TITLE:

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

Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Demonstration Year: Ten (07/01/14-10/31/15)
Second Quarter Reporting Period: 10/01/2014-12/31/2014

INTRODUCTION:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SENIORS AND PERSONS WITH DISABILITIES (SPD)

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

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

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

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

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

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

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

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

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

Enrollment information:

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

TOTAL MEMBER MONTHS FOR MANDATORY SPDs BY COUNTY
October 2014 – December 2014

County	Total Member Months
Alameda	92,196
Contra Costa	50,902
Fresno	70,191
Kern	56,524
Kings	7,765
Los Angeles	588,963
Madera	7,525
Riverside	94,338
San Bernardino	110,598
San Francisco	52,980
San Joaquin	51,174
Santa Clara	69,568
Stanislaus	37,363
Tulare	33,296
Sacramento	116,111
San Diego	118,842
Total	**1,558,336**

TOTAL MEMBER MONTHS FOR EXISTING SPDs BY COUNTY
October 2014 – December 2014

County	Total Member Months
Alameda	47,154
Contra Costa	19,312
Fresno	24,845
Kern	16,415
Kings	2,468
Los Angeles	495,220
Madera	2,423
Marin	18,962
Mendocino	17,643
Merced	47,643
Monterey	47,318
Napa	14,043
Orange	345,584
Riverside	79,897
Sacramento	44,360
San Bernardino	79,565
San Diego	121,230
San Francisco	28,551
San Joaquin	17,208
San Luis Obispo	25,149
San Mateo	70,503
Santa Barbara	44,863
Santa Clara	44,462
Santa Cruz	30,626
Solano	57,957
Sonoma	52,287
Stanislaus	8,360
Tulare	11,842
Ventura	81,730
Yolo	25,578
Total	**1,923,198**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL NON-COHS COUNTIES
October 2014 – December 2014

County	Total Member Months
Alpine	56
Amador	635
Butte	9,409
Calaveras	954
Colusa	359
El Dorado	2,493
Glenn	833
Imperial	5,802
Inyo	417
Mariposa	435
Mono	134
Nevada	1,628
Placer	4,643
Plumas	546
San Benito	245
Sierra	83
Sutter	2,637
Tehama	2,578
Tuolumne	1,363
Yuba	2,950
Total	**38,200**

TOTAL MEMBER MONTHS FOR SPDs IN RURAL COHS COUNTIES
October 2014 – December 2014

County	Total Member Months
Del Norte	7,981
Humboldt	26,919
Lake	18,719
Lassen	4,070
Modoc	2,054
Shasta	41,128
Siskiyou	11,001
Trinity	3,108
Total	**114,980**

Enrollment (October 2014 – December 2014)
During the quarter, mandatory SPDs had an average choice rate of 57.97%, an auto-assignment default rate of 14.33%, a passive enrollment rate of 20.59%, a prior-plan default rate of 0.66%, and a transfer rate of 6.51%. In December, overall SPD enrollment in Two-Plan and GMC counties was 537,185 (point-in-time), a 4% increase from September's enrollment of 516,527. For monthly aggregate and Medi-Cal managed care health plan (MCP)-level data, please see the attachment "DY10-Q2 Defaults Transfers 2Plan GMC."

Outreach/Innovative Activities:

Medi-Cal Managed Care Quarterly Performance Dashboard (October 2014 – December 2014)
During the reporting period, the Managed Care Quality and Monitoring Division (MCQMD) continued to update the Medi-Cal Managed Care Performance Dashboard (MMCPD). The MMCPD assists DHCS, Managed Care Plans (MCP), and other stakeholders to identify trends and better observe and understand the program on multiple levels—statewide, by managed care plan model (i.e., COHS, GMC, Two-Plan, Regional, San Benito and Imperial) and by individual MCP. On November 20, 2014, MCQMD released the fourth iteration of the dashboard via public webinar. It includes, but is not limited to, metrics that quantify and track quality of care, enrollee satisfaction, utilization and continuity of care. It also stratifies reported data by beneficiary populations including Medi-Cal-only SPDs, dual eligibles, children transitioned from the Healthy Families Program and the ACA optional expansion population. The most significant additions to the fourth dashboard iteration include Continuity of Care (COC) metrics related to the LIHP transition and mental health benefit. Also, year-to-date trend analyses were added to the COC and Medical Exemption Request metrics for all populations.

The fifth edition of the dashboard will be released in March 2015 and MCQMD will conduct a webinar to present the dashboard to MCPs and other stakeholders. The dashboard was originally developed with funding from the California Health Care Foundation (CHCF).

Operational/Policy Issues:

Network Adequacy
Between October 2014 and December 2014, the Department of Managed Health Care (DMHC) completed a provider network review of all Two Plan and GMC model MCPs. DMHC's reviews, based on quarterly provider network reports, provide DHCS with an updated list of providers SPDs may contact to receive care. DHCS and DMHC conducted a joint review of each MCP's provider network and identified no systemic access to care issues. The two departments are working aggressively with the MCPs to ensure that all areas of network adequacy are addressed.

Consumer Issues:

Section 1115 Medicaid Waiver Stakeholder Advisory Committee

On December 3, 2014, DHCS's Section 1115 Medicaid Waiver Stakeholder Advisory Committee (SAC) convened. There were no specific discussions relating to SPDs. Full documentation from the meeting is available at: http://www.dhcs.ca.gov/Pages/SAC-12-3-Meeting-Materials.aspx

Office of the Ombudsman (October 2014 – December 2014)

The Office of the Ombudsman experienced an overall decrease in customer calls between the periods July-September 2014 (DY10-Q1) and October-December 2014 (DY10-Q2). During DY10-Q2, the Ombudsman received 43,113 total calls, of which 13,440 concerned mandatory enrollment and 2,147 were from SPDs. During DY10-Q1, the Ombudsman received 45,367 total calls, of which 14,490 concerned mandatory enrollment and 2,471 were from SPDs. This represents a 4.97% decrease in total calls, a 7.25% decrease in calls regarding mandatory enrollment, and a 13.11% decrease in calls regarding mandatory enrollment from SPDs.

For DY10-Q2, 0.10% of SPD and 0.02% of non-SPD calls concerned access issues. This is a small decrease in SPD and non-SPD calls from DY10-Q1, during which 0.13% of SPD calls and 0.05% of non-SPD calls were related to access issues.

The number of State Hearing Requests (SHRs) decreased for overall measures, but increased slightly for SPD measures. Total SHRs decreased from 733 in DY10-Q1 to 594 DY10-Q2. The percentage of SHRs from SPDs increased slightly from 37% to 38%. The number of SHRs regarding the denial of eligibles' requests for exemption from mandatory enrollment into MCPs decreased from 214 in DY10-Q1 to 178 in DY10-Q2. The percentage of those requests from SPDs increased from 27% to 33%. There were no SHRs related to access to care or physical access during either quarter.

Quarterly aggregate and MCP-level data is available in the attachments "DY10 Q2 Ombudsman Report" and "DY10 Q2 State Hearing Report."

Medical Exemption Requests (MERs) (October 2014 – December 2014)

Nothing to report.

