TITLE:

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

Section 1115 Annual Report

Reporting Period:
Demonstration Year: Nine (07/01/13-06/30/14)

INTRODUCTION:

The Department of Health Care Services (DHCS) submits this Annual Report for Demonstration Year (DY) 9 to the Centers for Medicare & Medicaid Services (CMS) in accordance with Item 25 of the Special Terms and Conditions (STCs) in California's section 1115 Bridge to Reform Demonstration (11-W-00193/9). The report addresses the following areas of operations for the various Demonstration programs during the Demonstration Year:

- Accomplishments
- Project Status
- Quantitative findings
- Qualitative and case study findings
- Utilization data
- Policy and administrative issues

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 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. Department of Health Care Services 2

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 and 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 these progress reports.

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

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

- Increase authorized funding for the Safety Net Care Uncompensated Care Pool in DY 7 by the amount of authorized but unspent funding for HCCI and the Designated State Health Programs in DY 6.
- Reallocate authorized funding for the HCCI to the Safety Net Care Uncompensated Pool for DY 7.

TIME PERIODS:

Demonstration Year

The periods for each Demonstration Year will consist of 12 months, with the exception of DY 6, which will be 8 months, and DY 10, which will be 16 months. The periods are:

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

Annual Report

This report covers the period from July 1, 2013 through June 30, 2014.

I. General Reporting Requirements

- **Item 7 of the Special Terms and Conditions- Amendment Process**

1. *Rural Managed Care Expansion Amendment:*

   On August 29, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow the Department of Health Care Services (DHCS) to expand Medi-Cal managed care to beneficiaries currently receiving Medi-Cal services on a Fee-For-Service (FFS) basis in the following 28 rural California counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba.

2. *Medi-Cal Expansion to Newly Eligible Individuals / Integration of Medi-Cal Outpatient Mental Health Services into Medi-Cal managed care:*

   On December 24, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the 1115 Demonstration Waiver to allow DHCS to:

   a. Extend Medicaid services to the childless adult population described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, many of who are already enrolled in the Low-Income Health Program.

   b. Provide a seamless transition for Low-Income Heath Plan (LIHP)

beneficiaries into Medi-Cal managed care.

c. Enroll newly eligible populations who qualify for Medi-Cal based on expanded income eligibility criteria.

d. Require Medi-Cal managed care health plans to cover outpatient mental health services provided by licensed health care professionals acting within the scope of their license.

3. *Coordinated Care Initiative (CCI) Amendment:*

On March 19, 2014, CMS approved an amendment to the 1115 Demonstration Waiver that enables DHCS to implement the State of California's CCI to mandate managed care enrollment for dual eligibles in eight select counties. In addition, this amendment allows DHCS to integrate Medicare and Medicaid benefits for individuals eligible for Medicare and Medicaid (Duals), and integrate Managed Long Term Services and Supports (MLTSS) as managed care benefits.

The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than April 1, 2014.

After receiving feedback from the CCI counties, enrollment was divided into two separate categories; one for enrollment of Duals and one for MLTSS. Implementation dates vary by county and are summarized below.

	County	Cal MediConnect (CMC)	MLTSS
ii.	Alameda	7/1/2015	7/1/2015
iii.	Los Angeles	7/1/2014	4/1/2014
iv.	Orange	7/1/2015	7/1/2015
v.	Riverside	5/1/2014	4/1/2014
vi.	San Bernardino	5/1/2014	4/1/2014
vii.	San Diego	5/1/2014	4/1/2014
viii.	San Mateo	4/1/2014	4/1/2014
ix.	Santa Clara	1/1/2015	7/1/2014

4. *Community-Based Adult Services (CBAS)*

On June 13, 2014, DHCS submitted an amendment to the 1115 Demonstration Waiver to CMS to allow for a seamless transition of CBAS to continue beyond the initial Demonstration Waiver implementation and transitional phase from Adult Day Health Care that was effective on April 1, 2014. In addition, this amendment allows for ongoing services beginning September 1, 2014.

5. *Supplemental Payments to IHS and 638 Facilities:*

   On December 24, 2013, the Centers for Medicare and Medicaid Services (CMS) approved an amendment to the Demonstration to extend payments to the end of calendar year 2014 for tribal providers for eliminated optional benefits provided to Medi-Cal beneficiaries.

6. *Non Designated Public Hospital (NDPH) Safety Net Care Pool (SNCP) Uncompensated Care Pool Amendment:*

   On August 12, 2014 DHCS sent a letter to CMS withdrawing the request to add NDPHs to the SNCP. DHCS intends to propose the NDPHs be included in the subsequent 1115 waiver.

- **Item 14 of the Special Terms and Conditions- Public Notice, Tribal Consultation and Consultation with Interested Parties**

1. Rural Managed Care Expansion Amendment –

   Public Notice:

   - Stakeholder meetings. Meeting agendas and summaries are available on DHCS's Medi-Cal Managed Care Rural Expansion website at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDRuralExpansion.aspx

   - Webinars.

     - Stakeholders were invited to participate in person or over the internet. Webinars were recorded and posted on DHCS's website (see link above).

     - Post rural managed care implementation and additional stakeholder activity can be found at the following link: http://www.dhcs.ca.gov/services/Pages/PostImpManagedCareExp.aspx.

   Tribal Notice:

   - On February 22, 2013, DHCS issued a tribal notice regarding this amendment and the Medi-Cal managed care rural county expansion.

- On March 7, 2013, DHCS conducted a presentation on this amendment and the Medi-Cal managed care rural county expansion at the annual Tribal and Designees Advisory meeting/training.

2. CCI Amendment -

Public Notice:

- Public budget hearings held in 2012 and 2013, as well as inclusion in the state budget in these years.

- Numerous stakeholder meetings regarding the policy development of CCI with beneficiaries, advocates, health plans, providers and their representatives, and county representatives. Stakeholder meeting events, agendas and summaries are maintained on the DHCS's website at: http://www.dhcs.ca.gov/Pages/DualsDemonstration.aspx.

- The development of a stakeholder distribution list. DHCS developed and continues to maintain a stakeholder list that includes beneficiaries, advocates, health plan representatives and other interested parties. This list currently has over 3,500 participants and is ongoing.

Tribal Notice:

- On April 13, 2012, DHCS issued a Tribal Notice regarding the first major component of the CCI.

- On August 24, 2012, DHCS issued a second notice discussing the second and third components of CCI, which are the mandatory enrollment of Duals into Medi-Cal managed care, and the inclusion of MLTSS as a Medi-Cal managed care benefit.

- On February 22, 2013, DHCS issued a third notice with updates on the status the CCI resulting from the development of the Memorandum of Understanding (MOU) with CMS.

3. Medi-Cal Expansion to Newly Eligible Individuals / Integration of Medi-Cal Outpatient Mental Health Services into Medi-Cal managed care –

Public Notice:

- Various stakeholder meetings, including but not limited to Stakeholder Advisory Committee meetings, through in-person meetings, webinars, and teleconferences.

- Legislative and budget hearings.
- Published Governor's Budget.

Tribal Notice:

- On August 21, 2013 DHCS issued a tribal notice regarding the State's intention to request a Demonstration Waiver amendment for the inclusion of newly eligible individuals into Medi-Cal managed care and the carve-in of outpatient mental health services into the managed care delivery system.
- On August 30, 2013, DHCS presented on this Demonstration Waiver amendment proposal at the "Medi-Cal Tribal and Designee Quarterly Webinar Regarding Proposed Changes to the Medi-Cal Program."

4. CBAS -

Public Notice:

a. Stakeholder Meetings beginning in October 2013, including Stakeholder Workgroup meetings, through April 2014. Meetings conducted were in-person meetings, webinars, and teleconferences. All information and PowerPoints have been posted on the California Department of Aging (CDA) website, available at:
   http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/Stakeholder_Process/

b. A two-week Public Comment period was available for comments on the draft STCs and SOPs from April 24 through May 8, 2014. A summary of comments is also posted on the CDA website at the above link.

c. June 10, 2014, a webinar review of updates made from Public Comment period was presented, with a public posting of all submitted Amendment draft documents available after being submitted to CMS.

Tribal Notice:

d. DHCS's Primary, Rural, and Indian Health Division submitted a request to CMS and received approval on March 27, 2014, for no Tribal Notice.

5. Supplemental Payments to IHS and 638 Facilities –

Tribal Notice

- On October 4, 2013, DHCS issued a tribal notice regarding this amendment and the Medi-Cal managed care rural county expansion.
- On October 22, 2013, DHCS held a conference call regarding this amendment where interested parties could call in and ask questions.

6. Non Designated Public Hospital (NDPH) Safety Net Care Pool (SNCP) Uncompensated Care Pool Amendment –

Nothing to report.

- **Item 21 of the Special Terms and Conditions- Contractor Reviews**

Medi-Cal Managed Care/Rural Managed Care Expansion –

Pursuant to Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), the health omnibus budget trailer bill, DHCS expanded Medi-Cal managed care to Medi-Cal beneficiaries residing in the following 28 rural FFS counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba. This statewide expansion was part of Governor Brown's 2012-2013 Budget. The following contracts were entered into for the purposes of this expansion.

On September 1, 2013, DHCS entered into a contract with Partnership Health Plan of California (PHC) to provide services to Medi-Cal beneficiaries in the eight rural counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

On November 1, 2013, DHCS entered into contracts with Anthem Blue Cross and California Health and Wellness Plan to provide services to Medi-Cal beneficiaries in the 18 rural counties of: Alpine, Amador, Butte, Calaveras, Colusa, El dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. In addition, DHCS contracted with Kaiser Foundation Health Plan in the following rural counties to ensure continuity of care for beneficiaries: Amador, El Dorado, and Placer.

On November 1, 2013, DHCS entered into contracts with California Health and Wellness Plan and Molina Health Care of California to provide services to Medi-Cal beneficiaries in the rural county of Imperial.

On November 1, 2013, DHCS entered into a contract with Anthem Blue Cross to provide services to Medi-Cal beneficiaries in the rural county of San Benito.

California Children's Services (CCS)

In the course of DY 9, SCD completed a financial review on HPSM's DP quarterly reports; specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with 85%< being the target. Please refer to Attachment #1, Department of Health Care Services – Systems of Care Division, Health Plan of San Mateo: Plan Analysis.

During the end of DY 9, SCD began development of a Family Satisfaction Phone Survey and a Provider Satisfaction email Survey to satisfy one of several components of the operational review for the Health Plan San Mateo (HPSM) California Children's Services (CCS) Demonstration Pilot (DP). The surveys will be administered in DY 10. This Survey will help the Department improve the services provided to CCS clients and to determine how the program is functioning for CCS clients enrolled within the CCS Program.

- **Item 23 of the Special Terms and Conditions- Demonstration Quarterly Reports**

  The quarterly Progress reports provide updates on demonstration programs' implementation activities, enrollment, program evaluation activities, stakeholder outreach, as well as consumer operating issues. Four reports for DY 9 were submitted to CMS electronically on the following dates:

  - Quarter 1 (7/1/13-9/30/13) – Submitted November 27, 2013
  - Quarter 2 (10/1/13-12/31/13) – Submitted February 28, 2014
  - Quarter 3 (1/1/14-3/31/14) – Submitted May 30, 2013
  - Quarter 4 (4/1/14-6/30/14) – Submitted August 29, 2014

- **Item 24 of the Special Terms and Conditions- SPD Specific Progress Reports**

  DHCS submits SPD specific progress reports in the quarterly waiver reports.

- **Item 26 of the Special Terms and Conditions- Transition Plan and Implementation Milestones**

Delivery System Reform Incentive Pool (DSRIP) Evaluation Plan –

On September 30, 2014 UCLA submitted to the state their interim evaluation findings. This report was reviewed by the state and submitted to CMS on October 1, 2014 as required by the STCs. UCLA is currently on track for providing their final evaluation findings 120 days after the end of the demonstration which is at the end of February. The state has remained in contact with UCLA throughout their evaluation process to ensure they had the technical assistance needed to execute their research properly. We will continue to provide this support and partnership throughout the duration of their analysis.

Behavioral Health Services Plan Implementation -

On July 21st, DHCS launched its statewide stakeholder initiative, the Behavioral Health Forum, thereby initiating the first in a series of quarterly meetings during which DHCS staff provides updates to stakeholders regarding key policy and program issues impacting public mental health and substance use disorder services (MHSUDS). The Forum is an opportunity for stakeholders to learn about the status of more than 100 program and policy issues identified in the DHCS Business Plan, as well as from other sources (e.g., the California Mental Health and Substance Use System Needs Assessment and Service Plan), which have been organized into a grid format and assigned to four Forum committees (Strengthen Specialty Mental Health and Drug Medi-Cal County Programs and Delivery Systems; Coordinated and Integrated Systems of Care for MHSUDS and Medical Care; Coordinated and Useful Data Collection, Utilization, and Evaluation of Outcomes, and Cost Effective and Simplified Fiscal Models). The Forum provides an opportunity to report back to stakeholders across the state and to solicit additional input from interested parties. Meeting information and materials, including a grid summarizing issues identified thus far, may be downloaded from the DHCS website. Anyone who is interested in participating in one or all of the Forum's committees, and/or the consumer and family member "open to all" forum, may contact DHCS at MHSUDStakeholderInput@dhcs.ca.gov.

