the September 2012 quarterly CMS-64

Report below the levels that the State would have normally expected; and

B. Also as a result of the waiver's transition from DMH to DHCS, county MHPs were required to execute new contracts for waiver services with DHCS beginning October 1, 2012. Many county MHPs were delayed in executing their contracts, with the result that a number of counties could not submit claims for services which the counties paid during the October thru December 2012 quarter. This reduced the reporting of CA.17.R07.02 costs in the December 2012 CMS-64 Report below levels that the State would have normally expected.

Though the December 2012 CMS-64 Report includes "catching up" and paying and reporting to CMS of most of the claims for the July 15 – August 31, 2012 period (during which the State's automated accounting system was off-line) that would have normally been reported in the September 2012 CMS-64 Report– the State believes the December 2012 CMS-64 Report did not include a certain proportion of claims for county MHP costs that would have ordinarily been reported for the October through December 2012 period. DHCS believes Factors A and B above resulted in some underreporting of R2 claims on a PMPM basis compared to what the Governor's Budget for SFY 2012/13 (e.g. R2) projects. DHCS will continue to monitor whether any underreporting of R2 claims did occur, and will seek a program/policy/pricing amendment to this Section D for Prospective Years if DHCS determines that Prospective Year costs will likely be higher than those projected in this Section D.

2. _X_ [Required, to trend BY/RY to PYin the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. _X__ State historical cost increases. Please indicate the years on which the rates are based: BYs **The BY PMPM costs per MEG are based on R2 as the BY and are trended for P1 through P5 utilizing CMS' HHAMB computing the annual percentage change in the HHAMB 4 Quarter Moving Average for each PY. DHCS' projected increase in costs per member per month does not include other factors. No expenditures or member months for the third or fourth quarters of R2 are included in Appendices D1-D7. Only the first and second quarter R2 actual expenditures and member months are included. The two quarter period January 1, 2013 to June 30, 2013 is a gap period in Section D.**

The State Plan service trend percentage increases for P1 through P5 based on the HHAMB are: i) 3.9 percent for P1; ii) 2.7 percent for P2; iii) 2.8 for P3; iv) 2.9 percent for P4; and v) 2.8 percent for P5.

Estimated costs per member per month for each MEG for P1 through P5 were multiplied by the estimated Medi-Cal beneficiaries to compute estimated expenditures by MEG in Appendix D6 for each prospective year. The percentage change between each prospective year is included for each MEG and reported on Appendix D5 as the State Plan Inflation Adjustment.

Because of the lag in including costs in the CMS-64 Reports for R2 subsequent to the county MHPs paying for services, as described in Section J.a.1., items A. and B., the projections contained in this Section D may be inaccurate once complete costs for each Prospective Year in this waiver renewal are reported to CMS through the CMS-64 Reports.

For the CA.17 waiver, the actual expenditures from the CMS-64 Reports do not predictably account for the normal and expected lag in claims processing. The typical lag in the CA.17 waiver program is that about 95 percent of claims in a given waiver year quarter are reported to CMS from 5 to 8 quarters subsequent to the waiver quarter in which the county MHPs pay for the services. In contrast, 95 percent of member months for each quarter are reported within that waiver quarter. This lack of alignment between the reporting of costs versus the reporting of member months for the CA.17 waiver program results in an uneven PMPM due to expenditures being reported far later, and in an unpredictable fashion, than member months are reported.

a. NORMAL LAG IN REPORTING COSTS

Since the Medi-Cal Specialty Mental Health Services (SMHS) waiver CA.17 program utilizes MHPs who receive FFP on a post-service fee-for-service (FFS) cost-reimbursement basis utilizing certified public expenditures (CPEs); there is a normal 5 – 8 quarter lag between the quarter in which the county MHPs actually pay for the services and the quarter in which the State draws down the FFP and reports these service costs in the CMS-64 Reports. Thus, services for which the county MHPs have already paid do not appear in the CMS-64 Reports until a much later time.

This pattern reflects the cost-based reimbursement system by which the CA.17 waiver program draws down FFP after county MHPs as providers have paid for services.