Health Risk Assessment Data (April 2014 – June 2014)

According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs newly enrolled 39,051 SPDs between April 2014 and June 2014. Of those, MCPs stratified 16,155 (41.37%) as high-risk SPDs and 14,859 (38.05%) as low-risk SPDs. Of the high-risk SPDs, MCPs contacted 25.94% by phone and 34.19% by mail. Of the total high-risk SPDS, 24.44% completed a health risk assessment survey. Of the low-risk SPDs, MCPs contacted 23.35% by phone and 73.79%by mail. Of the total low-risk SPDS, 25.35% completed a health risk assessment survey. After the health risk assessment surveys were completed, MCPs determined 2,640 SPDs to be in the other risk category, which is 6.76% of the total enrolled in the quarter.

Quarterly aggregate and MCP-level data is available in the attachment "Q2 2014 Risk Data."

Continuity of Care Data (July 2014 – September 2014)
According to the data reported by MCPs operating under the Two-Plan and GMC models, SPDs submitted 1,559 continuity-of-care requests between July and September 2014. Of these, MCPs approved 1,132 requests (72.61% of all requests); held 59 requests (3.78%) in process; and denied 368 requests (23.60%). Of the requests denied, 39.67% of the requests arose from provider refusing to work with managed care. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 Continuity of Care."

Plan-Reported Grievances (July 2014 – September 2014)
According to the data reported by MCPs operating under the Two-Plan, GMC and COHS models, SPDs submitted 2,892 grievances between July and September 2014. Of these grievances, 0.31% were related to physical accessibility, 9.89% were related to access to primary care, 3.98% were related to access to specialists, 1.83% were related to out-of-network services, and 83.99% were for other issues. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 SPD Grievance."

Medical Exemption Requests (MERs) Data (July 2014 – September 2014)
From July through September in 2014, 7,541 SPDs submitted 8,527 MERs, an average of 1.13 MERs per SPD who submitted a MER. MCQMD approved 6,364 MERs, denied 2,138, and found 25 to be incomplete. The top five MER diagnoses were Complex (662), Cancer (252), Neurological (145), Transplant (129), and Dialysis (74). Summary data is available in the attachment "Q3 2014 MERs Data."

Health Plan Network Changes (July 2014 – September 2014)
According to data reported by MCPs operating under the Two-Plan, GMC and COHS models, MCPs added 990 primary care physicians (PCPs) and removed 747 PCPs across all networks, resulting in a total PCP count of 27,060. Quarterly aggregate and MCP-level data is available in the attachment "Q3 2014 Network Adequacy," including MCP-level changes in Specialists.

Financial/Budget Neutrality:

Nothing to report.

Quality Assurance/Monitoring Activities:

SPD Evaluation (October 2014 – December 2014)
Nothing to report.

Encounter Data (October 2014 – December 2014)
DHCS initiated the Encounter Data Improvement Project (EDIP) in late 2012, with the goal of improving its encounter data quality and establishing the Encounter Data Quality

Monitoring and Reporting Plan (EDQMRP). The EDQMRP, currently under development, is DHCS' plan for measuring encounter data quality, tracking it from submission to its final destination in DHCS's data warehouse, and reporting data quality to internal data users and external stakeholders.

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

EDQU also worked with Medi-Cal MCPs as they transitioned to DHCS' new encounter data processing system, PACES, which will enhance DHCS' ability to implement the EDQMRP. The first group of Medi-Cal MCPs successfully transitioned to the new system in December 2014 and the transition will continue through early 2015. Although these efforts did not specifically target SPDs, improving the quality of DHCS's encounter data will enable it to better monitor the services and care provided to this population.

Outcome Measures and All Cause Readmissions (October 2014 – December 2014)

Healthcare Effectiveness Data Information Set (HEDIS) Measures
As HEDIS rates are reported annually, there will be no new data until July 2015. MCPs will report the following indicators for SPDs versus other members: all cause readmissions to the hospital, ambulatory visits (outpatient and emergency department), monitoring for patients on persistent medications, and children and adolescents' access to primary care practitioners.

Consumer Assessment of Healthcare Providers and Systems
The Department of Health Care Services (DHCS) has approved and posted the 2013 CAHPS® Survey Summary Report on DHCS's Managed Care Quality and Monitoring Division's Quality Improvement & Performance Measurement Reports website: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx#cahps.

The survey was conducted by DHCS's external quality review organization, Health Services Advisory Group. The report measures member satisfaction with four global ratings and five composite measures. For example, it measures members' satisfaction with the care provided by their personal doctors and the customer service provided by their MCPs. The MCPs' National Comparison results for the Global Ratings and Composite Measures either improved or stayed the same when compared to the 2010 CAHPS® Summary Report. However, the 2013 CAHPS® Survey Summary Report indicates that MCPs have the greatest opportunities for improvement on the following

measures: *Rating of Health Plan*, *Getting Care Quickly*, and *How Well Doctors Communicate*—suggesting that low performance in these areas may point to issues with access to and timeliness of care.

DHCS is utilizing CAHPS® performance data to drive improvement, such as by conducting data analysis related to Smoking and Tobacco Use Cessation and sharing the results with MCPs.

DHCS provides CAHPS® survey information to Medi-Cal beneficiaries through the Consumer Guide and the Office of Patient Advocacy Report Cards to assist them in making informed decisions when they select a health plan.

Utilization Data (October 2013 – December 2013)
During the period October through December 2013, MCPs in Two-Plan and GMC counties enrolled 531,421 unique SPDs. Below is a breakdown of these SPDs' utilization of services.

ER Services:

- 13.83% (73,506) of the SPD population visited an ER.
- Each SPD who visited an ER went an average of 1.71 times.
- Each SPD who visited an ER generated an average of 2.71 ER claims.

Pharmacy Services:

- 67.83% (360,489) of the SPD population accessed pharmacy services.
- Each SPD who accessed pharmacy services generated an average of 14.06 claims.

Outpatient Services:

- 48.25% (256,434) of the SPD population accessed outpatient services.
- Each SPD who accessed outpatient services generated an average of 6.89 visits.
- Each SPD who accessed outpatient services generated an average of 10.91 claims.

Inpatient Services:

- 4.97% (26,424) of the SPD population accessed inpatient services.
- Each SPD who accessed inpatient services generated an average of 2.85 visits.
- Each SPD who accessed inpatient services generated an average of 3.70 claims.

Hospital Admissions:

- 5.72% (30,396) of the SPD population were admitted to a hospital.
- Each SPD admitted to a hospital generated an average of 1.96 visits.

Top Ten Services Accessed by SPDs

12,267,575 total claims

	Oct 2013 – Dec 2013
1	Prescribed Drugs
2	Physicians
3	Lab and X-Ray
4	Other Clinics
5	Other Services
6	Outpatient Hospital
7	Personal Care Services
8	Hospital: Inpatient Other
9	Targeted Case Management
10	Rural Health Clinics

For the top ten diagnosis categories, MCPs submitted data for a total of 3,002,648 encounters. Mental Illness was in the top rank with 37.96% of the encounters. "Symptoms; signs; and ill-defined conditions and factors influencing health status" accounted for 15.74%. In the third position, "Diseases of the nervous system and sense organs" was 8.14%. The remaining seven categories ranged from 8.03% to 2.99% of the encounters.