- **Item 28 & 29 of the Special Terms and Conditions- Evaluation design and implementation**

  Low Income Health Program (LIHP) –

  DHCS received approval from CMS on August 11, 2014 for the LIHP evaluation plan.

  During the third year, UCLA continued to successfully conduct the planned evaluation activities. Evaluation areas include assessment of program implementation, enrollment and retention, coverage expansion, access to and quality of care, and the administrative transition of enrollees into Medi-Cal or Covered California in 2014. The evaluation focuses on rapid reporting via multiple evaluation publications and products, including monthly and quarterly reports to DHCS, quarterly performance dashboards for use by LIHPs, and regular publications on key aspects of the evaluation.

  SPD-

  DHCS is currently finalizing an evaluation proposal to be submitted to CMS pertaining to the SPD Demonstration Waiver program. The time period for the evaluation will be 12 months with the start date of June 1, 2012. DHCS identified policy questions in five areas: eligibility and enrollment processes, coverage, access to care, quality of care and value based care (costs associated with the services provided to SPDs in managed care as compared to FFS costs).

  A minimum of three sources of data will be used for the evaluation: (1) Management Information Systems/Decision Support Section (MIS/DSS) claims data; (2) encounter data; and (3) a comprehensive survey study, conducted by UC Berkeley and funded by the California Health Care Foundation (CHCF), focusing on satisfaction and enrollee experience. DHCS is currently finalizing the methodology to be used to evaluate each of the five focus areas mentioned above.

  During Calendar Years 2013 and 2014, SPD beneficiaries were/will be transferred from FFS to Medi-Cal managed care in 27 rural counties (SPD beneficiaries' enrollment into managed care plans will remain voluntary in San Benito since only one managed health plan is operating there). DHCS proposes to conduct a similar evaluation as described above for the SPD Demonstration Waiver population in those rural counties.

  CCS -

  In DY 9, UCLA facilitated an introductory meeting at HPSM on July 12, 2013. UCLA's site visit included meeting with various HPSM departments (IT, legal, etc.). Since August 2013 the interagency agreement (IA) has not progressed further since only two of the original five proposed plans will most likely be implemented.

DSRIP –

The DSRIP evaluation plan will assess whether the projects implemented during DSRIP met the requirements of the program and the intended milestones. In addition, the evaluation plan will examine whether the projects resulted in an impact beyond the program requirements, including improved experiences of care (better care), population's health (better health), and fiscal impact (lower costs/cost avoidance) for the program overall (Exhibit 1). These program outcomes are expected to be achieved through implementation of changes in infrastructure, system redesign, and delivery of care to patients with complex conditions, those in the inpatient care setting, and those with HIV/AIDS.

DSRIP categories are interconnected in order to lead to the overall goal of the DSRIP in helping Designated Public Hospitals (DPH) to become more integrated, coordinated systems of care. Attachment Q of the Waiver's Special Terms and Conditions explain this connection[1]:

- "While they are highly related projects, each improvement project is distinct;
- All of the proposed improvement projects are oriented to create more integrated, coordinated delivery systems; and
- Being an integrated delivery system allows DPHs to more fully enact improved patient experience, population health and cost control."

Accordingly, the evaluation plan proposed that infrastructure development will increase the likelihood of achieving integrated, coordinated delivery systems by providing the resources for redesign of care delivery and delivery of services in the inpatient setting and to complex or HIV/AIDS populations. Similarly, system redesign will increase the likelihood of improved care delivery in the inpatient setting and to complex or HIV/AIDS populations. Improved care delivery in turn will increase the likelihood of achieving better outcomes. The conceptual framework highlights the anticipated relationships of DSRIP interventions and is used to guide the analyses in this proposal. However, the types of projects implemented by participating DPHs are diverse and a direct link between the interventions and the Triple Aim cannot be established in all cases.

- **Item 30 of the Special Terms and Conditions- Revision of the State Quality Strategy**

On behalf of DHCS, the Office of the Medical Director is overseeing the annual revision to the DHCS Strategy for Quality Improvement in Health Care (the Quality Strategy). All Divisions and Offices have been asked to update their

[1] Special Terms and Conditions for California's 1115 Medicaid Waiver, "Bridge to Reform," Attachment Q, page 134, http://www.dhcs.ca.gov/provgovpart/Documents/California%20STCs.pdf

respective quality improvement projects. In addition, new initiatives are being outlined. The Quality Strategy serves as a blueprint, outlining specific programs and policies the Department is undertaking to improve clinical quality and to advance population health among the members, patients, and families we serve. The 2014 Quality Strategy will be released by December. It will be the third version of the blueprint to be distributed by the Department.

- **Item 32 of the Special Terms and Conditions- Cooperation with Federal Evaluators**

Nothing to report.

- **Item 39(b)(ii) of the Special Terms and Conditions – SNCP DSHP**

There are no new DSHP amendments or STC revisions to report under this item. An update to the DSHP program is provided in the "Program Updates" section below.

In DY 9 DHCS worked with the Department of Finance, the Universities of California, California State Universities, and California Community Colleges to finalize a claiming methodology for Workforce Development Programs (WDP). On September 16, 2014, DHCS sent a plan to CMS outlining a proposed claiming methodology for WDPs. This proposal is pending CMS review.

- **Item 40 of the Special Terms and Conditions- General Finding and Reimbursement Protocol for SNCP Expenditures**

Safety Net Care Uncompensated Care Pool

On May 21, 2014, CMS approved revisions to Attachment F-Supplement 4 "Determination of Allowable Costs to Uninsured Individuals for Mental Health Services," and Attachment F –Supplement 6 "Determination of Allowable Costs for Contracted Services to the Uninsured."

Supplemental Payments to IHS and 638 Facilities

An update to the IHS/638 supplemental payments program is provided in response to STC 7 above. On December 24, 2013, CMS approved an amendment to extend supplemental payments to IHS/638 facilities through December 31, 2014.

Designated State Health Programs (DSHP)

An update to the DSHP program is provided in the "Program Updates" section below.

Workforce Development in Low Income/Underserved Communities

An update to the WDP is provided in response to STC 39 above. On September 16, 2014, DHCS sent a plan to CMS outlining a proposed claiming methodology for WDPs.

- **Item 47 of the Special Terms and Conditions- LIHP Cost Claiming Protocols**

DHCS submitted a revised county specific cost claiming protocol for Alameda on November 18, 2013 and San Bernardino on April 23, 2014, to add other governmental entities, under Attachment G, Supplement 1, Section K. Alameda's revised protocol would allow Alameda County Medical Center, a designated public hospital, to report Certified Public Expenditures (CPE) to Alameda LIHP for the period of November 1, 2010 – June 30, 2011. San Bernardino's revised protocol would add three district hospitals.

DHCS has developed an annual reconciliation process per Attachment G, Supplement 1 of the Special Terms and Conditions – LIHP Cost Claiming Protocol and has begun the implementation of that process.

DHCS initially submitted the LIHP Attachment G, Supplement 2, "Cost Claiming Protocol for Health Care Services Provided under the LIHP-Claims Based on Capitation" to CMS on April 25, 2012. In response to CMS comments, the revised Attachment G, Supplement 2 was submitted to CMS on July 1, 2014 for review and approval.

- **Item 48 of the Special Terms and Conditions- LIHP Maintenance of Efforts (MOE)**

DHCS is working with each local LIHP to determine compliance with the MOE requirements for LIHP that total non-Federal expenditures in each Demonstration Year meets or exceeds the annual MOE amount through December 31, 2014.

- **Item 49 of the Special Terms and Conditions- Prior Approval of Claiming Mechanisms**

"The Low Income Health Program (LIHP) Attachment J Administrative Cost Claiming Protocol" and "Low Income Health Program Administrative Costs Claiming Protocol Implementation Plan" (Implementation Plan) received CMS approval December 12, 2013. Shortly after receiving the final approval, all local LIHPs completed time studies that are being used to calculate reimbursement amounts based on the Implementation

Plan. DHCS has begun processing claims and continues to do so as contractors submit them to LIHP. DHCS anticipates LIHP Administrative Activities (AA) claims will continue to be submitted, and processed through FY 2014/2015.

- **Item 51 of the Special Terms and Conditions- HCCI Allocations**

  Nothing to Report.

- **Item 55 of the Special Terms and Conditions- Encounter Data Validation Study for New Health Plans**

  Medi-Cal Managed Care Division (*MMCD)* –

  During DY 9, MMCD worked collaboratively with its External Quality Review Organization (EQRO) to conduct an encounter data validation study of its contracted Managed Care Organizations (MCOs). Year two of this study included a comparison of the encounter data stored in the State's data warehouse with the associated medical records procured from MCO provider networks. This comparison was used to assess the completeness and accuracy of DHCS's managed care encounter data. The results of this study will be published in MCO-specific reports and a statewide aggregate report in DY 11.

  In addition, DHCS continued the Encounter Data Improvement Project (EDIP) to improve the timeliness, reasonableness, accuracy and completeness of encounter data. The Encounter Data Quality Unit within MMCD continued to develop the Encounter Data Quality Monitoring and Reporting Plan (EDQMRP). The EDQMRP is DHCS's plan for measuring encounter data, tracking encounter data from submission to storage in DHCS's data warehouse, and reporting on data quality internally and externally.

  CCS –

  Nothing to Report.

- **Item 55 of the Special Terms and Conditions – Encounter Data Validation Study for New Health Plans**

  MMCD-

  During DY 8, DHCS submitted encounter data to the Medicaid Statistical Information System (MSIS) in accordance with Federal law, policy and regulation. DHCS shares MCO-specific eligibility data with its contracted plans to ensure that encounters are properly linked with Medi-Cal beneficiary identifiers when submitted to DHCS.

- **Item 60 of the Special Terms and Conditions- Network Adequacy (CCS, SPD, 1915 (b) Waiver Populations**

  SPD/1915(b) Waiver Populations/Managed Care Expansion Population/New Adult Group –

  MMCD requires health plans to submit quarterly reports that include network adequacy data and notice of significant changes. Data summaries are included with 1115 Demonstration Waiver Quarterly Reports to CMS. MMCD contract managers actively work with the health plans to resolve any concerns identified. No significant changes to report for DY9.

  CCS –

  During Demonstration Year (DY) 8, the Health Plan San Mateo (HPSM) contract was executed and became operational on April 1, 2013. The Department of Health Care Services (DHCS) sent a letter to the Federal Centers for Medicare and Medicaid Services (CMS) on March 22, 2013 addressing HSPM's network adequacy, along with San Mateo County network certification executive summary. At that time, DHCS had conducted a comprehensive review of the health plans' network adequacy and had concluded that HPSM met the network adequacy Special Terms and Conditions (STCs) requirements as stipulated by CMS.

  No network adequacy has been conducted for RCHSD this DY, the Department is currently in the process of contract and rate negotiations.

II. Waiver Demonstration Program Updates

LOW INCOME HEALTH PROGRAM (LIHP)

Low Income Health Program (LIHP) is a county based elective program that consists of two components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). The MCE is not subject to a cap on federal funding, and provides a broader range of medical assistance than the HCCI. Ten legacy HCCI counties implemented their LIHP program July 1, 2011. Since July 2011, additional LIHPs implemented programs for a total representation of 53 of 58 California Counties. The program will sunset December 2013, when it will provide a bridge to the Affordable Health Care Act that will begin implementation January 1, 2014.

ACCOMPLISHMENTS

The county specific cost claiming protocol for Monterey County was approved by Centers for Medicare & Medicaid Services (CMS), July 9, 2013. County specific cost claiming protocols for all 19 LIHPs have now been approved.

CMS approved Tulare County's amendment A-01 to increase add-on health care services for their LIHP on July 24, 2013.

DHCS held the LIHP Conference, "At the Forefront: LIHP Transition Prepares California for Health Care Reform" on August 14-15, 2013, at the Sacramento Convention Center. There were over 150 attendees from numerous State agencies and stakeholder groups, including: Department of Managed Health Care, Legislative Analyst's Office, Covered California, local LIHP representatives, county social services department representatives, advocates, healthcare consultants, health plan representatives, CMS and other interested stakeholders.