Per State law, once a county pays for services, the county has 12 months to submit claims to the State to begin the process of drawing down FFP and reporting the costs in CMS-64. Once the State receives the claims from the counties, the State takes 30 days to complete adjudication to determine federal Medicaid eligibility, draw down appropriate FFP from California's federal Health Care Deposit Fund, pay the FFP to the county MHPs, and report these costs in the next CMS-64 Report to be transmitted to CMS.

b. UNIQUE LAG FACTORS IMPACTING THE CA.17.R07 WAIVER

As described in Section J.a.1., items A and B, there may have been a unique lag in the reporting of R2 costs which depressed the State Plan PMPM due to:

A. The State's automated accounting system being off-line for 6 weeks from July 15 – August 31, 2012 for transition from DMH to DHCS, thus significantly reducing R2 costs reported in the September 2012 CMS-64 Report; and

B. Though much of the "missed" CMS-64 reporting in the September 2012 quarter was included in the December 2012 CMS-64 Report – many county MHPs did not have executed contracts for the period October 1 through December 31, 2012. As a result, these county MHPs were not able to claim for services which they provided and paid for during the December 2012 quarter. Overall, this may have resulted in lower than expected R2 reporting in the December 2012 CMS-64 Report.

Other unique circumstances which continue to have some impact in delaying county MHPs' submitting claims for FFP and the State's reporting of these costs in the CMS-64 Reports include: i) continuing to implement federal Health Insurance Portability and Accountability Act (HIPAA) requirements in the SD2 system with respect to claims payment and privacy of information: ii) the need for county MHPs to implement their own county-level information technology (IT) HIPAA-compliant systems which interface with SD2 for claiming purposes; iii) the need for the State and county MHPs to implement dual-eligible/Medi-Medi and additional Other Health Coverage (OHC)/Third Party Liability (TPL) claims processing edits; and iv) a change in State law effective July 1, 2012 allowing county MHPs 12 months from the date of service to

submit claims to the State rather than the previous 6 month billing deadline.

In addition, any delayed approval of the State Budget after the June 30th deadline of each SFY would force county MHPs to hold back claims since the CA17 waiver program does not have continuous appropriation authority, thus resulting in a lag in CMS-64 Reporting.

Given the "I. NORMAL LAG IN REPORTING COSTS" which are paid to the county MHPs as described above, it is approximately one to two quarters after the quarter in which a county MHP has paid for services, before those county expenditures begin appearing in the CMS-64 Reports. Costs for a given waiver year then rapidly increase over the next two to four quarter period. After this peak period, claims for a given waiver year taper off, with this "normal" lag thus following a bell-shaped curve model of reporting of costs to CMS after the close of each waiver year.

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. **As described above, PMPM costs are trended for PYs utilizing the HHAMB. The State's cost increase calculation does not include any factors other than a price increase.**

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between RY and P1 and between years P1 and PY.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. _X_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The RY data was adjusted for changes that will occur after the R2 and during PY that affect the overall Medicaid program.
Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from RY to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._X_ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv._X_ Changes brought about by legal action (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.__X_Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D._____ Other (please describe):

The State is implementing a State Plan Services Programmatic/Policy/Pricing Change Adjustment for P1 and on-going to implement provisions of the KATIE A, etc., et al, v. DIANA BONTA, etc. et al, CLASS ACTION SETTLEMENT AGREEMENT (Case No. CV-02-05662 AHM [SHx]). This December 2011 Katie A. court settlement provides for an increase in existing State Plan Service provision under the CA.17 waiver program for dates of service beginning January 1, 2013. Per the 2013 Governor's Budget for SFY 2013-14, the projected annual increase in CA.17 waiver program existing State Plan services costs for P1 and future PYs is projected to be 1.73 percent

v._X__Changes in legislation (please describe):

For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B._X__ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____X_Other (please describe):

The State is implementing a State Plan Services Programmatic/Policy/Pricing Change Adjustment for P1 and on-going to implement provisions of AB 1297, Chesbro (Chapter 651, Statutes of 2011) and pending State Plan Amendment (SPA) #09-004. AB 1297 amended California Welfare and Institutions (W&I) Code section 5720 to allow county MHPs, effective July 1, 2012, to seek reimbursement up to actual cost consistent with federal Medicaid requirements and applicable federal Medicaid upper payment limits (UPLs). Pending SPA #09-004 implements these same provisions.