Quarterly aggregate and MCP-level data is available in attachment "DY10 Q2 Utilization Data."

Enclosures/Attachments:

- "DY10 Q2 Defaults Transfers 2Plan GMC"
- "DY10 Q2 Ombudsman Report"
- "DY10 Q2 State Hearing Report.
- "Q2 2014 Risk Data"
- "Q3 2014 Continuity of Care"
- "Q3 2014 SPD Grievance"
- " Q3 2014 MERs Data"
- "Q3 2014 Network Adequacy"
- "DY10 Q2 Utilization Data"
- "MMCD AG Meeting Minutes 12 12 14"
- "Managed Care Enrollment Quarterly Report"

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

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

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

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

Enrollment information:

The current quarter monthly enrollment for Health Plan of San Mateo (HPSM) CCS Demonstration Project (DP) is shown in the table below. Eligibility of HPSM's CCS DP members is extracted from the Children's Medical Services Network (CMSNet) system, verified by Information Technology Services Division (ITSD) using Medi-Cal Eligibility Data System (MEDS), and forwarded to Office of HIPAA Compliance (OHC) where the file is then sent to HPSM and an invoice is generated from the CAPMAN system.

Month	HPSM Enrollment Numbers	Difference
Prior Quarter September 2014	1,435	
October 2014	1,413	-22
November 2014	1,405	-8
December 2014	1,421	16

Outreach/Innovative Activities:

During the months of July through September 2014, the Department of Health Care Services (DHCS) developed and administered a "Family Satisfaction Phone Survey" (survey) to HPSM CCS DP families. The Department conducted this survey to satisfy one of several components of the operational review for the CCS DP. DHCS was able to contact 385 HPSM families. Of those contacted, 380 families (98.7%) agreed to complete the survey. The survey objective was to assess the families' knowledge and satisfaction of the CCS DP, their knowledge and satisfaction with their care coordinator, their access and satisfaction with providers, and their satisfaction with the medical services provided. This survey will help the Department improve the services provided to CCS clients and to determine how the DP is working for CCS clients enrolled within the CCS DP.

Operational/Policy Issues:

DHCS continued to collaborate with Demonstration entities relative to issues and challenges specific to each of the model locations. Challenges vary among the demonstration models but include determination of the target population, determination of disease specific groups, general organizational structure, reporting requirements, rate development, etc.

Health Plan of San Mateo Demonstration Project

Department Communications with HPSM

DHCS and HPSM conducted bi-weekly conference calls to discuss various issues,

inclusive of those related to finance, information technology, and report deliverables. On October 17, 2014, DHCS conducted site visits with HPSM and San Mateo County (SM County) for a first annual review of the demonstration project. Documents were provided for review and discussions were focused on what was working well and what were challenges with the CCS DP. Overall, the program was working well.

Capitation Rates
DHCS has been working on adjusting HPSM's capitated rate in compliance with the physician fee increase required by Section 1202 of the Affordable Care Act, Senate Bill 78 and Assembly Bill 1422.

The Department worked to implement a 9D aid code which will allow CCS State-Only children to enroll in CCS DPs. The goal is to be able to automate enrollment of CCS State-Only children into a CCS DP.[1] It is anticipated the 9D aid code for "CCS State-Only beneficiaries" will be active March 2015.

Aid Codes
HPSM DP began to enroll children into the pilot with eligibility codes 7U, 7W, and K1. The effective date for these codes was November 25, 2014.

Rady Children's Hospital of San Diego Demonstration Project

SCD had been working with Rady Children's Hospital of San Diego (RCHSD) towards commencing their CCS DP. Communications include review of contract documents (scope of work, reporting requirements etc.), covered services, covered pharmaceuticals, readiness review documents, capitated rates, risk corridors, and other operational matters.

Cost Utilization Data
On November 6, 2014, the Department sent RCHSD a second Data Library Confidentiality Agreement (DUA) for review and approval. The DUA will allow DHCS to release cost utilization data for three fiscal years (FY) FY 2011 to 2012 through FY 2013 to 2014 for the three original conditions (Sickle Cell, Cystic Fibrosis, Hemophilia) and two additional conditions (Acute Lymphoblastic Leukemia and Diabetes Type I and II for ages 1-10 yrs). The DUA was signed by RCHSD and returned to the Department on November 25, 2014. A fully executed DUA was returned to RCHSD on December 11, 2014.

Capitated Rates
DHCS continued work on rate development. Development of rates was been delayed due to discussions regarding conditions covered, pharmaceuticals covered, and risk corridors.

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

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

- **PHARMACEUTICALS / PMB**
  RCHSD was investigating partnerships with different Pharmaceutical Benefits Management (PBM) firms; however, this had been a challenge due to PBMs' reluctance to contract for services with a DP with an initial small population size. Until such time when a PBM is secured, the DP will initially include only Hemophilia associated pharmaceuticals such as blood factors.

- **MEMBER HANDBOOK / EVIDENCE OF COVERAGE (MH/EOC)**
  The revised Member Handbook (MH) and Evidence of Coverage (EOC) were submitted to DHCS on November 12, 2014. On, December 11, 2014, the Department returned the MH/EOC delineating corrective items needed per the SOW requirements.

- **FINANCIAL REPORTS**
  On October 2, 2014, RCHSD submitted financial reports for DHCS to review. On November 6, 2014, RCHSD submitted IBNR templates along with policies and procedures (P&Ps).

- **PROVIDER MANUAL**
  RCHSD continued development of their provider manual to satisfy a Readiness Review component.

- **SITE REVIEW TOOL**
  RCHSD continued development of their Site Review Tool to satisfy a Readiness Review component.

- **MEMBER ELIGIBILITY FILE**
  County, RCHSD Information Technology (RCHSD IT), and the Department's IT discussed the "flow and process" of member eligibility files. DHCS IT worked on providing an eligibility test file to RCHSD.

- **RCHSD READINESS REVIEW DELIVERABLES**
  On July 2, 2014, RCHSD began submitting their policies and procedures (P&Ps) to DHCS for review, as indicated in the Readiness Review document.[2] As of December 24, 2014, the Department approved 52 deliverables, 8 deliverables were not approved, and 7 deliverables were under DHCS review.

- **CONTRACT ITEMS**
  As of December 2014, contract terms being discussed include: clarification of provisions in Exhibit E such as data certification, appeals process, financial working

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

papers and in Exhibit B regarding the catastrophic coverage limitation provision.

- **NETWORK DEVELOPMENT**
  Throughout the months of October and November, discussions occurred between RCHSD and community clinics.

- **EVALUATION METRICS**
  On November 6, 2014, RCHSD submitted a proposed evaluation metrics that included objectives, baseline definitions, and measurement for all covered disease states.