In preparation for the LIHP transition to Medi-Cal and Covered California eligibility on January 1, 2014, DHCS offered a series of educational webinars during the year for physicians and other providers. The webinars offered were:

- General Provider Training for the LIHP Transition – November 14, 2013
- Navigating the LIHP Transition in a County Operated Health System (COHS) – November 20, 2013
- LIHP Patients, Providers, and Managed Care Assignment – November 21, 2013
- Mental Health & Substance Use Disorder Treatment Needs During the LIHP Transition – November 26, 2013
- Complex & Chronic Conditions: Managing the LIHP Transition – December 3, 2013

LIHP provided health care coverage to approximately 1,084,000 unique individuals throughout the July 1, 2011 through December 31, 2013, duration of the

program. Starting January 1, 2014, DHCS successfully transitioned over 717,000 former LIHP enrollees to Medi-Cal under the Affordable Care Act.

On March 26, 2014, DHCS held a LIHP Administrative Activities webinar for local LIHPs which provided them with instructions on how to claim their LIHP administrative costs, including their back casting period administrative claims.
With the May 21, 2014, technical corrections to the Special Terms and Conditions (STCs), DHCS received CMS approval of an edit to Attachment G, Supplement 1 to make necessary revisions regarding the cost claiming process for mental health services, including services provided in a subcontract, provided by non-designated public hospital (DPH)-based LIHPs which are other than mental health services provided at a hospital operated by a non DPH-based LIHP. This specific edit is required pursuant to Attachment G, Supplement 1, Section F, of the STCs.

With the May 21, 2014 technical corrections to the STCs, DHCS received CMS approval to correct the close-out period date reference from 2013 to 2014 in the Attachment J administrative costs claiming protocol.

On May 27, 2014, University of California – Los Angeles (UCLA) Center for Health Policy Research organized the 2014 "Looking Back at the Bridge to Reform: Innovative Strategies from the Low Income Health Program" convening in Sacramento, which included a retrospective look at the program's history, data, and achievements. In addition to DHCS, this convening was attended by local LIHPs and other stakeholders.

All 19 local LIHPs have executed contracts with the California Correctional Health Care Services (CCHCS), which provide the eligibility and claiming process for state populations determined eligible for LIHP by DHCS. DHCS continues to provide technical assistance to the local LIHPs regarding this process.

DHCS worked with California Department of Social Services (CDSS) on the completion of the IA for the LIHP State Fair Hearings and Appeals. The IA was executed on June 27, 2014.

A revised LIHP Inmate Program Policy Letter (PPL) was released October 25, 2013. The PPL reflected overall changes and developments in the inmate program and language to align the services with those described in Attachment G, Supplement 1, of the Bridge to Reform Demonstration waiver.

DHCS 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 the year:

- DHCS reviewed the aggregate annual report.

- California Health Care Safety Net Institute submitted their aggregate annual report for DY8.
- DHCS worked to clarify the Category 5 HIV carry-forward process for milestones not fully achieved by DPHs in a particular demonstration year
- Plan modifications for the purpose of adding each DPH's identified Category 5b performance targets to the DPHs Category 5 plan for Alameda, Contra Costa, Kern, Los Angeles, Riverside, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties were approved by CMS.

PROJECT STATUS

Effective January 1, 2014, local LIHPs no longer provided health care services to LIHP enrollees, but have been focusing on LIHP administrative close-out activities.

DHCS worked with local LIHPs on the increase in FPL for Placer County from 100% to 133% effective July 24, 2013, and Monterey and San Joaquin counties from 100% and 80% respectively, to 133% effective August 1, 2013.

The Department approved requests for enrollment caps for Santa Cruz County, effective July 1, 2013, and Tulare County, effective September 23, 2013.

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

The Department is awaiting CMS' decision on the request submitted December 27, 2013, regarding the exclusion of HCCI for the Primary Care Provider (PCP) increased payment per the CMS ruling on 42 CFR Part 438, 441, and 447 which entitles the LIHP PCPs to receive the increased amount for certain services provided during calendar year 2013.

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

DHCS continued to conduct and/or participate in the following stakeholder engagement processes during the year. 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:

- Monthly teleconferences with the local LIHP counties to address important questions relating to the LIHP operational and transition activities.

- Quarterly teleconferences with advocacy groups to address questions and concerns regarding the LIHP.

- Bi-weekly meetings of DHCS/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 LIHP Division/Medi-Cal Eligibility Division/Safety Net Financing Division, CCHCS, and California Department of Corrections and Rehabilitation (CDCR), for discussion on populations determined eligible for Medi-Cal and LIHP by DHCS.

DHCS continues 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. DHCS continues to maintain the LIHP website by updating program information for the use of stakeholders, consumers, and the general public.

QUANTITATIVE FINDINGS

The following table illustrates Certified Public Expenditures (CPE), Intergovernmental Transfers (IGT), Federal Financial Participation (FFP), and Total Funds paid.

Payment Type	FFP Payment	Other Payment (IGT)	(CPE)	Service Period	Total Funds Payment
Counties & CDCR					
(DY9Q1) CDCR	$12,673,848	$0	$25,347,696	DY7	$3,014,532
				DY8	$9,659,316
(DY9Q1) Health Care	$257,563,572	$0	$515,127,144	DY7	$13,364,087
				DY8	$244,199,485
(DY9Q1) Administrative	$982,902	$0	$1,965,804	DY7	$982,902
(DY9Q2) CDCR	$28,628	$0	$57,256	DY7	$28,628
	$2,782,967	$0	$5,565,934	DY8	$2,782,967
	$1,145,730	$0	$2,291,460	DY9	$1,145,730
(DY9Q2) Health Care	-$845,041	$0	-$1,690,082	DY7	-$845,041
	$112,086,652	$0	$224,173,304	DY8	$112,086,652
	$172,295,221	$0	$344,590,442	DY9	$172,295,221
	$34,502,252	$34,502,252	$0	DY7	$69,004,504
	$2,774,641	$2,774,641	$0	DY8	$5,549,281
(DY9Q3) CDCR	$981,624	$0	$1,963,248	DY7	$981,624
	$4,529,615	$0	$9,059,230	DY8	$4,529,615
	$687,230	$0	$1,274,460	DY9	$687,230
(DY9Q3) Health Care	-$489,228	$0	-$978,456	DY6	-$489,228
	$851,975	$0	$1,703,950	DY8	$851,975
	$128,175,825	$0	$256,351,650	DY9	$128,175,825
	$900,000	$900,000	$0.00	DY7	$1,800,000
	$35,671,379	$35,671,379	$0.00	DY8	$71,342,758
(DY9Q4) CDCR	$109,109	$0	$218,218	DY7	$109,109
	$2,928,913	$0	$5,857,826	DY8	$2,928,913
	$6,481,750	$0	$12,963,500	DY9	$6,481,750
(DY9Q4) Health Care	$1,983,528	$0	$3,967,056	DY7	$3,901,022
	$12,344,016	$0	$24,688,032	DY8	$12,344,016
	$116,278,570	$0	$232,557,140	DY9	$116,278,570
	$1,950,511	$1,950,511	$0	DY7	$3,901,022
	$6,528,773	$6,528,773	$0	DY8	$13,057,546
	$656,070	$656,070	$0	DY9	$1,312,140
Total	**$646,323,612**	**$82,983,626**	**$729,307,238**		**$1,001,462,151**

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Nothing to report.

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 wither: 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.

ACCOMPLISHMENTS:

Nothing to report.

PROJECT STATUS:

Nothing to report.

QUANTITATIVE FINDINGS:

ENROLLMENT (July 2013 through June 2014)

Managed care enrollment in Two-Plan and GMC counties rose from 4,516,435 beneficiaries in July 2013 to 5,710,970 in June 2014, representing a 26 percent increase. Total SPD enrollment in Two-Plan and GMC counties was 481,678 beneficiaries in July 2013 and rose to 492,630 beneficiaries in June 2014, representing a 2.27 percent increase. While the SPD population grew slightly, the percentage of the total population increased greatly. In July 2013, SPDs represented 10.67 percent of the population while in June 2014, SPDs represented 8.63 percent of the population. [NOTE: Enrollment numbers for the Regional, Imperial and San Benito models are not included in this report since SPDs are not currently mandatory populations in these models. In COHS models, all populations are mandatory; therefore, the Demonstration Waiver amendment for the mandatory enrollment of SPDs was not necessary for the COHS health plans. Therefore, only enrollment numbers for Two-Plan and GMC are included for this reporting period]

There were 23,595 instances of SPDs disenrolling from Medi-Cal managed care plans during this period. The stated reasons for 95.17 percent of the disenrollments were due to issues regarding beneficiary choice (beneficiary could not choose the doctor they wanted, plan did not meet beneficiary needs, doctors did not meet beneficiary needs, too far away, did not choose this plan, moving out of county, other reason).

CONTINUITY OF CARE (July 2013 through June 2014)

There was a total of 2,797 extended continuity of care requests submitted to health plans between July 2013 and June 2014. Eighty-one percent or 2,263 of these requests were approved, 29 were in process at the time of reporting, and 505 (18 percent) were denied. For those denied, 85 were due to no link between SPD and provider; 1 was due to quality of care issues; 119 were because the provider would not accept the reimbursement rate; 12 were because the provider refused to work with managed care and 288 were due to other reasons.

MEDICAL EXEMPTION REQUESTS (MERs) (July 2013 through June 2014)

For July 2013 through June 2014, 17,244 unique SPDs submitted 21,255 MERs indicating an average of 1.23 MERs being submitted per unique SPD that submitted

MERs. The top diagnosis code was Complex with 2,480 MERs (11.67 percent) between July 2013 and June 2014.

Of the MERs received, 15,113 (71.1 percent) were approved, 421 (1.98 percent) were incomplete and 5,721 (26.92 percent) were denied.

RISK DATA (July 2013 through June 2014)

Through a risk stratification process, 38,604 SPDs were identified as High Risk by health plans and 81,174 SPDs were identified as Low Risk. Approximately 80 percent (98,616 SPDs) of the 122,717 SPDs in High or Low Risk categories were successfully contacted by health plans to participate in a risk assessment survey. The survey asks health questions that further assist the plans in assessing the needs of the beneficiary and assure that the beneficiaries are seen by the appropriate providers. 32,680 SPDs completed the risk assessment survey (27 percent of SPDs that were determined as High or Low Risk). As a result of the risk assessment survey, 10 percent of SPDs (12,557 of respondents) were determined to belong in a different risk category than what was determined through the stratification process.

OMBUDSMAN DATA (July 2013 through June 2014)

There were 6,548 calls regarding mandatory SPD enrollment into managed care (7.73 percent of total calls to the MMCD Office of the Ombudsman). There were 20 SPD calls (0.18 percent of total SPD calls) compared to 14 calls from other members (0.03 percent of total other member calls) regarding access issues.

PLAN GRIEVANCES (July 2013 through June 2014)

Approximately 13 percent out of 8,051 total SPD grievances, or 1,029 were related to access issues.

QUALITATIVE FINDINGS/CASE STUDIES

Nothing to report.

UTILIZATION DATA:

Enrollment of SPDs grew from 518,416 in the third quarter of 2012 to 525,828 in the second quarter of 2013. For this time period, of the SPD population, approximately 47 percent had outpatient visits, 5 percent had inpatient visits, 68 percent had pharmacy claims, 6 percent had hospital admissions, and 13 percent had emergency room visits.

On average, each SPD that utilized the services had 6.18 outpatient visits, 2.99 inpatient visits, 13.43 pharmacy claims, 2.17 hospital admissions, and 1.67 emergency room visits. This demonstrates that a small portion of the SPD population has a high usage of each service.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

DHCS evaluated the SPD transition and identified several lessons learned and strategies for improvement as follows:

- Lesson Learned #1: Collaboration across entities and settings improves plan and provider readiness.
    - DHCS strategies/improvement:
        - Discuss readiness and outreach opportunities with the plans on a bi-weekly basis.
        - Work with plans on establishing town hall meetings to increase outreach to providers and beneficiaries in the community.
        - Emphasize the importance of high completion percentages for the Health Risk Assessments (HRAs).
    - Plan strategies/improvement:
        - Participate in town hall meetings and other outreach opportunities.
        - Utilize all available resources to increase HRA return rates.
- Lesson Learned #2: Plans need timely access to beneficiary data to improve plan readiness and care coordination.
    - DHCS Strategies/Improvement:
        - Provide utilization data and Treatment Authorization Request (TAR) data for new members to plans 30 days prior to enrollment.
        - Utilize a linkage process for plan assignment for those beneficiaries that do not make an active plan choice.
        - Provide technical assistance to refine the process for data sharing.
        - Mail choice packets to beneficiaries 75 days prior to enrollment which will allow more time for beneficiaries to make a plan choice and have any questions they have addressed.
- Lesson Learned #3: Developing adequate provider networks to prepare for an expansion was both a challenge and an opportunity.
    - DHCS strategies/improvement:
        - Provide payment increases for the SPD population.
        - Provide plans with rendering and billing provider information to identify specialists who are being accessed in the area.
        - Work with the Department of Managed Health Care to expand network adequacy reviews.
        - Engage with providers on outreach efforts.
        - Hold regularly scheduled meetings with the plans to discuss network issues.
    - Plan strategies/improvement:
        - Offer incentive programs for providers, including paying higher amounts for the SPD population.