In R2, approximately $340,804,213 in medical assistance costs were for dates of service beginning July 1, 2012 and thereafter, reflecting total reimbursement (both FFP and non-federal match) above the SMA and below the lower of actual cost consistent with federal Medicaid requirements or the applicable federal UPL. This is due to the "normal" and "unique" claim lag factors described in sections I.J.a.1 and I.J.a.2. The remaining $1,028,487,507 for R2 does not reflect the increase of elimination of the SMA. The January 2013 Governor's Budget projects that an additional $233,992,000 total funds expenditure will be paid for SFY 2012-13, and $251,991,000 total funds expenditure will be paid in P1 (e.g. SFY 2013-14) on an accrual basis due to elimination of the SMA. Subtracting out the $340,804,213 in R2 costs which likely include reimbursement over the SMA, and converting the annual 2013 Governor's Budget amount to a cash basis (more closely aligned to CMS-64 Reporting), the State projects that the full State Plan Services cost impact of eliminating the SMA will be a 7.89 percent annual increase above the PMPM projected for P1 and future PYs based only on the R2 PMPM and HHAMB. The State is thus projecting a programmatic/policy/pricing increase of 7.89 percent to P1 and future prospective years to reflect this change.

Amendment #1 – Appendix D4 and Appendix D5 (Column N, lines 16 & 33, and Column O lines 16 and 33) – makes projected adjustments for: i) the OAME population who will receive Medi-Cal SMHS and non-SMHS mental health services; and ii) additional non-SMHS mental health services projected to be provided by Medi-Cal MCPs to currently non-disabled Medi-Cal beneficiaries age 21 and older. These adjustments are effective January 1, 2014 and impact the last 6 months of P1 and all of P2.

Per Appendix A, Analysis of Mental Health and Substance Use Benefits for the Medi-Cal Coverage Expansion Population included in DHCS' "*Bridge to Reform Waiver, Mental Health and Substance Use Disorders Services Plan (Services Plan)*" to be submitted to CMS in October 2013, it is projected that 575,184 average monthly eligibles (3,451,104 member months) and $112,540,468 in total Medi-Cal SMHS and non-SMHS mental health service costs will be incurred for the last 6 months of P1 for these beneficiaries. For P2, 757,405 average monthly eligibles (9,088,860 member months) and $311,207,217 in total costs are included in Appendix A for these beneficiaries.

For the above service costs, the "*Services Plan*" states that 13% of the funding for Medi-Cal SMHS is projected for county administration. As a result, of the $18.88 Per Member Per Month (PMPM) ($65,156,824/3,451,103 member months = $18.88) projected in Appendix A for Medi-Cal SMHS in P1, 13% or $2.4544 PMPM is for Administative costs. ($2.4544 PMPM times 3,451,103 member months = $8,470,387 P1 administrative costs).Of the $19.82 PMPM ($180,177,622/9,088,860 member months = $19.82) projected for Medi-Cal SMHS in P2, 13% or $2.5766 PMPM is projected for Administrative costs. ($2.5766 PMPM times 9,088,860 member months = $23,418,357). All of the funding contained in Appendix A for Medi-Cal MCP mental health and mental health pharmacy are for State Plan services and not administration.

As a result, Appendix A and the "*Services Plan*" projects $104,070,081 (i.e. $112,540,468 minus $8,470,387 = $104,070,081) for State Plan Services costs for the second half of P1 and $287,788,860 (i.e. $311,207,217 minus $23,418,357 = $287,788,860) for State Plan Services costs for P2 for OAME beneficiaries.

The Trend Data and Appendix D1 include the member months for P1 and P2 projected in Appendix A from the "*Services Plan*". Appendix D5, Columns N and O, lines 16 & 33, includes the projected increase in PMPM State Plan Services costs for the "OTHER" MEG needed to include the OAME utilization PMPM.

vi.___ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.___Other (please describe):

c. _X___**Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X_ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of PY. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

iii._X_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: BYs **are state FYs 2006-07, 2007-08 and 2008-09.** In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

CA17 administration inflation rates for P1 through P5 are based on a 3 year weighted average trend of administrative costs calculated for SFYs 2006-07 through 2008-09. This inflation rate cost increase calculation does not include any factors other than a price increase.