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

DHCS drafted 90, 60, and 30-Day notices to patients, providers, and the GMC plans. These notices will be used to communicate the disenrollment of eligible clients from five Geographic Managed Care (GMC) plans into RCHSD CCS DP. Content within the notices consist of the following:

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

DHCS will coordinate with the enrollment broker on the member and provider notice.

RCHSD – Site Visit

On November 4, 2014, DHCS met with RCHSD and San Diego County representatives. The CCS DP implementation discussion topics with RCHSD consisted of the following: Rates (pharmacy, risk corridor, data for the conditions); County Administration Allocation fund (components of the administration rate, responsibilities that would remain with San Diego County, and duties that would transfer to RCHSD under the CCS DP); contract language (letter of credit, disclosure statements for subcontractors); authorization process for carved out services (pharmacy, mental health, etc); 90/60/30-Day notices; evaluation metrics (review metrics, time window for cohort study, patient/provider surveys); and catastrophic cases unrelated to CCS conditions. Discussion topics with San Diego County consisted of the following: update on the CCS DP, administration fee, authorization processes for carve-outs, and clarification of roles (eligibility and enrollment, potential authorizations for pharmacy); metrics/evaluation review; and mini Sickle-Cell pilot.

On December 30, 2014, the Department met with San Diego County representatives. Discussions focused on San Diego County administration allocation fund; health plan

Memorandum of Agreement (MOA); San Diego CCS Pre- and Post-Pilot Assessment/Evaluation; and CCS Tools such as Frequently Asked Questions (FAQs).

Pilot Schedule

It is anticipated RCHSD CCS DP will be operational in Spring 2015. It should be noted the projected implementation time table is contingent on a number of factors including, development and acceptance of capitated rates by RCHSD, the ability of the contractor to demonstrate readiness to begin operations, and approvals by CMS.

There is no projected starting date for the remaining three pilot models at this time.

- Los Angeles Care Health Plan (LA Care)
- Children's Hospital of Orange County (CHOC)
- Alameda County Health Care (Alameda)

Milestones

HPSM

The Department has developed a Provider Satisfaction eMail Survey (Provider Survey) this quarter for the HPSM CCS DP. It is anticipated the Provider Survey will be e-Mailed to providers next quarter. The providers feedback will help evaluate the current level of success of the HPSM DP and identify those areas that need improvement.

On October 17, 2014, DHCS conducted site visits with both HPSM and San Mateo County. This first annual site review addressed the main goals of the DP, which focused on care coordination, medical home, and family centered-care.

Complaints, Grievances, and Appeals

On December 30, 2014, HPSM submitted a "Pending and Unresolved Grievances Quarterly Report" for the third quarter, April - June 2014. The Grievances Report showed during the quarter:

- 8 grievances were received; (Coverage/Benefit 2, Medical Necessity 1, Access 0, Customer Service 4, Privacy Issues 0, Fraud/Waste/Abuse 0, Other 1)
- 4 grievances were resolved timely
- 4 grievances not resolved timely
- 7 grievances took over 30 days for resolution

The Grievances Report further disseminates the types of grievances that are tracked and follow: Coverage/Benefit, Medical Necessity, Quality of Care, Access, Customer Service, Privacy Issues, Quality of Care, Fraud/Waste/Abuse, and Other.

Consumer Issues:

On December 3, 2014, the Department presented an update on the CCS pilots to advisory board members of the CCS Redesign Stakeholder Process. A PowerPoint

presentation “Section 1115 Waiver Renewal Stakeholder Workgroup Update” gave a CCS Update. Attached below is the presentation link:
http://www.dhcs.ca.gov/Documents/Wvr_Rnwl_Sh_Wkgrp_Upd_MC_1-26.pdf

Quality Assurance/Monitoring Activities:

On December 30, 2014, HPSM submitted “Enrollment and Utilization Table” report. Please refer to the table below.

Quarter	Total Enrollees At End of Previous Period	Additions During Period	Terminations During Period	Total Enrollees at End of Period	Cumulative Enrollee Months for Period
4/1/2013 – 6/30/2013	0	1,474	116	1,358	3,951
7/1/2013 – 9/30/2013	1,358	140	130	1,368	4,093
10/1/2013 – 12/31/2013	1,368	241	119	1,490	8,382
1/1/2014 – 3/31/2014	1,490	108	129	1,469	12,786
4/1/2014 – 6/30/2014	1,469	86	115	1,440	17,166
7/1/2014 – 9/30/2014	1,440	198	99	1,539	4,492

HPSM deliverables submitted during this quarter are listed in the table below, in addition to the Department’s internal review and approval for each deliverable.

Report Name	Date Due	Received	Pending Review	DHCS Approved
Provider Network Report (Rpt #6)	10/30/2014	12/1/2014		YES
Grievance Log/Reports (Rpt #6)	10/30/2014	12/30/2014		YES
Quarterly Financial Statements (Rpt #6)	11/17/2014	11/14/2014	✓	
Report of All Denials of Services Requested by Providers (Rpt #5)	11/17/2014			

Evaluations:

During this quarter, DHCS analyzed the results from the Family Satisfaction Phone Survey (survey) that was administered to the HPSM CCS DP families. This survey will help the Department improve services provided to CCS clients and determine how the demonstration program pilot is working for CCS clients enrolled within the CCS Program. The Family Survey was used to establish a “baseline” of information to compare against in outlying years.

Enclosures/Attachments:

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

LOW INCOME HEALTH PROGRAM (LIHP)

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

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

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

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

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

As of January 1, 2014, LIHP enrollees transitioned to Medi-Cal and to health care options under Covered California.

Enrollment Information:

Nothing to report.

Outreach/Innovative Activities:

Nothing to report.

Operational/Policy Issues:

DHCS continued working to obtain CMS approval for the revised county specific cost claiming protocols submitted by Alameda and San Bernardino LIHPs under Attachment G Supplement 1, Section K, "Total Funds Expenditures of other Governmental Entity", to add other entities that could provide CPEs for claiming purposes.

The Department continued working to obtain CMS approval for the revised Attachment G, Supplement 2, "Cost Claiming Protocol for Health Care Services Provided under the LIHP – Claims Based on Capitation" for CMS approval.

DHCS continued to provide technical expertise and recommendations to the counties for evaluation and monitoring of activities to optimize federal financial participation (FFP) and maximize financial resources.

The Department continued collaboration with the University of California Los Angeles (UCLA), Center for Health Policy Research, the independent evaluator for the LIHP, to produce data reports that are used to monitor and measure the effectiveness of the local LIHPs and aid in the evaluation project. UCLA released the Increased Service Use Following Medicaid Expansion Is Mostly Temporary: Evidence from California's Low Income Health Program policy brief in October 2014.