        - Encourage plans to continually seek opportunities to expand their networks through various organizations.
- Lesson Learned #4: The transition impacted the organizational structure and resources of those who served the SPD population.
    - DHCS strategies/improvement:
        - Incorporate provisions that require plans to provide specialized training to staff working with SPDs.
        - Incorporate contract provisions to address linguistic and cultural competencies, SPD sensitivity training, and case management.
        - Include oversight of these contract provisions in the health plan readiness reviews.
        - Provide utilization, TAR, and demographic data to plans that identify high utilizers and those needing specialty services.
        - Update member notices to add language on Medical Exemption Requests (MERs) and Continuity of Care.
        - Require plans to honor fee-for-service (FFS) TARs for up to 60 days or until a new authorization is completed by the plan to minimize care disruption.
        - Work with plans on provider outreach materials.
    - Plan strategies/improvement:
        - Regularly conduct provider trainings.
        - Provide specialized outreach to particular provider types, if needed.
        - Look to partner with community organizations to improve resource utilization and communication.
        - Make MER and Continuity of Care information available in their Evidence of Coverage and Member Services Departments.
- Lesson Learned #5: The transition generated an even greater need for care coordination.
    - DHCS strategies/improvement:
        - Review the plans' policies and procedures for care coordination to ensure processes are in place.
        - Work with the plans to address any deficiencies.
        - Require the plans to correct any deficiencies prior to implementation.
        - Monitor the plans' administrative readiness, including staffing, training and education.
        - Hold bi-weekly meetings with the plans to discuss care coordination, among other topics.
    - Plan strategies/improvement:
        - Provide ongoing specialized staff training.
        - Ensure medical contacts are available 24 hours a day to coordinate services.
- Lesson Learned #6: Capitalize on improving beneficiary experience during the transition.
    - DHCS strategies/improvement:

        - Notification and informing materials to include the benefits of managed care, timing of the transition, how the change affects the beneficiary and key contact information for questions and information.
        - Notices to include information on how a beneficiaries can remain on FFS through the MER process, if they qualify.
        - Development of a Continuity of Care website.
    - Plan strategies/improvement:
        - Improve beneficiary informing materials.
        - Help beneficiaries navigate their plan options, find doctors in the network, and educate on medication changes.
        - Using FFS utilization data, link beneficiaries to a primary care doctor, if possible.

2013 MANAGED CARE EXPANSION

MMCD provides high quality, accessible, and cost-effective health care through managed care delivery systems.

MMCD contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

Assembly Bill (AB) 1467 (Committee on Budget, Chapter 23, Statutes of 2012), the health omnibus budget trailer bill, authorized DHCS to expand Medi-Cal managed care to Medi-Cal beneficiaries residing in the following 28 rural FFS counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Mono, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba. This statewide expansion was part of Governor Brown's 2012-2013 Budget. The General Fund cost savings of this expansion were projected at $2.7 million in 2012-2013 and $8.8 million in 2013-2014.

In preparation for this statewide expansion, in March 2012, DHCS issued a Request for Information to solicit health plan interest in providing health care services to Medi-Cal beneficiaries in these rural counties. In November 2012, DHCS issued a Request for Application (RFA) inviting interested health plans to submit formal applications to DHCS.

On February 27, 2013, DHCS released an administrative bulletin excluding the following seven counties from the RFA: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Pursuant to Welfare and Institutions Code Section 14087.98(b) and authorized under AB 1467, DHCS chose to enter into an exclusive health plan contract with an existing COHS, Partnership Health Plan of California, for these seven counties. DHCS also chose to enter into an exclusive health plan contract with the same COHS to include Lake County, which was not part of the original RFA.

Also on February 27, 2013, DHCS announced Anthem Blue Cross and California Health and Wellness Plan as the selected plans in the following 18 counties: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba. Final health plan contracts were contingent upon all the plans' completion of State and federal plan readiness activities. Additionally, DHCS contracted with Kaiser Foundation Health Plan in three of these counties (Amador, El Dorado and Placer) to ensure continuity of care for beneficiaries given Kaiser's staff model for delivery of care was already in place.

DHCS, in collaboration with the Imperial County Public Health Department, participated in a community meeting for stakeholders in Imperial County on December 6, 2012. Local providers and Medi-Cal managed care health plans attended and participated in

the meeting. The purpose of this meeting was to discuss the managed care model options with stakeholders and to answer questions and obtain information about the geography of Imperial County's desert landscape and how it affects access to services. Based upon CMS and DHCS collaboration, DHCS contracted with two plans in Imperial County: California Health and Wellness Plan and Molina Healthcare.

San Benito County, which originally planned to join an existing COHS plan (Central California Alliance for Health), instead operates as a single plan model (Anthem Blue Cross).

As a result of this expansion effort, as of June 2014, which is the end of the reporting period, approximately 7.7 million Medi-Cal beneficiaries in all 58 California counties were enrolled in Medi-Cal managed care and received their health care through the following models of managed care:

1. Two-Plan, which operates in 14 counties.
2. COHS, which operates in 22 counties.
3. GMC, which operates in two counties.
4. Regional Model, which operates in 18 counties.
5. Imperial Model, which operates in one county.
6. San Benito Model, which operates in one county.

ACCOMPLISHMENTS:

On September 1, 2013, DHCS successfully completed the expansion of Medi-Cal managed care in the eight rural FFS counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity.

On November 1, 2013, DHCS successfully completed the expansion into the remaining 20 rural FFS counties of: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne and Yuba.

PROJECT STATUS:

Noted in "Accomplishments" above

QUANTITATIVE FINDINGS:

ENROLLMENT (September/November 2013 through June 2014)

In September 2013, enrollment in the eight COHS counties of: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity was approximately 110,024. In June 2014, enrollment increased to approximately 152,706, which is a 38.79 percent increase.

In November 2013, enrollment in the 20 Regional, Imperial, and San Benito Model counties of: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne and Yuba was approximately 174,001. In June 2014, enrollment increased to approximately 266,406, which is a 53 percent increase.

CONTINUITY OF CARE (September 2013 through April 2014)

A total of 1,493 extended continuity of care requests were submitted to health plans between September 2013 and April 2014. Eighty-nine percent or 1,327 of these requests were approved, 112 (8 percent) were in process at the time of reporting, and 53 (less than 4 percent) were denied. For those denied, one was due to quality of care issues; three were because the provider would not accept the reimbursement rate; three were because to the provider refused to work with managed care and 48 were due to other reasons.

MEDICAL EXEMPTION REQUESTS (September 2013 through April 2014)

For September 2013 through April 2014, a total of 756 MERs were received, 429 (56.75 percent) were approved and 244 (32.28 percent) were denied.

RISK DATA (July 2013 through June 2014)

Nothing to report.

OMBUDSMAN DATA (July 2013 through June 2014)

Nothing to report.

PLAN GRIEVANCES (July 2013 through June 2014)

Approximately 8.31 percent of 311 total rural grievances, or 27 were related to access issues.

QUALITATIVE FINDINGS/CASE STUDIES:

Nothing to report.

UTILIZATION DATA:

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Nothing new to report.

DESIGNATED STATE HEALTH PROGRAMS (DSHP)

INTRODUCTION :

Designated State Health Programs: The Special Terms and Conditions of California's Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) allow the State to claim Federal Financial Participation (FFP) using the certified public expenditures (CPE) of approved Designated State Health Programs (DSHP). The annual FFP limit the State may claim for DSHPs during each Demonstration Year is $400 million for a five year total of $2 billion.

ACCOMPLISHMENTS:

In DY 9 DHCS completed the following DY 6 final reconciliations for Safety Net Care Pool Designated State Health Programs (DSHP).

- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)

PROJECT STATUS:

Assembly Bill 1467 gave the Department the statutory authority to use excess Designated Public Hospital CPEs to claim against the $400 million annual DSHP limit, to the extent that program expenditures were not sufficient to claim up to this amount. DHCS is developing a methodology to claim excess CPEs in order to reach our annual limit.

QUANTITATIVE FINDINGS:

As of June 2014, DHCS has claimed a total of $326,355,257 for DSHPs in DY 9. The table below lists the claim detail for each program:

State Only Medical Programs	
California Children Services (CCS)	$76,953,182
Genetically Handicapped Persons Program (GHPP)	$44,276,143
Medically Indigent Adult Long-Term Care (MIA/LTC)	$18,932,427
Breast & Cervical Cancer Treatment Program (BCCTP)	$1,914,925
AIDS Drug Assistance Program (ADAP)	$56,509,702

County Mental Health Services Program	$44,583,820
Department of Developmental Services (DDS)	$63,713,848
Every Woman Count (EWC)	$0
Prostate Cancer Treatment Program (PCTP)	$906,687
State Only Medical Programs Total	**$307,790,734**
Workforce Development Programs	
Song Brown HealthCare Workforce Training	$7,278,000
Steven M. Thompson Physician Corp. Loan Repayment Program	$6,193,621
Mental Health Loan Assumption	$5,092,902
Workforce Development Programs Total	**$18,564,523**
Grand Total for DSHPs	**$326,355,257**

QUALITATIVE FINDINGS/CASE STUDIES

Not Applicable

UTILIZATION DATA:

Not Applicable

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION:

Not Applicable

COMMUNITY BASED ADULT SERVICES (CBAS) AND ENHANCED CASE MANAGEMENT (ECM)

The Department of Health Care Services amended this Waiver to include CBAS, which was approved by CMS on March 30, 2012, for the period of April 1, 2012, through August 31, 2014. Adult Day Health Care (ADHC) services were being eliminated from the Medi-Cal program under Assembly Bill 97 (Chapter 3, Statutes of 2011); however, a class action lawsuit, Esther Darling, et al. v. Toby Douglas, et al., challenged the elimination. A Settlement Agreement was reached with ADHC benefit being eliminated under the Medi-Cal program effective March 31, 2012, and being replaced with a new CBAS program effective April 1, 2012.

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

PROGRAM REQUIREMENTS

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/from the program, to Medi-Cal beneficiaries that meet CBAS eligibility criteria. CBAS providers are required to: 1) meet all applicable licensing and certification, Medicaid waiver program standards; 2) provide services in accordance with the participant's multi-disciplinary team members and physician-signed Individualized Plan of Care (IPC); 3) adhere to the documentation, training, and quality assurance requirements as identified in the 1115 Demonstration Waiver; and 4) exhibit ongoing compliance with above requirements.

CBAS is a managed care benefit in all but four counties that have CBAS Centers (26 of California's 52 counties have Centers). The final four counties - Butte, Humboldt, Imperial and Shasta - will transition CBAS to a managed Care benefit on December 1, 2014. If any individual is exempt from Managed Care, CBAS is available, and will continue to be available, as a Fee-for-Service benefit.

PROJECT STATUS

Enrollment Information for CBAS:
Enrollment for CBAS remains steady as it continues as a managed care benefit in 22 counties. Approximately 1,700 participants remain in fee-for-service CBAS.

The annual preliminary CBAS Enrollment data is broken down Quarterly (below) for both Managed Care organizations (MCO) and Fee-for-Service (FFS) beneficiaries in each county of participation. This Annual data is updated from the previous Demonstration Year 9, *Preliminary* Quarterly 4 Enrollment Data Report. The data source for the prior Quarter 4 Enrollment data used self-reported Center data that differed from the managed care data source used previously and below. This data for

the DY 9 Annual Report, is consistent with the data used in previous quarters and is consistent with all previous reported data from the managed care plans, along with claims data for FFS enrollment.