PMPM costs for Administration for R1 and the first two quarters of R2 were calculated by apportioning total administration costs for each of waiver years R1 and R2 to each MEG based on the ratio of each MEGs State Plan Service costs for the waiver year to the total State Plan Service costs for that same waiver year as contained in Appendix D3. This calculated ratio of each MEGs Administration costs are then divided by the actual Member Months per MEG as reported in Appendix D1 for the same waiver year to obtain the Administration PMPM for each RY.

Estimated costs per member per month for each MEG for Administration for P1 through P5 are then multiplied by the estimated Medi-Cal beneficiaries projected for each PY to compute estimated administration expenditures by MEG for each prospective year in Appendix D6. The percentage change between each prospective year is then computed for each MEG and reported on Appendix D5 as the Administration Inflation Adjustment.

NORMAL LAG IN REPORTING ADMINISTRATION COSTS – The same "normal" lag as described for reporting State plan services costs in the CMS-64 Reports in sections I.J.a.1 and I.J.a.2 applies to the reporting of CA17 Administration costs for R1 and R2. As a result, actual Administration costs reported for R1 and R2 of the CA17.R07 waiver renewal do not properly reflect expected Administration cost claiming.

UNIQUE LAG IMPACTING THE CA.17.R07 WAIVER – There is also a "unique lag" in the reporting of actual Administration costs for R1 and R2 in Appendices D2A and D3. On September 28, 2011 the State issued guidance to county MHPs via All County Letter (ACL) #11-01 changing the manner in which counties were to bill the State for: i) county administration; ii) quality assurance and utilization review (QA-UR); and iii) specialty mental health Medi-Cal Administrative Activities (MAA) costs. There was a delay to make necessary changes to the State accounting reimbursement system in order to process, pay and report these Administration costs in the quarterly CMS-64 Reports. The State needed to re-program their accounting reimbursement system to handle the revised county administrative claim form beginning in December 2011. However, the transition of staff from the specialty mental health services program and the State's accounting reimbursement system to DHCS from September 2011 through July 2012 delayed the State from implementing these changes. DHCS staff instead focused on making the necessary changes to the accounting reimbursement system in order to continue payment of county MHP medical assistance costs through the calendar year 2012 transition period. The State had to delay completion of the system changes needed in order to reimburse counties (and report in the CMS-64 Reports) payments for Administration. As a result, very little of the CA.17.R07.01 and CA.17.R07.02 Administration costs incurred by county MHPs have yet been reported in the CMS-64s. The change in county billing requirements and delay in implementing State system changes resulted in very low levels of county Administration being reported for R1 and R2. DHCS completed implementation of the USL-Financial system changes to pay Administration costs in January 2013. The vast majority of CA.17.R07.01 and CA.17.R07.02 Administration costs will be reported in the upcoming March 2013 and June 2013 CMS-64 Reports. In upcoming CMS-64 Reports, DHCS anticipates annual payment of Administration costs to be approximately $280 million dollars for each of waiver years CA.17.R07.01, CA.17.R07.02 and approximately $359.7 million in P1.

The State is thus adding a lag factor in Appendix D5, Column Y, to project Administration costs from R2 to P1 to accurately reflect the Administration costs contained in the most current January 2013 Governor's Budget for

county administration for P1. With the accounting reimbursement system changes for Administration costs now completed, DHCS projects reporting of Administration costs in the CMS-64 Reports to return to an approximate $359.7 million per year in P1 plus the applicable Administration cost inflation factors included in Appendix D5 for P2 through P5.

The percentage change between each prospective year from P1 through P5 is computed for each MEG and reported on Appendix D5 as the Administration Inflation Adjustment utilizing the 3 year weighted average trend of administrative costs described above.

Amendment #1 –Appendix D4 and Appendix D5 (Column AC, lines 16 & 33, and Column AD lines 16 and 33) – makes a projected Administrative cost adjustment for the OAME population who will receive Medi-Cal SMHS. This adjustment is effective January 1, 2014 and impacts the last 6 months of P1 and all of P2.