DHCS continued to work on implementation of the primary care provider (PCP) increased payment claiming process for specified evaluation and management and vaccine administration services for which enhanced payments are required per Title 42, Part 447 of the Code of Federal Regulations (CFR). On October 8, 2014, CMS approved the exclusion of the HCCI component from the PCP increased payment claiming process for specified evaluation and management and vaccine administrative services. Additionally, on October 10, 2014, CMS provided guidance that the enhanced Federal Medical Assistance Percentage (FMAP) will only be for the difference between the Medicare rate and the payment rate applicable to such services under the State plan as of July 1, 2009. Any differential that may exist between what LIHP paid in 2013 and what Medi-Cal paid for the same service on July 1, 2009, can only be reimbursed at the standard FMAP. DHCS continued to work on the implementation of the PCP increased payment claiming process by developing a revised invoice and communicating with the local LIHPs. Additionally, the Department began working

to provide State online registry data to local LIHPs.

The Department worked with each local LIHP to determine compliance with the Maintenance of Effort (MOE) contract requirement that total non-federal expenditures in each Demonstration Year meet or exceed the annual MOE amount through December 31, 2014.

DHCS continued LIHP transition to Medi-Cal activities. Specific tasks and activities included, but were not limited to:

- DHCS monitored transition data to determine status of the LIHP transition and any remaining issues.
- DHCS provided guidance on the transition process and data to assist in the continued transition of LIHP enrollees.
- DHCS developed and provided LIHP transition reports to the local LIHPs and county social services agencies to aid in monitoring the transition of LIHP enrollees and provide data on cases that need investigation regarding eligibility status and transition issues.

The Department continued to work with the California Department of Public Health, Office of AIDS (OA), to ensure the smooth transition of eligible former Ryan White clients (who transitioned to a local LIHP prior to January 1, 2014) to Medi-Cal or Covered California eligibility. In addition, the following activities regarding the Delivery System Reform Incentive Pool (DSRIP) Category 5 HIV Transition Projects occurred during this quarter:

- Designated Public Hospitals (DPHs) submitted their annual report for DY9.
- DHCS reviewed the DPHs' semi-annual and annual reports.

DHCS was the liaison between UCLA and CMS regarding the UCLA DSRIP External Evaluation. The Department reviewed California's DSRIP Interim Evaluation Report.

DHCS continued the process to initiate the receipt of funds for reimbursement of costs that the Department has incurred related to inputting LIHP data into the Statewide Medi-Cal Eligibility Data Systems (MEDS).

Consumer Issues:

The Department continued to conduct and/or participate in the following stakeholder engagement processes during the quarter. These processes continued as needed after the LIHP transition on January 1, 2014, to ensure that LIHP enrollees successfully transitioned to Medi-Cal or Covered California eligibility:

- Bi-weekly meetings of the LIHP/OA Stakeholder Advisory Committee (SAC) to discuss issues related to the transition to health care coverage under Medi-Cal of

individuals diagnosed with HIV, who had been receiving health care services through the Ryan White programs and had transitioned to a local LIHP prior to January 1, 2014. In addition, DHCS meets with OA on a bi-weekly basis to confer on and respond to issues raised by the SAC and other stakeholders.

- Weekly DHCS and California Department of Corrections and Rehabilitation for discussion on populations determined eligible for Medi-Cal and LIHP by the Department.

DHCS continued to provide guidance to, and solicit feedback from, stakeholders and advocates on program policy concerns, and to respond to issues and questions from consumers, members of the press, other state agencies, and legislative staff through the LIHP e-mail inbox and telephone discussions. The Department updated appropriate communication processes with local LIHP and other stakeholders during program close-out activities. DHCS continued to maintain the LIHP website by updating program information for the use of stakeholders, consumers, and the general public.

Financial/Budget Neutrality:

LIHP Division Payments					
Payment Type	**FFP Payment**	**Other Payment (IGT)**	**(CPE)**	**Service Period**	**Total Funds Payment**
Health Care (Qtr.2)	-$470,077.12		-$940,154.24	DY6	-$470,077.12
	$10,524,196.84		$21,048,393.68	DY7	$10,524,196.84
	$3,784,800.67		$7,569,601.34	DY8	$3,784,800.67
	$22,519,948.89		$45,039,897.78	DY9	$22,519,948.89
	$10,524,196.84	$10,524,196.84	$0.00	DY7	$21,048,393.68
Total	**$46,883,066.12**	**$10,524,196.84**	**$57,407,262.96**		**$57,407,262.96**

Quality Assurance/Monitoring Activities:

DHCS continued the contract compliance process with LIHPs. The Department requested and reviewed LIHPs' submissions to ensure compliance with their LIHP contracts, including the annual quality improvement reports for FYs 2011/12, 2012/13, and 2013/14. DHCS communicated with LIHPs to follow up and complete contract compliance reporting as necessary.

Enclosures/Attachments:

- DY10 Q2 LIHP Evaluation Design Progress Report

COMMUNITY BASED ADULT SERVICES (CBAS)

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

In anticipation of the end of the CBAS BTR Waiver period, DHCS and California Department of Aging (CDA) conducted extensive stakeholder input regarding the continuation of CBAS. CMS approved an amendment to the CBAS BTR waiver which extended CBAS for the length of the overall BTR Waiver, with an effective date of December 1, 2014.

CBAS is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to State Plan beneficiaries that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing, Medicaid , and waiver program standards; 2) provide services in accordance with the participant's physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements identified in the CMS approved BTR waiver; and 4) demonstrate ongoing compliance with above requirements.

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

The State must assure CBAS access/capacity in every county in which ADHC services had been provided on December 1, 2011.[3] From April 1, 2012, through June 30, 2012, CBAS was only provided through Medi-Cal fee-for-service (FFS). On July 1, 2012, 12 of the 13 County Organized Health System (COHS) (See Attachment 4) began providing CBAS as a managed care benefit. The final transition of CBAS benefits to managed care counties took place beginning October 1, 2012, with Two-Plan Model (TPM) (available in 14 counties) and the Geographic Managed Care (GMC) plans

[3] CBAS access/capacity must be provided in every county except those that did not previously have ADHC centers, as identified in STC 91.l.i: Del Norte, Siskiyou, Modoc, Trinity, Lassen, Mendocino, Tehama, Plumas, Glenn, Lake, Colusa, Sutter, Yuba, Nevada, Sierra, Placer, El Dorado, Amador, Alpine, San Joaquin, Calaveras, Tuolumne, Mariposa, Mono, Madera, Inyo, Tulare, Kings, San Benito, and San Luis Obispo.

(available in two counties), along with the final COHS county (Ventura) also transitioning at that time. As of October 1, 2012, Medi-Cal FFS only provides CBAS coverage for those CBAS eligible beneficiaries who: 1) do not qualify for managed care enrollment, 2) have an approved medical exemption, or 3) reside in CBAS geographic areas where managed care is not available (four counties: Shasta, Humboldt, Butte; Imperial).

If there is insufficient CBAS center capacity to satisfy the demand in counties with ADHC centers as of December 1, 2011 (as a base date), eligible beneficiaries receive unbundled CBAS (i.e., component parts of CBAS delivered outside of centers with a similar objective of supporting beneficiaries, allowing them to remain in the community. Unbundled services include senior centers to engage beneficiaries in social/recreational activities and group programs, home health nursing and therapy visits to monitor health status and provide skilled care, and In-Home Supportive Services (IHSS) (which consists of personal care and home chore services to assist the beneficiary's Activities of Daily Living or Instrumental Activities of Daily Living) through Medi-Cal FFS or, if the beneficiary is enrolled in managed care, through the beneficiary's Medi-Cal managed care health plan.