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

	DY9 Q1 July - Sept 2013			DY9 Q2 Oct - Dec 2013			DY9 Q3 Jan - Mar 2014			**DY9 Q4 Apr - June 2014**		
County	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	Capacity Used	FFS	MCO	
Alameda	10	490	83%	9	535	90%	8	465	79%	8	464	
Butte	46		45%	42		41%	39		38%	35	-	
Contra Costa	12	193	64%	14	185	62%	10	119	40%	9	194	
Fresno	10	615	68%	9	604	67%	7	659	69%	9	590	
Humbolt	234		60%	116		30%	110		28%	109	-	
Imperial	394		70%	389		70%	380		68%	369	-	
Kern		113	34%		85	26%		89	26%	-	119	
Los Angeles	1,193	15,255	55%	1,039	15461	55%	1,020	15177	54%	1,000	14,898	
Merced		99	54%		110	60%		101	55%		105	
Monterey			0%		66	35%		66	35%		77	
Orange	12	1,870	60%	9	1899	61%	5	2515	81%	8	2,217	
Riverside	22	386	38%	21	425	41%	18	389	38%	14	388	
Sacramento	28	478	62%	25	398	47%	30	549	65%	20	532	
San Bernardino	20	412	80%	19	477	92%	14	411	78%	14	418	
San Diego	41	1,549	47%	33	1418	43%	36	1405	42%	33	1,448	
San Francisco	68	666	50%	58	746	55%	55	699	49%	55	688	
San Mateo		142	70%		146	72%		136	67%		147	
Santa Barbara		4	4%		4	5%		3	3%		9	
Santa Clara	2	728	56%	4	592	46%		559	43%		588	
Santa Cruz		104	72%		105	73%		100	66%		101	
Shasta	82		57%	40		28%	40		28%	40	-	
Ventura	8	486	36%	7	959	71%	10	911	67%	7	893	
Yolo*	3	227	61%	3	225	60%	2	220	59%	1	215	
Marin, Napa, Solano**		271	54%		220	44%		224	45%		235	
Total	**2,185**	**24,227**	**54%**	**1,837**	**24,660**	**54%**	**1,782**	**24,791**	**54%**	**1,731**	**24,326**	
Combined Totals	**26,412**			**26,497**			**26,573**			**26,057**		

Enrollment Information for ECM:

The ECM participant data has continued to drop during this past year. The ECM Table below, indicates those ECM-eligible individuals that were found not eligible for CBAS as of April 2012 and have continued to remain eligible for ECM. ECM-eligible class members enrolled with managed care health plans receive ECM through their plans case management services.

The ECM Table below tracks the ECM participant data for individuals eligible to receive ECM services through the FFS system over this reporting period of July 2012 through June 2014.

** 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 area.

*Yolo updated data

ECM Participant Average 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
DY8 - Q3			
Jan.-Mar'13	453	19	25
DY8 - Q4			
April-June'13	**414**	**11**	**50**
		DHCS ECM Data 07/01/2014	

Outreach/Innovative Activities:

Stakeholder Process -

The CBAS Stakeholder workgroup began in September 2013, with monthly webinars and in-person meetings to develop recommendations and essential CBAS components for the waiver amendment. The purpose of these meetings were to work on reaching consensus on priorities and objectives for CBAS, establish parameters for provider input, and identify key stakeholders for further workgroup activities so the Waiver Amendment can be submitted timely. Some of the key issues included facilitating diversification of CBAS by population or service focus (e.g. dementia or DD populations, chronic care management to post- acute rehabilitation), allowing managed care payment by services, population or level-of-care, and changing existing laws and oversight mechanisms.

Stakeholders include representatives from Managed Care Plans, Medical Directors, Providers and various advocates, consumers, legislative staff members. The monthly meeting concluded with the submission of the Waiver Amendment, in June 2014. Follow-up meetings will occur with the finalization of the Waiver Amendment.

Operational/Policy Development/Issues

CBAS Transition to Managed Care –

While there are a total of 26 counties in California that have CBAS Centers, Managed

Care has transitioned to all 58 counties in California. Of the 26 counties that have CBAS Centers, fee-for-service benefits remains in four of those counties (Shasta, Humboldt, Butte, and Imperial). These four counties are the only rural counties that have CBAS Centers with the CBAS benefit being carved out, until December 1, 2014. CBAS will move to a Managed Care benefit in the above four counties, making CBAS a fee-for-service benefit, only if the participant is exempt from Managed Care.

CBAS Fair Hearings -

CBAS Fair Hearings 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 for DY 9, an average of four CBAS cases (out of the approximate 26,000 participants) per quarter were filed/heard, for a total of 16 CBAS cases for the entire Demonstration Year. Several of the Hearings have been related to Managed Care enrollment; other Hearings relate to increases in service days or authorization of days of attendance.

Consumer Issues:

DHCS continues to regularly respond to issues and questions, in writing or by telephone, from CBAS consumers, CBAS providers, managed care plans, members of the Press, and members of the Legislature on various aspects of the CBAS program, if requested. DHCS also maintains the CBAS webpage for the use of all stakeholders. Emails are directed to CBAS@dhcs.ca.gov , from providers and beneficiaries for answering a variety of questions. Most issues are related to consumers changing managed care plans, changing between Medi-Cal FFS and managed care plans, as well as changing of their Medi-Cal eligibility.

Complaints –

Issues that generate CBAS complaints are minimal from both beneficiaries and providers. Complaints are collected by calls and emails directed to CDA, for the most part, the complaints are from CBAS providers. Summarized below, are the complaints that came in during DY 9:

Demonstration Year 9 - Data on CBAS Complaints					
Year	**Demo Year 9 Quarters**	**Beneficiary Complaints**	**Provider Complaints**	**Total Complaints**	**Percent to Total**
2013	DY9 - Qrt 1 (Jul 1 - Sep 30)	7	3	10	0.46%
2013	DY9 - Qrt 2 (Oct 1 - Dec 31)	8	9	17	0.93%
2014	DY 9 - Qrt 3 (Jan 1 - Mar 31)	6	2	8	0.44%
2014	**DY 9 - Qt 4** (Apr 1 - Jun 30)	**5**	**18**	**23**	**0.08%**
				CDA data - Phone & Email Complaints	

Financial/Budget Neutrality Development/Issues:

Nothing to report.

Quality Assurance / Monitoring Activity:

DHCS continues to monitor CBAS Center locations and accessibility, and the Department considers provider requests as part of its ongoing monitoring of CBAS access as required under the BTR Waiver. AB 97 (Chapter 3, Statutes of 2011) imposed a 10% rate reduction on specified Medi-Cal providers including ADHCs. Based on DHCS' Medi-Cal Access Study of ADHCs, certain ADHCs were exempted from the 10% provider reduction. All rate reductions and exemptions applicable to ADHC were applicable to CBAS beginning on April 1, 2012. Centers may submit requests to DHCS for review of possible exemption to the 10% rate reduction, due to various hardships in their county area. DHCS and CDA review specifics to determine if exemptions need to be reviewed by the administration and approved for possible implementation. The Table below indicates the consistency of each county's licensed capacity since the CBAS program became an approved Waiver benefit in April 2012. The licensed Capacity used below in Table 1, also shows that overall utilization of licensed capacity by Medi-Cal and non-Medi-Cal beneficiaries is 60% statewide. There is space available in almost all counties where CBAS is available to allow for access to CBAS by Medi-Cal beneficiaries.

County	CBAS Centers Licensed Capacity										
	Apr- Jun 2012	Jul- Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013	DY9-Q1 Jul-Sept 2013	DY9-Q2 Oct-Dec 2014	DY9-Q3 Jan-Mar 2014	DY9-Q4 Apr-Jun 2014	Percent Change Between Last Two Quarters	Capacity Used
Alameda	415	415	355	355	355	**355**	**355**	**355**	**355**	0%	79%
Butte	60	60	60	60	60	**60**	**60**	**60**	**60**	0%	34%
Contra Costa	190	190	190	190	190	**190**	**190**	**190**	**190**	0%	63%
Fresno	590	590	530	530	547	**572**	**572**	**572**	**572**	0%	61%
Humboldt	229	229	229	229	229	**229**	**229**	**229**	**229**	0%	28%
Imperial	250	250	250	315	315	**315**	**330**	**330**	**330**	0%	66%
Kern	200	200	200	200	200	**200**	**200**	**200**	**200**	0%	28%
Los Angeles *	17,735	17,590	17,430	17,505	17,506	**17,613**	**17,810**	**18,084**	**18,184**	0.6%	52%
Marin	75	75	75	75	75	**75**	**75**	**75**	**75**	0%	22%
Merced	109	109	109	109	109	**109**	**109**	**109**	**109**	0%	53%
Monterey	290	290	290	-	-	**110**	**110**	**110**	**110**	0%	41%
Napa	100	100	100	100	100	**100**	**100**	**100**	**100**	0%	53%
Orange*	1,897	1,897	1,747	1,747	1,747	**1,847**	**1,847**	**1,847**	**1,910**	3%	69%
Riverside	640	640	640	640	640	**640**	**640**	**640**	**640**	0%	37%
Sacramento	529	529	529	529	529	**529**	**529**	**529**	**529**	0%	62%
San Bernardino	320	320	320	320	320	**320**	**320**	**320**	**320**	0%	80%
San Diego*	2,132	2,052	1,957	1,992	1,992	**2,007**	**2,007**	**1,923**	**1,873**	-2.6%	47%
San Francisco	803	803	803	803	803	**803**	**866**	**866**	**866**	0%	51%
San Mateo*	120	120	120	120	120	**120**	**120**	**120**	**135**	12.5%	64%
Santa Barbara	55	55	55	55	55	**55**	**55**	**55**	**55**	0%	5%
Santa Clara*	820	820	820	820	750	**770**	**770**	**770**	**840**	9.1%	41%
Santa Cruz	90	90	90	90	90	**90**	**90**	**90**	**90**	0%	66%
Shasta	85	85	85	85	85	**85**	**85**	**85**	**85**	0%	28%
Solano	120	120	120	120	120	**120**	**120**	**120**	**120**	0%	26%
Ventura	806	806	806	806	806	**806**	**806**	**806**	**806**	0%	67%
Yolo	224	224	224	224	224	**224**	**224**	**224**	**224**	0%	57%
SUM =	29,009	28,739	28,214	28,099	27,967	**28,344**	**28,619**	**28,809**	**29,007**	0.69%	53%

CDA Licensed Capacity as of 06-30-2014

Los Angeles - 3 centers increased license capacity
Orange - 1 center increased license capacity
San Diego - 1 center closed
San Mateo - 1 center increased license capacity
Santa Clara - 1 center opened
Note: License capacities for centers that run a dual-shift program are now being counted twice, once for each shift.

CBAS Research Study Comparing ADHC in 2010-11 to CBAS in 2012 through 2014:

The Table below further compares the annual participant health status of measurable areas for individuals enrolled in the ADHC program during 2012 as to those compared to being enrolled in the CBAS program as of 2012-13 and 2013-14. Since the CBAS program requires a higher level of medical necessity to determine eligibility, we expect the population to have a higher percentage of health needs and less percentage of independence. Over a longer period of time, research hopes to find that these frail individuals are maintained in the community at a lower-risk of hospitalization and higher quality of life.

CALIFORNIA CHILDREN SERVICES (CCS)

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

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

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

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

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

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

ACCOMPLISHMENTS:

Program Timeline

Date	Action Items – Applies to the Remaining Pilots (CHOC/CalOptima, LA Care, and Alameda)
July 30, 2013	LA Care returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
August 6, 2013	Cal Optima / CHOC returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
August 19, 2013	Released cost utilization data (LA Care and Cal Optima) for analysis and rate discussion
On hold as of July 1, 2014	OIL to MMIS 0242 Table for CHOC/Cal Optima for Procedure and Accommodation codes
On hold as of July 1, 2014 (Originally established May 2012)	OIL to MMIS 0242 Table for Alameda for Procedure and Accommodation codes
Anticipated November 1, 2014	OIL (Operational Instruction Letter) to MMIS 0242 Table for RCHSD for Procedure and Accommodation codes
Date	**HPSM Pilot Action Items**
April 1, 2013	HPSM CCS Demonstration became operational under the DHCS Waiver
February 10, 2014	SCD received authorization from MCED, ITSD, and CA-MMIS to develop and implement a new aid code (9D) for CCS State-Only beneficiaries
April 2014	Health Code Plan (HCP) Request to include 27 new aid codes available for HPSM's use in the enrollment of children into the CCS DP
April 2014 (bi-weekly) Ongoing	SCD and HPSM conduct bi-weekly conference calls to discuss and resolve issues with the CCS DP operational phase
May 2014 (November 1, 2013, Retroactively)	9D Aid Code established for CCS-Only population
June - July 2014	SCD drafting a Family Satisfaction Phone Survey and work plan to satisfy the operational review component
June - July 2014	SCD drafting a Provider Satisfaction email Survey and work plan to satisfy the operational review component
June – July 2014	SCD drafting a Facility Site Visit questionnaire to satisfy another component to the operational review
Date	**RCHSD Pilot Action Items**

July 2012 – Present	Continuation of the Contracting Process – RCHSD (includes the development of the Readiness Review Deliverables matrix and the CMS Contract Checklist)
July 12, 2013	RCHSD returned a signed and dated Addendum to the Data Use Agreement which allows the Department to provide cost utilization data that complies with DHCS HIPAA security and confidentiality requirements
July 15, 2013	Released cost utilization data to RCHSD for analysis and rate discussion
July 2013 – Present	RCHSD began submission of Policies and Procedures (P&Ps) for review
March 13, 2014 - Weekly (Ongoing)	SCD and RCHSD conduct weekly conference calls to discuss and resolve issues with the contract and P&Ps
June 17, 2014	SCD Management and RCHSD in-person meeting (site-visit in San Diego)
June 26, 2014	Additional Conditions added to the CCS DP: Acute Lymphoblastic Leukemia and Diabetes Type I and II (ages 1 – 10 yrs of age)
Anticipated - Winter 2014	RCHSD pilot scheduled to be phased in
Committees / Advisory Groups / Stakeholders Meetings	
July 2013 – June 2014 (Bi-Monthly)	CMS Regional and State Conference Calls
September 2013 – September 2014 (Quarterly)	CCS Executive Committee Meetings
August 5, 2013; October 21, 2013; November 20, 2013; February 21, 2014; and May 7, 2014	DHCS Waiver Stakeholder Advisory Committee Meetings

The milestones listed below were achieved during DY 9 (July 1, 2013 through June 30, 2014).