The "*Services Plan*" states that 13% of the funding for Medi-Cal SMHS contained in Appendix A of the Service Plan is projected for county administrative costs. As a result, of the $65,156,824 projected in Appendix A for Medi-Cal SMHS in P1, $8,470,387.20 (e.g. 13%) is for Administative costs and of the $180,177,622 projected for Medi-Cal SMHS in P2, $23,418,356.68 (e.g. 13%) is projected for Administrative costs.

Appendix D5, Columns AC and AD, lines 16 & 33, includes this projected increase in Per Member Per Month (PMPM) for Administrative costs.
The lack of alignment between the reporting of Administration costs versus the reporting of member months for the CA.17 waiver program results in an uneven and unpredictable Administration PMPM due to expenditures being reported far later than member months are reported.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** NOT APPLICABLE The State must document the amount of 1915(b)(3) services in the RY/BY **Section D.I.H.a** above. The RY/BY already includes the actual trend for the 1915(b)(3) services in the

program. This adjustment reflects the expected trend in the 1915(b)(3) services between the RY/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (PY). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or last RY is more than 3 months prior to the beginning of P1 to trend BY or RY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or last RY is trended to the last PY. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: BYs_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** NOT APPLICABLE
Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe): NOT APPLICABLE

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust PY to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees

and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment**: Rebates that States receive from drug manufacturers should be deducted from BY costs if pharmacy services are included in the capitated base. If the BY costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
  Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the BY costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

The State utilizes a cost effectiveness monitoring process whereby any variances in PMPM cost by MEG are identified, researched and discussed so that the State can discuss such findings with CMS and prepare any necessary waiver amendments.

The State monitors retrospective year costs based on all actual costs for each waiver year reported in the CMS-64 Reports during that waiver year. The State updates and reviews cumulative costs for each RY at the time each final quarterly CMS-64 Report during that waiver year is transmitted by the State to CMS. The State compares both the aggregate and PMPM costs per MEG for State Plan Services and

Administration for each retrospective waiver year to the Appendix D6, RO Targets. If the PMPM per MEG for any waiver year within a particular waiver term exceeds the Appendix D6 targets, the State determines what factors caused the PMPM to exceed the waiver year projection – including State Plan Trend and Administration Cost factors such as: i) changes in the CMS-64 Reporting lag and those factors causing the change; ii) reporting of costs by county; iii) reporting of costs by service type; iv) the number of beneficiaries that received services per waiver quarter/year compared to member months for the same waiver quarter/year *(e.g.. "caseload" or penetration rate)*; v) the number of services per beneficiary *(e.g. utilization)*; vi) rate changes; vii) administrative/statutory/legal changes; and/or viii) other changes that may impact quarterly or annual PMPM costs.

The unpredictable lag in reporting payments made by the county MHPs in the CMS-64 Reports due to both the "normal" lag and any "unique" lag factors makes it difficult to align actual waiver year expenditure data with actual member months for the same waiver years. Collating, reviewing and trending State plan service and Administration costs over more retrospective years may better identify actual costs for each waiver year. Without reviewing waiver costs over a greater number of retrospective years, the projections contained in this Section D for waiver renewal CA.17.R08 may be inaccurate until complete costs for each RY are reported to CMS in future CMS-64 Reports.

The State may request additional amendments to this Section D in the future to properly align actual costs and member months for each waiver year and address any other programmatic/policy/pricing changes to either the State Plan Trend or Administration Costs that occur during this waiver term.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to PY.

As described in Part I Section J.a.1. and I.Ja.2, and included in Appendix D5, Column J, the State has included the HHAMB inflation factor for State Plan services in each PY.

As described in Part I Section J.c.2.iii., and included in Appendix D5, Column Y, rows 13 through 16 – the State has included a "unique" lag factor increase from R2 to P1 in Appendix D4 and Appendix D5 for Administration costs. This adjustment accounts for the lack of reporting of R1 and R2 Administration costs due to the factors described in Section J.c.2.iii.A. This adjustment aligns R2 to P1 Administration costs with those Administration costs included/projected in the January 2013 Governor's Budget for SFY 2013/14 (e.g. P1) for R2 to P1.