Beneficiaries that received ADHC services between July 1, 2011 and February 29, 2012, and are determined to be ineligible for CBAS are eligible to receive Enhanced Care Management (ECM) services as defined in the BTR waiver. ECM will be provided through Medi-Cal FFS or, if the beneficiary is enrolled in Medi-Cal managed care, through the beneficiary's Medi-Cal managed care health plan.

Enrollment and Assessment Information:

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

The CBAS Enrollment data (per STC. 99) for both Managed Care Organizations (MCO) and FFS beneficiaries per county for DY10, Quarter 2 is shown at the end of this section in Table 2, *Preliminary CBAS Unduplicated Participant Data for MCO and FFS Enrollment,* at the end of this report section. Table 1 provides the county capacity available per county, which is also incorporated into Table 2.

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

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

CBAS Assessments Determined Eligible and Ineligibility:

DY 10	MCOs			FFS		
	New Assessments	**Eligible**	**Not Eligible**	**New Assessments**	**Eligible**	**Not Eligible**
Quarter 1 (7/1-9/31/ 2014)	2,299	2,251 (98%)	48 (2%)	260	256 (98.5%)	4 (1.5%)
Quarter 2 (10/1-12/31/2014)	**2,860**	**2,812 *** (98%)	**48** (2%)	**62 ***	**60** (96.8)	**2** (3.2)
5% Negative change between last Quarter	NA	NA	NA	NA	NA	NA

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

During Quarter 2, there was over 220 eligibility inquiry requests submitted DHCS, of which over 170 were referred to managed care for CBAS benefits. Approximately 12 of the FFS face-to-face assessments were completed from requests submitted in the prior Quarter (September). There were 62 individuals that remained in FFS and had face-to-face assessments during Quarter 2, as noted above.

CBAS provider-reported data (per CDA) (STC 99.b)

Below are the most recent participant statistics available from recent claims data and provider reported data:

CDA - CBAS Provider Self-Reported Data	
Counties with CBAS Centers	26
Total Calif. Counties	58
Number of CBAS Centers	245
* Non-Profit Centers	62
* For-Profit Centers	183
ADA @ 245 Centers	19,584
* ADA per Centers	80

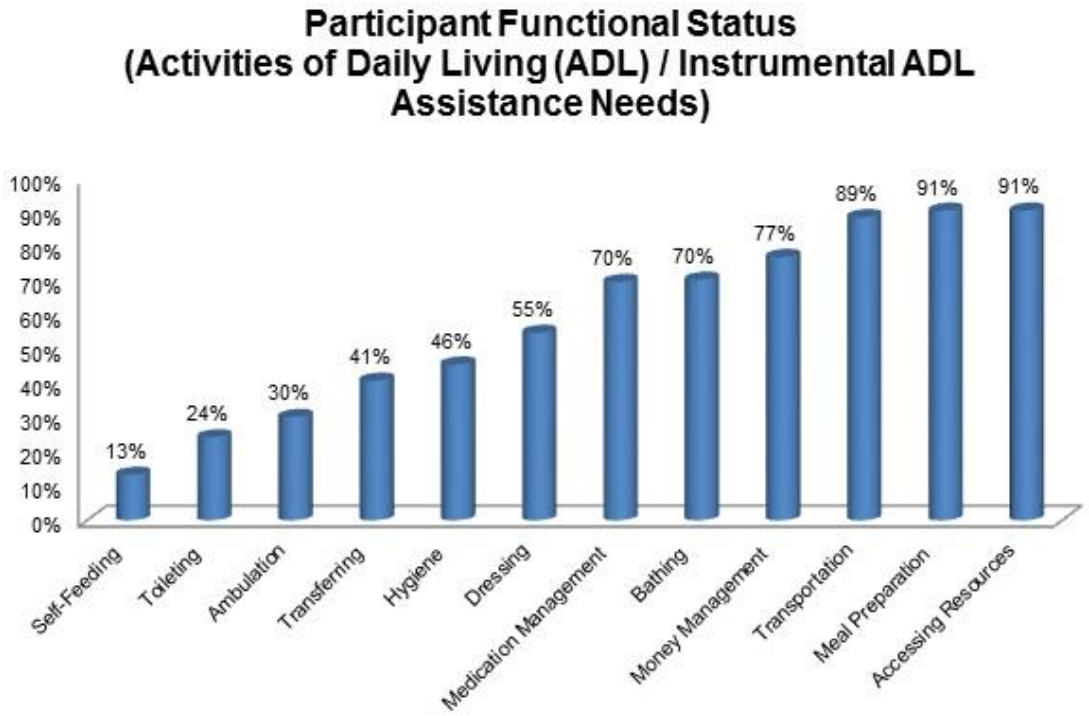
CDA – MSSR data 12/2014

Demographic Makeup	
Female	**61%**
Male	39%
Age 18-64	22%
Age 65-74	18%
Age 75-84	**38%**
Age 85+	22%

DHCS estimate percentages of Medi-Cal Paid Claims data (service period from 1/1/13 - 6/30/13, paid through 6/24/13, run date 8/3/13).

Participant Profile			
Diagnoses *	**%**	**Conditions/Needs**	**%**
Psych Diagnosis	48%	Fall Risk	81%
Dementia	30%	Special Diet	75%
Mental Retardation or DD	7%	Use Cane/Walker/Wheelchair	62%
Other	15%	Incontinent	43%
		Behavioral Symptoms	39%

CDA Participant Characteristics, FY 2013-14



Source: CDA Participant Characteristics Report (CDA CBAS 293), Fiscal Year 2013-14

Enhanced Case Management (ECM) – *Ended August 31, 2014*

Per the Waiver Amendment, ECM services sunset on August 31, 2014. Eligible participants' ECM and care coordination had been established beginning in April 2012, and the need for further interaction diminished. To notify all possible beneficiaries that ECM would be ending, a notice was sent to over 900 managed care and FFS beneficiaries. This notice allowed beneficiaries to contact DHCS' ECM nursing staff through September 22, 2014, with any questions, concerns or additional outreach or care coordination needed. Managed care participants continue to receive the care coordination services through their existing provider plan network.

The ECM Participant Quarterly Data (Table below) shows the number of FFS ECM-eligible individuals since ECM began in April 2012, through August 2014. These individuals had been served at a local ADHC Center (between July 1, 2011, to March 31, 2012) before CBAS began on April 1, 2012; and were not-eligible for CBAS as they did not meet the program requirement for medical necessity. ECM-eligible members that enrolled in managed care health plans received ECM through their plan's case management services. ECM-FFS members received ECM with DHCS nurses contacting participants regarding their care needs, coordinating services and community referrals. Many participants requested no further contact regarding ECM services as their needs had been met.