- May 30, 2013: DHCS sent to RCHSD an updated version of the contract, (including the SOW, exhibits, and attachments) for their review.

- July 11, 2013: DHCS provided RCHSD a copy of the Readiness Review document for their review.

- July 12, 2013: An Evaluation meeting occurred between the Department of Health Care Services (DHCS) SCD staff met in-person with HPSM and County Staff and UCLA.

- July 12, 2013: RCHSD returned to SCD a signed Addendum that allows DHCS to release cost utilization data to the Demonstration contractor.

- July 15, 2013: DHCS released cost utilization data to RCHSD for analysis and rate discussion.

- July 18, 2013: DHCS received questions from RCHSD regarding the most current draft contract.

- July 19, 2013: DHCS sent to Mercer (Department's Actuary for rates) a copy of RCHSD's draft contract for their review.

- August 13, 2013: DHCS had a conference call with RCHSD to discuss the impact of the Knox-Keene Waiver and health plan requirements (i.e., network, ID cards, credentialing).

- September 4, 2013: DHCS sent to RCHSD a matrix containing answers to their questions/comments, along with a copy of a Knox-Keene Protection Quick Reference.

- February 10, 2014: SCD received the "go-ahead" from MCED, ITSD, and CA-MMIS to develop a new aid code "9D" for HPSM DP CCS State-Only beneficiaries.

- April 9, 2014: DHCS sent to RCHSD an updated version of the contract, (including the SOW, exhibits, and attachments), CMS Checklist, and Readiness Review document for their review.

- May 2014 (November 1, 2013 - retroactively): 9D Aid Code established for CCS-Only population for HPSM DP enrollment.

- May 20, 2014: RCHSD submitted to SCD drafts of the Member Services Handbook and Evidence of Coverage (EOC).

- June 2014: SCD developed a "DHCS Family Satisfaction Phone Survey" for the Department's use to improve services provided to CCS clients and determine how the DP is functioning for CCS clients.

- June 16, 2014: SCD completed a financial review on HPSM DP quarterly reports specifically, of their Administrative Costs, Profit Margin, and Medical Loss Ratio with 85%< being the target.

- June 17, 2014: DHCS Management and RCHSD site visit in San Diego (in-person meeting).

- June 30, 2014: SCD provided comments to RCHSD's Member Services Handbook/EOC for consideration.

PROJECT STATUS:

Department Communications with CMS

DHCS participated in pre-scheduled reoccurring meetings with the Centers for Medicare & Medicaid Services which included CMS Region IX staff, CMS Central Office staff and other DHCS organizations who are participating in other components of the 1115 Bridge to Reform Waiver. The Department's SCD also maintains separate communications with CMS Regional IX staff relative to issues for any of CMS's requirements.

Evaluation Design and Implementation

UCLA conducted a site visit to HPSM on July 12, 2013. UCLA's visit included meeting with various HPSM departments (IT, legal, etc.), a review of how the HPSM programs worked, the integration of the CCS Demonstration, how the implementation of the pilot was working, and goals/objectives to measure progress over a time span.

Capitation Rate Data Library Confidentiality Agreement & Addendum

DHCS's Privacy Officer, Office of Legal Services (OLS), and upper management agreed upon an administrative vehicle that would allow the Department to provide to the Demonstration contractors cost utilization data that complied with HIPAA security and confidentiality requirements. In June 2013, the Office of HIPAA Compliance requested a two page Addendum to the existing Capitation Rate Data Library Confidentiality Agreement. The Addendum was required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk. This Addendum was emailed to the Contractors on June 21, 2013 and each Contractor was to sign and return to the Department. As of August 19, 2013, cost utilization data was released to RCHSD, CHOC/Cal Optima, and LA Care.

HPSM – Contract

The CCS Demonstration for HPSM became operational on April 1, 2013.

HPSM – Bi-Weekly Conference Calls

SCD implemented bi-weekly conference calls with HPSM, which began on April 25, 2014 to discuss and resolve any issues that have occurred during the operational phase of the CCS DP.

Topics discussed during these bi-weekly conference calls consisted of enrollment, financials, and required report deliverables. Additionally, as the bi-weekly conference calls progressed, issues discussed with HPSM ranged from the enrollment of the CCS-Only population to HPSM's rate negotiations.

HPSM - Outreach / Innovative Activities

On July 12, 2013, DHCS SCD staff met in-person with HPSM and County Staff and UCLA. The meeting consisted of the following: HPSM/UCLA reviewed the evaluation component of the CCS Demonstration Program. During this meeting, HPSM also provided a short review of the HPSM CCS Pilot for UCLA.

RCHSD – Weekly Conference Calls

DHCS implemented weekly conference calls with RCHSD on March 13, 2014 to discuss and resolve various issues such as:

- In an effort to control costs, especially those associated with blood factors, RCHSD is proposing to contract with preferred pharmaceutical vendors (three to five).
- RCHSD is analyzing data to consider the inclusion of additional CCS conditions into the CCS DP. Currently the conditions are Sickle Cell, Cystic Fibrosis, Hemophilia, and the additions of Acute Lymphoblastic Leukemia (A.L.L.) and Diabetes Type I and II (ages 1-10 yrs of age).
- RCHSD historically has not operated as a health plan; as such, they are in the process of developing a Member Services Guide, a Provider Network Guide, and various policies and procedures.
- The process for disenrollment of eligible clients from five San Diego GMC plans and enrollment into the CCS demonstration.
- RCHSD is in the process of enhancing their provider network to include additional Federally Qualified Health Centers (FQHCs) that are currently serving the target population.

RCHSD - Capitation Rates

Continuing from the prior Demonstration Year (mid-October 2011), DHCS has been working on development of reimbursement rates with the Department's actuarial contractor, Mercer. RCHSD has requested that Mercer supply the rates for their review. SCD Management has had communications with Mercer regarding the development of the requested rates once the population is finalized.

RCHSD - Knox-Keene License / Requirements

DHCS was able to procure an exemption to the Knox-Keene licensure for RCHSD on March 4, 2013. This exemption to the Knox-Keene licensure would not waive conformance with Knox-Keene performance requirements. Conformance will be monitored through contract compliance and shall be administered by DHCS SCD staff. This request recognized that there was a large financial burden associated with pursuing licensure as well as acknowledging the nature of this project as a demonstration with specific timeframes. RCHSD has reviewed the Knox-Keene protections to ensure compliance with the requirements.

RCHSD – Contract

In preparation for a conference call that took place on July 18, 2013, SCD provided the Readiness Review document to RCHSD on July 11, 2013. The conference call allowed both the Department and RCHSD to discuss both the Contract and Readiness Review document, lessons learned with implementing HPSM DP, policies and procedures (P&Ps), identification card (ID card), and the thirty (30) and sixty (60) Day Notices to eligible enrollees into the DP.

On August 13, 2013, SCD and RCHSD had a conference call to review draft contract language for the following: Knox-Keene and health plan requirements (provider network, ID cards, credentialing), requirements for 24/7 coverage, process and timing of contract language and covered services (pharmacy, mental health, organ transplants, investigational services, long-term care, family planning services, and comprehensive perinatal services).

Ongoing discussions continued for the current draft contract language with RCHSD and SCD throughout Spring 2014 (March – June).

RCHSD Readiness Review Deliverables

The Department developed a Readiness Review Deliverables Matrix tool, which was originally used with the HSPM DP. This Matrix includes both outreach and readiness tools to operationalize RCHSD pilot. The Readiness Review Deliverables Matrix lists deliverables that the RCHSD pilot will need to submit to the Department's SCD prior to going live. These P&Ps ensure that the RCHSD DP has safeguards in place for access to care and family centered care practices. On July 11, 2013, SCD emailed the Readiness Review Matrix to RCHSD for their review and to refer to during the conference call for discussion purposes of the draft contract and Readiness Review Matrix. SCD and RCHSD held weekly conference calls from March 13, 2014 through April 29, 2014 to discuss the Readiness Review document, P&Ps, Member Services Handbook, EOC, and Provider Network Guide. On April 3, 2014, RCHSD provided sample deliverables required in the Readiness Review Matrix to SCD which consisted of P&Ps for SCD's review, feedback and suggestions. As of May 18, 2014, RCHSD was creating the Member Services Guide/EOC, Provider Network Guide, and P&Ps not currently in place. On May 22, 2014, RCHSD provided to SCD drafts of both the Member Services Guide and EOC to satisfy many deliverables in the Readiness Review. On June 26, 2014, SCD provided feedback for RCHSD's consideration on the Member Services Guide.

RCHSD – Site Visit

On June 17, 2014, in San Diego, the Department's SCD Management met in-person with RCHSD and San Diego County representatives. CCS DP implementation discussion topics consisted of the following: Patient population, patient identification (eligibility and enrollment), Imperial County (feasibility, timing, data analysis/rate

impact), medical home assignment, provider network and Medi-Cal rates, geo-mapping requirements, pharmaceutical needs and utilization information (factor purchasing for Hemophilia patients), rates, Family Advisory Council, outcomes regarding the recommended project evaluation approach, and a timeline for the critical components necessary to implement the DP.

QUANTITATIVE FINDINGS:

Enrollment

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

Month	HPSM Enrollment Numbers	Difference Prior Month	Month	HPSM Enrollment Numbers	Difference Prior Month
July 2013	1,370		January 2014	1,468	-11
August 2013	1,364	-6	February 2014	1,469	1
September 2013	1,369	5	March 2014	1,468	-1
October 2013	1,375	6	April 2014	1,475	7
November 2013	1,413	38	May 2014	1,464	-11
December 2013	1,479	66	June 2014	1,438	-26

Aid Codes

As of January 1, 2014, a list of new ACA aid codes became available, SCD staff determined which aid codes should be available for HPSM's use in the enrollment of children into the CCS DP. Anticipating effective August 1, 2014, 27 additional enrollment aid codes will be available for HPSM's use in the enrollment of children into the CCS DP. In July 2014, SCD put in a Health Code Plan request for the Table 0242 to include three "foster care" aid codes (07, 43, and 49) for HPSM's use in in the enrollment of children into the CCS DP.

Financial/Budget

SCD has met with ITSD, Medi-Cal Eligibility Division (MCED) and OHC multiple times during the Demonstration Year 9 to enroll the CCS-Only children into San Mateo County

into the HPSM CCS DP. The goal is to have an automated process with invoicing occurring through the Capitated Payment System for Medi-Cal Managed Care (CAPMAN). This system provides a functionality that allows business users to manage the Capitation Payment process from end to end. However, the automated process will take several months to implement.

On October 10, 2013, SCD Management had a conference call with HPSM stating that SCD was working on an interim manual system. SCD drafted a "high-level" flow chart on how the division envisions this occurring. SCD Management agreed to share a copy of this flow chart, so HPSM could review and see if this appears to be feasible to them as well.

On February 10, 2014, SCD received the approved memorandum form Medi-Cal Eligibility Division (MCED) to ITSD and California Medicaid Management Information System (CA-MMIS) to request the development and implementation of a new aid code "9D" for CCS State-Only beneficiaries. The aid code will be identified as 9D, CCS State-Only, Child Enrolled in a Health Care Plan. The 9D aid code was established May 2014 and was made retroactive to November 1, 2013. In May 2014, the 9D aid code was activated for the CCS population and it is anticipated to be implemented in September 2014.

QUALITATIVE FINDINGS/CASE STUDIES

HPSM - Report Requirements

On June 4, 2013, SCD emailed HPSM a Deliverable timeline indicating when the required reports are due to DHCS (monthly, quarterly, or annually).

During the October 10, 2013 SCD Management conference call with HPSM, HPSM had provided a copy of proposed changes to the contractual report requirements. During this discussion, SCD Management stated they were willing to reduce the multiple reports (monthly, quarterly, and semi-annual).

UTILIZATION DATA

The Department of Health Care Services and the demonstration pilots experienced significant challenge in obtaining and providing cost utilization data stemming from the need to conform to HIPAA security requirements. In June 2013, the Office of HIPAA Compliance requested a two page Addendum to the Capitation Rate Data Library Confidentiality Agreement (an administrative vehicle required to meet HIPAA requirements and provide the Demonstration contractors with cost utilization data necessary for determining financial risk). On June 21, 2013, emails were sent to each of the Contractors, and they were asked to sign and return the Addendum, which was added to the original agreement. As of August 19, 2013, cost utilization data has been release by the Department to RCHSD, CHOC/Cal Optima, and LA Care.