As described in Part I Section J.c.2.iii., and included in Appendix D5, Column Y for P2 through P5 – the State has included an Administration inflation adjustment.

As described in Part I Section J.b.2.iv. and reflected in Appendix D5, Column L, rows 13 through 16, the State has included a Programmatic/Policy/Pricing Change Adjustment for the Katie A. court settlement.

As also described in Part I Section J.b.2.iv. and also reflected in Appendix D5, Column L, rows 13 through 16, the State has included a Programmatic/Policy/Pricing Change Adjustment for AB 1297 which allows billing of State Plan Services above the former SMA up to the lower of actual cost consistent with federal Medicaid requirements or the applicable federal UPL.

As described in Part I., Section J.b.2.v. D and in Appendix D5, Columns N and O, lines 16 and 33, the State has included in Amendment #1 a State Plan Programmatic/policy/pricing adjustment for the newly eligible OAME population served under the Medi-Cal SMHS waiver and for increased non-SMHS services provided to adult non-disabled Medi-Cal enrollees by the Medi-Cal MCPs as a federal essential health benefit.

As described in Part 1., Section J.c.2.iii.A., and in Appendix D5, Column AC and AD, lines 16 and 33, the State has included in Amendment #1 an Administrative Cost Adjustment for the newly eligible OAME population served under the Medi-Cal SMHS waiver.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   Medi-Cal beneficiaries for the MCHIP MEG for the four quarters of calendar year 2013 (e.g. the period January 1, 2013 through December 31, 2013) are assumed to increase by the number of California Children's Health Insurance Program (CHIP) beneficiaries estimated to transition to Medi-Cal in each of these quarters described in the January 2013 Governor's Budget. This CHIP transition to MCHIP is estimated to occur in the last two quarters of R2 (e.g. the lag period) and first two quarters of P1. The estimated increase in MCHIP beneficiaries due to this CHIP transition are included in Appendix D1.

As described in Part I., Section E.c. for Renewal Waivers, Medi-Cal beneficiaries are estimated and assumed to change based on the percentage factors described for each MEG in Section E.c.

As described in Part 1., Section E.c.4., Amendment #1 projects an increase of 575,184 monthly eligibles for the last 6 months (January 1, 2014—June 30,2014), or 3,451,104 member months, for the new OAME population in the "OTHER" Medicaid Eligibility Group (MEG) for P1 and 757,405 monthly eligibles, or 9,088,860 member months, for the OAME population in the "OTHER" MEG for P2.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**: **Unit cost changes are anticipated to increase from R2 to P1 as described in Part I. Section J.b.2.v. and reflected in Appendix D5, Column L, rows 13 through 16, as a result of implementation of AB 1297 and pending SPA #09-004.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**: **Utilization changes are anticipated to increase from R2 to P1 as described in Part I. Section J.b.2.iv. and reflected in Appendix D5, Column L, rows 13 through 16, as a result of implementation of the Katie A court settlement.**

   Utilization for the new OAME population in the "OTHER" MEG included in Amendment #1 for dates of service beginning January 1, 2014 is expected to be significantly higher than utilization by the existing "OTHER" MEG. California's OAME population reflects an older population with higher levels of chronic health conditions, including mental illness, than the current "OTHER" MEG which includes mostly families and children. In addition, enrollment in the OAME for the first two or three calendar years is anticipated to reflect "adverse selection" with those individuals most in need of health care services enrolling earlier. Appendix A of the "Bridge to Reform Waiver, Mental Health and Substance Use Disorder Services Plan" reflects a total $32.61 PMPM for the last 6 months of P1 and $34.24 PMPM for P2 for OAME. Of this amount, $2.45 PMPM and $2.58 PMPM reflects SMHS Administrative costs for the last half of P1 and P2 respectively. This is far greater than the existing $15.17 PMPM and $15.58 in State Plan Services costs and $1.49 PMPM and $1.57 PMPM in Administrative costs under the current waiver

renewal for the "OTHER" MEG for P1 and P2. Appendix D5, Columns N, O, AC, and AD, lines 16 and 33, reflects adjustments to these PMPMs to include the new OAME population in the "OTHER" MEG.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I. No other principle factors other than those described above contributed to the overall annualized rate of change in the cost per member per month.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.