This final report on ECM depicts the ECM-FFS Participant Data since ECM began in April 2012 (Original Count) to end date of ECM on August 31, 2014:

ECM Participant Quarterly Data

Report Quarters	Average Qrtly. Enrollment	Average Qrtly. Incoming Members*	Average Qrtly. Outgoing Members**
Original Count	**1560**		
DY7 - Q 4			
April-June'12	1422	66	107
DY8 - Q1			
July-Sept'12	1546	79	45
DY8 - Q2			
Oct.-Dec.'12	1126	20	210
DY8 - Q3			
Jan.-Mar'13	918	23	48
DY8 - Q4			
April-June'13	708	17	33
DY9 - Q1			
July-Sept.'13	646	16	74
DY9 - Q2			
Oct.-Dec. '13	459	13	200
DY9 - Q3			
Jan.-Mar'14	453	19	25
DY9 - Q4			
April-June'14	414	11	50
DY10 - Q1			
July-Sept.'14	398	3	26

* *FINAL ECM -- Closing August 31, 2014*

DHCS ECM Data 08/20/2014

Outreach/Innovative Activities:

With the approval of the CBAS Amendment from CMS on November 28, 2014, DHCS and CDA held a final Webinar to summarize final outcomes for the CBAS program. This final Webinar was held on December 2, 2014, at 2:00pm, and was open to all interested stakeholders, managed care plans, and providers. The Webinar highlighted updates to the STCs and SOPs that were negotiated with CMS through the Amendment process. To view the webinar, please click here.

A new Stakeholder process will begin in February 2015 that focuses on the CBAS amendment to the Home and Community-Based Setting Statewide Transition plan.

Operational/Policy Development/Issues:

With CMS' approval of the CBAS 1115 BTR Demonstration (11-W-00193/9) Amendment on November 28, 2014, DHCS and CDA provided a Webinar for all CBAS Providers and MCOs to better understand any changes and to confirm that CBAS was continuing as a Medi-Cal Managed Care benefit. The Webinar took place on December 2, 2014, and highlighted all new requirements.

Consumer Issues:

CBAS beneficiary / Provider Call Center complaints (FFS / MCO) (STC 99.e.iv)

DHCS continues to regularly respond to issues and questions, in writing or by telephone, from CBAS participants, CBAS providers, managed care plans, members of the Press, and members of the Legislature on various aspects of the CBAS program, as requested. DHCS and CDA maintain CBAS webpages for the use of all stakeholders. Emails are directed to CBAS@dhcs.ca.gov from providers and beneficiaries for answering a variety of questions.

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

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

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

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

CBAS grievances are held through the MCOs and in Quarter 2, there were a total of 5 grievances filed and resolved.

The State Fair Hearings / Appeals continue to be held through the normal State Hearing process, with the California Department of Social Services (CDSS) Administrative Law Judges' hearing all cases filed. As of DY 10, Quarter 2, there were 2 cases filed/heard (from the approximate 29,000 participants), throughout the State. Hearings have typically been related to misunderstandings with Managed Care enrollment.

APPEALS / FAIR HEARINGS 2014	Initial Review	Rehearing Request	Total
October	0	0	0
November	3	0	3
December	1	0	1
QUARTERLY TOTAL	4	0	4

DHCS-CDSS ALJ Data Records 12/2014

Quality Assurance/Monitoring Activity:

DHCS continues to monitor CBAS Center locations, accessibility and capacity for monitoring access as required under the BTR Waiver. The table below indicates the consistency of each county's licensed capacity since the CBAS program was approved as a Waiver benefit in April 2012. The Licensed Capacity, below, shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 57% statewide. There is availability in almost all counties where CBAS is available to allow for access by Medi-Cal beneficiaries.

Table 1

County	CBAS Centers Licensed Capacity						
	DY7-Q4 Apr- Jun 2012	DY8-Q4 Apr-Jun 2013	DY9-Q4 Apr-Jun 2014	DY10-Q1 Jul-Sep 2014	DY10-Q2 Oct-Dec 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	355	355	355	**355**	0%	73%
Butte	60	60	60	60	**60**	0%	31%
Contra Costa	190	190	190	190	**190**	0%	62%
Fresno	590	547	572	572	**572**	0%	69%
Humboldt	229	229	229	229	**229**	0%	29%
Imperial	250	315	330	330	**330**	0%	66%
Kern	200	200	200	200	**200**	0%	32%
Los Angeles *	17,735	17,506	18,184	18,284	**18,284**	0%	57%
Marin	75	75	75	75	**75**	0%	22%
Merced	109	109	109	109	**109**	0%	52%
Monterey	290	-	110	110	**110**	0%	40%
Napa	100	100	100	100	**100**	0%	53%
Orange	1,897	1,747	1,910	1,960	**1960**	0%	70%
Riverside	640	640	640	640	**640**	0%	37%
Sacramento	529	529	529	529	**529**	0%	63%
San Bernardino	320	320	320	320	**320**	0%	87%
San Diego	2,132	1,992	1,873	1,873	**1,873**	0%	60%
San Francisco	803	803	866	866	**866**	0%	49%
San Mateo	120	120	135	135	**135**	0%	66%
Santa Barbara	55	55	55	55	**55**	0%	4%
Santa Clara	820	750	840	830	**830**	0%	39%
Santa Cruz	90	90	90	90	**90**	0%	70%
Shasta	85	85	85	85	**85**	0%	31%
Solano	120	120	120	120	**120**	0%	26%
Ventura	806	806	806	851	**851**	0%	65%
Yolo	224	224	224	224	**224**	0%	74%
SUM =	29,009	27,967	29,007	29,192	**29,192**	0%	57%

CDDA Licenced Capacity as of 12/31/2014

Los Angeles - 1 center closed, 2 centers opened

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

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

With participant enrollment numbers in counties with CBAS centers, there is ample licensed capacity with the current capacity levels utilizing just under 60%. The following Table 2 - *Preliminary CBAS Unduplicated Participant Data for FFS and MCO Enrollment* reflects a slightly lower count of participants than those actually serviced during this time period due to the lag in data.

Access Monitoring (STC 99.e.)

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

Unbundled Services (95.b.iii.)

For DY 10, Quarter 2, CDA, the Department that certifies and provides oversight of CBAS Centers, reported one CBAS Center closure that occurred in the Los Angeles County area (Christian ADHC) in October 2014. Participants moved to another local Center of received Unbundled Services; five participants received no additional services (able to receive necessary care with IHSS and family resources). Additionally two Centers opened in LA County in November 2014.

	DY10_Q2 UNBUNDLED SERVICES							
Services Started:	Within 1 Week	Within 2 Week	Within 3 Week	Within 1 Month	Within 2 Months	Within 3 Months	Within 5 Months	**TOTAL**
CBAS-Transfers	2	1						**3**
Unbundled Srvs.	11		6					**17**
No *New* Services	5							**5**
DHCS/CDA Complied Data 2/2015							**TOTAL**	**25**

Another Center closed on September 30 (A Day Away ADHC, also in LA County) which fell into DY10, Q1. Prior to the center closure, participants were discharged from the closed center and were able to transition to other centers within the vicinity. However, since the closure occurred on the last day of the quarter, details of that closure were not reported previously.