HPSM DP has been submitting to the Department quarterly report deliverables, entitled "Enrollment and Utilization" Table. Please refer to the table below.

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

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

Competing priorities with other DHCS Demonstration Projects, such as Dual Project, SPDs, LIHP, etc. are vying for available resources.

As stated under the section heading "Utilization Data" access to cost utilization data impacted four of the five Demonstrations, this data was critical to the pilots in determining financial risk.

DHCS continues to collaborate with the Demonstration entities relative to issues and challenges specific to each of the model location. A challenge that impacts all demonstration entities is the capitation rate determinations. This largely results from the need to determine the specific population(s) to be included in the demonstration. This, in turn, delays the State's ability to develop capitation rates. Other challenges vary among the demonstration models but can include final determination of target population, final determination of disease specific groups, general organizational structure, reporting requirements, etc.

It should be noted that the project implementation time table for each of the Demonstration Projects is contingent on a number of factors including acceptance of reimbursement rates by the contracting entity, the ability of the contractor to demonstrate readiness to begin operations, and approval of the contract by CMS.

HEALTHY FAMILIES CHILDREN TRASITIONING TO THE DEMONSTRATION

California Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of approximately 850,000 HFP children in four Phases throughout 2013. Children in HFP will transition into Medi-Cal's new Optional Targeted Low Income Children's Program (OTLICP) covering children with income up to and including 250 percent of federal poverty level (FPL). California Health and Human Services Agency (CHHS), in collaboration with the Department of Health Care Services (DHCS) who administers the Medi-Cal program, the Managed Risk Medical Insurance Board (MRMIB) who administers HFP, and the Department of Managed Health Care (DMHC) who oversees health plans, have been working closely with the Legislature and stakeholder partners to ensure a successful transition of the children from HFP to Medi-Cal.

CMS granted federal approval for DHCS to begin the Phase 1 transition on January 1, 2013 via the Bridge to Reform 1115 Demonstration Waiver. Federal approval for subsequent phases was contingent upon compliance with the Special Terms and Conditions (STC) which requires: public engagement, notices to children and families, consumer assistance, beneficiary surveys, services, a State Plan Amendment, network adequacy, monthly monitoring reports, and evaluation design upon completion of the transition.

ACCOMPLISHMENTS

Eligibility

Based on the collective information contained in the monitoring reports and network adequacy assessments covering all four phases of the transition, the State has been successful in transitioning 751,293 children from the HFP program to Medi-Cal. For the Demonstration Year 9, this report focuses on the final 136,842 beneficiaries that transitioned in Phases 3 (August 1, 2013), 4A (September 1, 2013), and 4B (November 1, 2013).

Table 1: Transitioned Populations[1]

Phase 3 August	Phase 4A September	Phase 4B November
104,915	6,840	25,087
		Total 136,842

[1] *Source: HFP Transition to Medi-Cal Monthly Monitoring Report December 18, 2013, http://www.dhcs.ca.gov/services/Documents/DHCS%20HFP%20Transition%20to%20Medi-Cal%20Monitoring%20Report%20December%202013.pdf*

All transitioned children receive comprehensive health, dental, mental health, and substance use disorder services under Medi-Cal. A majority of these children were able to maintain access to the same primary care providers that they had while enrolled in HFP.

For new beneficiaries enrolling into the program, the State established new OTLICP Medi-Cal aid codes and premium requirements for beneficiaries who would have previously qualified for HFP.

Table 2: New Aid Code Definitions

Aid Code	Age of Child *(up to the month of the 1st, 6th, or 19th birthday)*	FPL	Premium Requirement
H1	0 - 1	Above 200% - Up to and including 250%	None
H2	1 - 6	Above 133% - Up to and including 150%	None
H3	1 - 6	Above 150% - Up to and including 250%	$13 per child, max $39 per family
H4	6 - 19	Above 100% - Up to and including 150%	None
H5	6 – 19	Above 150% - Up to and including 250%	$13 per child, max $39 per family

For the duration of the transition, 286,679[2] total children gained access to services under Medi-Cal's new OTLICP. During the demonstration period (July 1, 2013 through December 31, 2013), 113,880 new beneficiaries enrolled into OTLICP coverage.

Table 3: OTLICP Enrollments and Percentage Distribution[3]

Month	***Total Children in OTLICP***	***H1***	**H2**	**H3**	**H4**	**H5**
Jul	17,378	1%	13%	17%	54%	16%
Aug	19,854	2%	12%	17%	52%	17%
Sept	19,680	2%	12%	18%	52%	17%
Oct	20,464	2%	11%	17%	52%	17%

[2] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

[3] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

Nov	18,424	2%	12%	18%	51%	17%
Dec	18,080	2%	11%	17%	50%	20%
TOTAL	**113,880**					

Health Care

In Phases 1 and 2, a minimal number of children had to change primary care providers (PCPs) because beneficiaries were assigned to the same health plan and in turn were able to stay with their same PCP. For the Phase 1A children, 1.04 percent changed PCP, 6.07 percent for Phase 1B, 14.81 percent for Phase 1C in the April 2012 transition, 27 percent for Phase 1C in the May 2012 transition, and 20.67 percent for Phase 2. Nearly all of the transitioned children had an assigned PCP. For children who are not assigned to their same PCP, they were provided 30 calendar days from the time of enrollment to choose a PCP before one was chosen for them.

In Phase 3, over half of the children coming into Medi-Cal were able to keep the same PCP, and a greater number (over 67 percent) had a PCP by linkage or assignment at the time of the transition. These children's families were able to choose a new plan ahead of the transition and had the option of choosing a PCP when they chose a plan.

The number of children that had to change PCPs in Phase 3 was higher than in Phases 1 and 2 because these children were coming from HFP plans that did not contract with Medi-Cal or have a subcontract with a Medi-Cal managed care health plan. For this reason, MRMIB provided the children's PCP information so that DHCS could make it available to the plans, which would allow plans to link children to their PCP whenever possible. Children who were not assigned to their same PCP were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

In Phases 4A and 4B, the vast majority of children were assigned to a PCP at the time of the transition. For Phase 4A, DHCS was not able to track whether these children were assigned to their same PCPs because the HFP plan in these counties, Anthem Blue Cross, operated an Exclusive Provider Organization (EPO) network and did not assign enrollees to PCPs. However, the Medi-Cal managed care health plan, Partnership HealthPlan, was able to contract with the majority of providers who had participated in the EPO network, so there was a high probability that children would be able to continue seeing their same providers.

In Phase 4B, two HFP plans that operated in these counties, Anthem Blue Cross and Kaiser, established a contractual relationship with DHCS to provide Medi-Cal services in these counties. Children who were in either Anthem Blue Cross or Kaiser were able to keep their plans when they transitioned to Medi-Cal. Since the children remained in the same plan, the expectation was that all children would be able to continue seeing their same providers. Kaiser was able to keep all of its HFP children and they remained with their same PCPs. The children's families that were not members of Anthem Blue Cross

or Kaiser were able to choose a new plan ahead of the transition. Per contractual requirements, these new members were provided 30 calendar days from the time of enrollment to choose a PCP or the plan would have chosen one for them.

Since the start of the transition in January 1 through November 30, 2013, health plans reported 182 requests for continuity of care. The following were common reasons for continuity of care requests:

- Member unable to remain with same PCP or health network;
- Provider not aware of existing prior authorization;
- Member requested to change PCP;
- Member does not qualify for specialty mental health; and,
- PCPs no longer accepting Medi-Cal due to reimbursement rates.

The health plans have resolved all cases by assisting beneficiaries with selecting new or changing PCPs, bridging information on prior authorizations, and clarifying the extent to which behavioral health services are covered.

Dental Care

For children who needed to secure a new dental provider, the beneficiary could contact Denti-Cal's Beneficiary Customer Service line or locate providers on the Denti-Cal website that are accepting new patients. DHCS has improved both sources to ensure beneficiaries can easily access providers and dental services. These changes included:

- Improved referral processes with the Beneficiary Customer Service line and providing for warm transfers (ensuring beneficiaries are connected to a provider and attempting to schedule an appointment before disconnecting from the call). As such, dental care successfully reached a 100 percent warm transfer rate each month.
- Improved ease of adding providers to the online list who are accepting new patients thus offering beneficiaries a wider selection of providers in their area. As such, 788 new FFS and dental plan providers were added during July – December 2013. The total number of dental providers added during the July 2013 through December 2013 period may include duplicated providers; and,
- Improved Denti-Cal website to include Denti-Cal provider network information allowing individuals to search for providers by State, name of provider, location of residence, specialty, accepting new patients, and other factors.

Mental Health

Children in the Medi-Cal program are eligible to receive the full range of Medi-Cal mental health services, and their specific mental health needs will determine the services they receive and the delivery system they will use to access such services. Most children previously in HFP that are seriously emotionally disturbed (SED) are already known to and served by the county MHPs; in these cases, the children continue to be served by the county MHP after they transition from HFP to Medi-Cal. The county MHPs will now receive new referrals from Medi-Cal managed care plans or self-referrals from former HFP enrollees for Medi-Cal specialty mental health services. The data in

the monitoring reports[4] illustrates that transitioned and OTLICP children are able to access Medi-Cal specialty mental health services following the transition.

Substance Use Disorder
Substance use disorder (SUD) treatment is a covered Medi-Cal benefit through the Drug Medi-Cal (DMC) program. Per regular communications with County Alcohol or Drug Program Administrators Association of California (CADPAAC) to ensure that transitioned children maintain access to treatment services, none of the transitioning children has experienced any break in the continuity of coverage or SUD treatment service thus far in the transition. From July 2013 – June 2014, 2880 transition and OTLICP children received SUD treatment services.

PROJECT STATUS

Reports
Monthly monitoring reports[5] were developed and submitted to CMS for purposes of satisfying the Bridge to Reform 1115 Demonstration Waiver, Special Terms and Conditions (STC) 117 and the statutory requirement to the California Legislature. The reports presented metrics that are relevant to the accomplishment of the HFP transition to Medi-Cal relative to the monitoring objectives, sources of data, and outcomes for the transition. The data provides state, Legislators, CMS, and stakeholders the ability to assess the ongoing success of the transition and the impact on children and families with regard to, maintaining coverage for transition children, the appropriate enrollment of new enrollees, timely access to care, continuity of care, provider capacity, and consumer satisfaction under each phase, consistent with Medicaid requirements. Monthly monitoring reports started on February 15, 2013 and continued through June 2014. Upon receipt of the each month's monitoring report, CMS and the State convened conference calls to discuss any questions or comments CMS had on the monitoring reports.

In addition, pursuant to W&I Code §14005.27(e)(10), the State developed and submitted a final comprehensive report[6] to the Legislature, CMS, and stakeholders on February 4, 2014. The information in this report summarizes:

- Populations of transitioned children and their integration into OTLICP, other Medi-Cal programs, or disenrollment from Medi-Cal;
- Children's ability to maintain services through the same/different providers and health plans (health, dental, mental health, and substance use disorder); and,
- Feedback from families via call centers, appeals, grievances, and surveys.

[4] *Healthy Families Program (HFP) Monitoring Reports* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx
[5] *Healthy Families Program (HFP) Monitoring Reports* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx
[6] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report*
http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

Federal Approval

On December 20, 2013, CMS approved State Plan Amendment (SPA) 13-005 effective November 1, 2013 for the transition of children from California's Children's Health Insurance Program (CHIP) to Medicaid under the Optional Targeted Low-Income Children's program. Specifically, this SPA disregards resources and family income above 200 percent of the federal poverty level and up to and including 250 percent of the federal poverty level for targeted low-income children. Also, this SPA imposes premiums for children whose family income is above 150 percent and up to and including 250 percent of the federal poverty level.

Administrative Vendor Contract

MRMIB had administered HFP enrollments, premium collection, data collection, and web services via an administrative vendor. Upon transitioning HFP to Medi-Cal, the State had developed and executed its own contract with the same administrative vendor to continue similar services for HFP beneficiaries under Medi-Cal effective January 1, 2013. The administrative vendor had been operative during the transition period with both MRMIB and DHCS. The newly established relationship with the DHCS has been collaborative and productive in providing a familiar source for former HFP families to obtain timely information during the transition phases.

Stakeholder Engagement

The State continued to convene regular meetings/webinars with stakeholders to provide updates and to review documents related to the HFP transition. Draft documents and final versions of documents are customarily posted on the HFP transition to Medi-Cal website[7] for public review and comment. An email address is posted on the website for questions and/or comments to be submitted to the State for response. Additionally, the various program areas: Eligibility, Managed Care, Dental, Mental Health, and Substance Use Disorders convened their own stakeholder meetings to have concentrated discussions on HFP transition efforts.

Beneficiary Notices

Per statutory requirements, beneficiaries subject to the transition must be notified in writing prior to the transition. A draft of these notices was provided to stakeholders and CMS for comment prior to mailing. Beneficiaries who transitioned in Phases 3, 4A, and 4B from July 1, 2013 through November 1, 2013 received all the required notices prior to their transition. The notices reminded children and families that the transitioning children would continue to receive coverage throughout their transition, what the changes to their health services would be if any and provided frequently asked questions and answers.

Information Systems Integration

Since the eligibility criteria for HFP and Medi-Cal are different, county information systems had to be changed to accommodate the new transition population and its information. The State led meetings with its county partners and technical stakeholders

[7] *HFP transition to Medi-Cal website http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx*

to define and execute the operational changes needed to transition HFP children to Medi-Cal. All transitioned children's case information has been successfully transferred to Medi-Cal for Phases 3, 4A, and 4B from July 1, 2013 through June 30, 2014.

Application and Enrollment Processes

Previously HFP enrollments were administered by the administrative vendor. Under Medi-Cal, applications would be processed by the county partners. Consequently, the State had a responsibility to establish policies and procedures for eligibility determinations, premium collection, cost sharing provisions, and performance metrics for application processing. The State worked closely with county partners, the administrative vendor, and stakeholders on these efforts. Ongoing communication and collaboration with these groups have yielded a mutual understanding of roles and responsibilities as well as new and continued coverage for beneficiaries.

Beneficiary Surveys

The State conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey was to provide direct feedback from impacted families on how the transition from HFP to Medi-Cal was going and to alert the State to any concerns. Beneficiaries' experiences were evaluated in areas of medical, dental, mental health, and substance use disorder services.

Evaluation Design

In compliance with the waiver amendment STCs, the State submitted a draft evaluation design to CMS on February 7, 2013. Subsequently, CMS provided comments and the State responded with revisions. The final evaluation design was submitted to CMS and shared with stakeholders on April 22, 20148. The evaluation design demonstrates the transition's successes with administrative efficiencies and minimal impact to beneficiaries.

QUANTITATIVE FINDINGS

The monthly monitoring reports[9] and the final comprehensive report[10] details the quantitative findings in various areas of the transition. Below are summaries of some of the results.

Eligibility

As of June 30, 2013, the State had successfully transitioned 614,495 children from HFP to Medi-Cal in Phases 1A, 1B, 1C, and 2, and enrolled 130,057 children into OTLICP. Upon completion of the transition for all phases, a total of 751,293 children transitioned from HFP to Medi-Cal with a total of 286,679 new children enrolled in OTLICP. Not all

[8] *HFP Transition to Medi-Cal Evaluation 4-22-14* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitionMedi-CalEval.pdf

[9] HFP Monitoring Reports http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx

[10] Healthy Families Program Transition to Medi-Cal Final Comprehensive Report http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

children initially identified to transition, actually did transition as a result of attrition and other factors such as failure to pay premiums or fulfill HFP reporting requirements.

In addition to the transitioned children and newly enrolled children, the State also processed annual renewals for transitioning beneficiaries. Table 4 shows the total number of children who underwent annual renewal in each month:

Table 4: Children in Annual Renewal[11]						
July 2013	**August 2013**	**September 2013**	**October 2013**	**November 2013**	**December 2013**	**Total Children**
22,700	22,740	22,747	22,748	22,753	22,762	***136,450***

Disenrollments were also captured during the transition as totals are shown for each month below[12]. There were no disenrollments in January 2013, as children would be evaluated for other Medi-Cal programs per Senate Bill 87. These children disenrolled from the transition population due to reasons of: eligibility for OTLICP, eligibility for other Medi-Cal programs, by request, failure to return annual eligibility redetermination, failure to respond to request for additional information, and other reasons.

Table 5: Disenrollment of Children[13]					
July 2013	**August 2013**	**September 2013**	**October 2013**	**November 2013**	**December 2013**
34,347	42,640	30,415	32,725	39,215	76,597

The high number of discontinuances in December 2013 shown in Table 5 was an accumulation of discontinuances not processed earlier in the year. For the period of January 2013 through March 2013, a manual process was implemented to disenroll children due to AERs not returned during those months. This manual process raised security concerns because it included emailing client data to counties via a secure email process. The manual process was ceased beginning with AERs due April 2013 and the automated process designed to disenroll children for non-receipt of AER forms was installed November 13, 2013. Because of the delay with the automated process, a large number of transitioned cases were not disenrolled until December 2013. The State sent discontinuance notices to beneficiaries and if responded to, beneficiaries

[11] *HFP Transition to Medi-Cal Monthly Monitoring Report January 22, 2014,* http://www.dhcs.ca.gov/services/Documents/HFPTransitiontoMedi-CalRprt1-22-14.pdf

[12] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

[13] *Healthy Families Program Transition to Medi-Cal Final Comprehensive Report* http://www.dhcs.ca.gov/services/hf/Documents/HFPTransitiontoMedi-CalFnlRprt(2-4-14).pdf

were reinstated to Medi-Cal coverage and the counties processed their AERs as appropriate.

Moreover, the State tracked continuity of care requests reported by the plans, and between January 1 through June 30, 2013, the health plans reported 182 continuity of care requests, which were resolved by assisting beneficiaries with selecting new or changing PCPs, providing information on prior authorizations, and clarifying behavioral health services covered.

In addition to tracking continuity of care requests, the State also tracked plan reports on grievances and appeals for transitioned children (Table 6), and call center volume (Table 7). Transitioning HFP beneficiaries were entitled to all the same appeal and grievance rights as existing Medi-Cal plan members. Grievances and appeals are filed when a member has an issue with access to providers or health services. The amounts are summarized the table below.

In evaluating the number of grievances and appeals reported by the plans in relation to the overall numbers of transitioning children, DHCS was satisfied that there were no outstanding concerns with plans or access that affected a significant number of the transitioning population.

Table 6: Grievances/Appeals for Transitioned Children[14]

	Jul	Aug	Sept	Oct	Nov	Dec
Eligibility Appeals	5	10	2	2	9	11
Member Health Plan Grievances (quarterly)	21			13		
Dental Appeals	1	2	3	6	5	2
Dental Grievances	7	5	4	2	4	6

Table 7 shows total calls received by our administrative vendors such as the Single Point of Entry (SPE), Health Care Options (HCO), Office of Ombudsman, Denti-Cal Beneficiary Customer Service Line, and Mental Health Ombudsman.

[14] *HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through June 30, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

Table 7: HFP Transition Related Calls Received[15]						
Call Centers	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Single Point of Entry	8,862	10,155	6,409	6,042	3,603	1,214
Health Care Options (HCO)	25,017	15,583	12,341	13,299	11,671	8,274
Office of Ombudsman (Medi-Cal Managed Care Division)	102	156	36	33	28	9
Denti-Cal (FFS) (not specific to HFP)	17,894	20,385	17,593	18,149	16,083	17,770
Mental Health Ombudsman	85	37	28	18	16	1

As the families became more familiar with the transition and fewer cases were transitioned to the State, the call volumes significantly reduced. During an actual transition month, with the exception of November where there was an unusual increase, call volumes seem to correlate with the family noticing process.

Calls to HCO would have been for not only plan choice, but also questions about the Medi-Cal Managed Care plans in the area and requests for Medi-Cal Managed Care materials. HCO call volume began to rise significantly in March and then nearly doubled in April, the month in which the 30-Day notice for Phases 1C and 2 were sent out and the month of transition for both of those phases, respectively. Call volume remained high over the summer, which was expected considering these were the months leading up to Phase 3 which required enrollment packets to be sent out an a plan choice to be made. After the Phase 3 transition, call volume began to decline toward the end of the transition.

The Medi-Cal Managed Care Ombudsman Office showed peaks in the months during which a transition was scheduled: January, March, April, and August mainly, though call volume remained low for the Phase 4 transition months of September and November. By the end of the year, the call volume had tapered off significantly.

Dental

From July 2013 to December 2013, the average number of days between scheduling an appointment and the actual appointment date for dental services was 6 days; average number of newly enrolled providers was 50.5 per month; average number of disenrolled

[15] *HFP Transition to Medi-Cal Monthly Monitoring Reports February 15, 2013 through January 22, 2014.* http://www.dhcs.ca.gov/services/hf/Pages/MonitoringReports.aspx.

providers was 25.33 per month; number of warm phone call transfers started from 580 in July to 373 in December; the percentage of warm transfers with a successful referral to a provider is 100%; average percentage of successful referrals that resulted in a scheduled appointment averages 78.5% per month; and, there were no continuity of care requests reported.

Mental Health

The number of transitioned and OTLICP children who received Medi-Cal specialty mental health services are as follow for each month:

Table 8: Children Received Specialty Mental Health Services *(As of 10/23/14)*					
July 2013	***Aug 2013***	***Sept 2013***	***Oct 2013***	***Nov 2013***	***Dec 2013***
8,542	9,528	10,188	11,176	11,217	10,837

The data in Table 8 was refreshed on 10/23/14 to show access to services for the remainder of the demonstration period, as data previously reported may be under represented due to the lag in claims submission. Nonetheless, the data shows transitioned and OTLICP children are able to access Medi-Cal specialty mental health services following the transition.

Substance Use Disorder

As of June 30, 2014, there were 564 certified Drug Medi-Cal providers. No county reported a waiting list for youth treatment. Below is a breakdown in the number of beneficiaries that received services per claims data:

Table 9: Children Received SUD Services (per claims data)					
Medicaid Aid Code	**5C**	**5D**	**H4**	**H5**	**Total**
July 2013	32	52	75	38	**197**
August 2013	36	59	102	56	**253**
September 2013	32	43	113	58	**246**
October 2013	26	57	127	65	**275**
November 2013	28	57	128	80	**291**
December 2013	16	44	126	85	**267**

QUALITATIVE FINDINGS/CASE STUDIES

Beneficiaries' experiences were evaluated in areas of medical, dental, mental health, and alcohol and drug services. The State conducted call campaigns to beneficiaries in each transition phase to survey their experiences with the transition. The purpose of the survey is to provide the State with direct feedback from impacted families on how the HFP transition to Medi-Cal is going and to alert the department to any concerns. Generally, transitioned beneficiaries scored the following for overall satisfaction:

Beneficiary Survey Satisfactory Ratings[16]							
	Phase 1A	**Phase 1B**	**Phase 1C/2**	**Phase 1C**	**Phase 3**	**Phase 4A**	**Phase 4B**
5 - Highest	63.61%	56.81%	57.14%	47.83%	49.22%	31.53%	40.62%
1 - Lowest	2.6%	5.5%	5.2%	7.4%	7.6%	14%	10.6%

For dental services, the State sent a survey to providers to determine provider capacity, their ability to accept new Medi-Cal beneficiaries, and to identify barriers to enrollment. Surveys were sent to three provider groups: Denti-Cal only billing providers, HFP only providers, and HFP/Denti-Cal providers. Survey results allowed the State to assess the number of providers that planned to enroll in Denti-Cal or contract with Medi-Cal dental managed care plans and continue providing services to their HFP children.

The results were: 11,852 surveys were mailed to providers and a little over 7,000 phone calls to providers were made using this survey. The State received a total of 9,328 surveys of which 4,683 were completed. Of those that submitted a completed survey, 2,784 Denti-Cal providers indicated that they would continue to treat children who transitioned from HFP to Medi-Cal. Survey results demonstrated providers' ability to increase their practice by a self-reported 391,000 beneficiaries across all counties. In addition, of the providers surveyed, 92 percent of HFP children would be able to remain with their same provider.

UTILIZATION DATA

Nothing to report.

POLICY AND ADMINISTRATIVE DIFFICULTIES IN THE OPERATION OF THE DEMONSTRATION

There were issues brought to the attention of the State regarding children diagnosed with autism and the access to applied behavioral analysis (ABA) services. Specifically, based on survey information provided by the health plans, approximately 500 children of

[16] *HFP Transition to Medi-Cal Beneficiary Surveys.* http://www.dhcs.ca.gov/services/hf/Pages/BeneficiarySurveys.aspx

the total transitioned population (.07 percent) were impacted. While ABA services are not discrete services available under Medi-Cal, other services used in the treatment of children with autism such as physical, speech or physical therapy are available based on the medical needs of the child and meeting medical necessity requirements for the identified services.

As previously mentioned regarding Table 5, there were a high number of discontinuances in December 2013 due to an accumulation of discontinuances not processed earlier in the year. The manual process to discontinue cases because of security concerns, beginning with AERs due April 2013 and the automated process designed to disenroll children for non-receipt of AER forms was installed November 13, 2013. As a result of the delay with the automated process, a large number of transitioned cases were not disenrolled until December 2013. The State sent discontinuance notices to beneficiaries and if responded to, beneficiaries were reinstated to Medi-Cal coverage and the counties processed their AERs as appropriate.