DHCS continues to review any possible impact on participants by CBAS Center closures. Prior to any Center closure, the CBAS Center is required to notify CDA on their planned closure date and to conduct discharge planning for all their CBAS participants. While most CBAS Centers notify CDA and carefully link participants with other local CBAS Centers or community resources, not all CBAS Centers do so. Occasionally, Centers will close, shutting their doors without any notification to participants, vendors, or CDA. Unfortunately, CDA finds out about the sudden or unexpected Center closure from CBAS participants or other CBAS Centers in the community.

There was not a negative change from quarter to quarter of more than 5%, provide probable cause as well as an analysis that addresses such variances

CBAS participants affected by a Center closure and that are unable to attend another local CBAS Center, can receive unbundled services. The majority of CBAS participants in most counties are able to choose an alternate CBAS Center within the participant's local area. The large, statewide volume of In-Home Supportive Service (IHSS) providers is a key characteristic of California's home and community-based services that help substitute institutional care for seniors and persons with disabilities. Participants can engage/employ their IHSS providers of choice and can self-direct their own care in their home and community setting.

CBAS Center Utilization (newly opened / closed Centers)

For DY 10, Quarter 2, CDA had 245 CBAS Center providers open and operating in California. There was one closure that occurred in the Los Angeles County area (A Day Away ADHC in La Mirada) on September 30, 2014, for the DY10, Q1 period. Participants were discharged from the closed center and were able to transition to other centers within the vicinity. Another closure occurred in Los Angeles in October, along with two Centers opening in November. Preliminary data on Center Utilization which includes this Quarter is as follows:

CBAS Center History

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

CDA Data as of 12/31/2014

There was not a negative change of more than 5% from the prior quarter, so no analysis is needed to addresses such variances.

Review County Enrollment for CBAS vs. Capacity per County

TABLE 2:

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

	DY9 Q3 Jan - Mar 2014			DY9 Q4 Apr - June 2014			DY10 Q1 Jul - Sept 2014			DY10 Q2 Oct - Dec 2014		
County	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used
Alameda	8	465	79%	8	464	79%	8	431	73%	5	490	82%
Butte	39	0	38%	35	0	34%	32	0	31%	1	42	42%
Contra Costa	10	119	40%	9	194	63%	6	194	62%	4	201	64%
Fresno	7	659	69%	9	590	62%	5	661	69%	11	625	66%
Humbolt	110	0	28%	109	0	28%	113	0	29%	0	105	27%
Imperial	380	0	68%	369	0	66%	367	0	66%	10	351	65%
Kern		89	26%	0	119	35%	0	110	32%	0	92	27%
Los Angeles*	1,020	15,177	54%	1,000	14,898	52%	941	16,707	57%	744	17,270	58%
Merced	0	101	55%	0	105	57%	0	96	52%	0	89	48%
Monterey	0	66	35%	0	77	41%	0	75	40%	0	83	45%
Orange	5	2,515	81%	8	2,217	69%	6	2,313	70%	1	2,248	68%
Riverside	18	389	38%	14	388	37%	13	383	37%	14	377	36%
Sacramento	30	549	65%	20	532	62%	20	544	63%	31	561	66%
San Bernardino	14	411	78%	14	418	80%	16	456	87%	16	498	95%
San Diego*	36	1,403	42%	33	1,448	47%	29	1,873	60%	32	1,530	49%
San Francisco	53	659	49%	55	688	51%	61	664	49%	63	686	51%
San Mateo	0	136	67%	0	147	64%	0	151	66%	0	148	65%
Santa Barbara	0	3	3%	0	9	10%	0	4	4%	0	2	2%
Santa Clara	0	559	43%	0	588	41%	1	544	39%	5	576	41%
Santa Cruz	0	100	66%	0	101	66%	0	107	70%	0	112	73%
Shasta	40	0	28%	40	0	28%	44	0	31%	1	42	30%
Ventura	10	911	67%	7	893	66%	1	940	65%	9	907	64%
Yolo	2	220	59%	1	215	57%	1	280	74%	1	274	72%
Marin, Napa, Solano**	0	224	45%	0	235	47%	0	177	35%	51	94	29%
Total	**1,782**	**24,791**	**54%**	**1,731**	**24,326**	**53%**	**1,664**	**26,727**	**57%**	**999**	**27,403**	**57%**
Combined Totals	**26,573**			**26,057**			**28,391**			**28,402**		

*Care1st has revised their methodology resulting in higher, more accurate particiant counts

DHCS / CDA Enrollment Data 2/2015

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

Financial/Budget Neutrality Development/Issues:

Nothing to report.

FINANCIAL/BUDGET NEUTRALITY: SNCP/DSRIP/DSHP

Payment	FFP Payment	Other (IGT)	(CPE)	Service Period	Total Funds Payment
Designated Public Hospitals					
SNCP					
(Qtr 1)	$ 0		$ 0		$ 0
Total:	**$ 0**		**$ 0**		**$ 0**
(Qtr 2)	$ 44,250,000		$ 44,250,000	DY 10 (Jul-Sept)	$ 44,250,000
Total:	**$ 44,250,000**		**$ 44,250,000**		**$ 88,500,000**
DSRIP					
(Qtr 1)	$ 0	$ 0			$ 0
(Qtr 2)	$328,893,774	$328,893,774			$ 657,787,548
Total:	**$ 328,893,774**	**$ 328,893,774**			**$ 657,787,548**
Designated State Health Program (DSHP)					
Payment	**FFP Claim**		**(CPE)**	**Service Period**	**Total Claim**
State of California					
(Qtr1)	$ 381,935		$ (477,266)	DY 6 (Oct-Jun)	$ (95,331)
(Qtr1)	$ 15,520,725		$ 15,440,725	DY 9 (Jul-Jun)	$ 30,961,450
(Qtr1)	$ 48,721,450		$ 48,775,451	DY 10 (Jul-Sept)	$ 97,496,901
(Qtr 2)	$ (8,369,990)		$ (6,020,068)	DY 6 (Sept-Oct)	$ (14,390,058)
(Qtr 2)	$79,804,676		$79,804,676	DY 10 (Jul-Dec)	$ 159,609,352
Total:	**$ 136,058,796**		**$ 137,523,518**		**$ 273,582,314**

I. DESIGNATED STATE HEALTH PROGRAM (DSHP) UPDATE

Program costs for each of the Designated State Health Programs (DSHP) are expenditures made through the Safety Net Care Pool (SNCP) for uncompensated care provided to uninsured individuals with no source of third party coverage. Under the waiver, the State receives federal reimbursement for programs that would otherwise be funded solely with state funds. Expenditures are claimed in accordance with CMS-approved claiming protocols. In September 2014, DHCS submitted a proposed claiming methodology for the inclusion of certain workforce programs as permitted under the STCs, that proposal is still in discussions with CMS.

This quarter, Designated State Health Programs claimed **$ 71,434,686** in federal fund payments for SNCP eligible services.

II. SAFETY NET CARE POOL UNCOMPENSATED CARE UPDATE

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

This quarter, designated public hospitals received **$ 44,250,000** in federal fund payments for SNCP eligible services.